End Homelessness St. John’s Intensive Case Management Program Model – Key Elements

June 2015

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July, 2015
Integrated case management puts clients at the centre – and gives them an active voice in shaping services that will support them in directing their own lives, now and in the future.¹

The choice to implement Intensive Case Management in a Housing First context speaks to a strong commitment to addressing issues of homelessness in a sustainable way.²

Case management for ending homelessness is: a collaborative community-based intervention that places the person at the centre of a holistic model of support necessary to secure housing and provide supports to sustain it while building independence.³

Housing is a right for all people, not the result of compliance or a reward.⁴


Goss Gilroy Inc.
### List of Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>Assertive Community Treatment</td>
</tr>
<tr>
<td>ASIST</td>
<td>Applied Suicide Intervention Skills Training</td>
</tr>
<tr>
<td>CMHHW</td>
<td>Community Mental Health and Housing Workers</td>
</tr>
<tr>
<td>EHSJ</td>
<td>End Homelessness St. John’s</td>
</tr>
<tr>
<td>GGI</td>
<td>Goss Gilroy Inc.</td>
</tr>
<tr>
<td>HF</td>
<td>Housing First</td>
</tr>
<tr>
<td>HPS</td>
<td>Homelessness Partnering Strategy</td>
</tr>
<tr>
<td>ICM</td>
<td>Intensive Case Management</td>
</tr>
<tr>
<td>IKH</td>
<td>Iris Kirby House</td>
</tr>
<tr>
<td>MHCC</td>
<td>Mental Health Commission of Canada</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>NLHHHN</td>
<td>Newfoundland and Labrador Housing and Homelessness Network</td>
</tr>
<tr>
<td>PWLE</td>
<td>People with Lived Experience</td>
</tr>
</tbody>
</table>
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1.0 Introduction

Goss Gilroy was contracted by the City of St. John's and End Homelessness St. John's (EHSJ) to lead the development of a coordinated Intensive Case Management (ICM) Program model and resulting Homelessness Partnering Strategy (HPS) proposal for approval by EHSJ. Jaime Rogers, manager with the Medicine Hat Community Housing Society, is the expert advisor to this project.

This report is in partial completion of this contract. It provides a comprehensive overview of the key elements of the proposed St. John’s ICM Program model.

2.0 The Context for the ICM Model

The 2014-2019 St. John's Community Plan to End Homelessness proposes a vision to end homelessness in St. John's by 2019. The Plan builds on, and is informed by, the experience gained since 2000 by EHSJ and its predecessor, the St. John's Community Advisory Committee on Homelessness. Over that period, the Committee has gained considerable expertise in developing partnerships and has channeled considerable government funding to improve the shelter and housing infrastructure and continuum of support services offered by community organizations and government.

The Plan is based on a systems approach grounded in Housing First (HF) as the guiding philosophy. HF calls for a person-centered approach where housing is a right, rather than a privilege. The principles behind the HF strategy involve a focus on housing individuals directly from the street or shelter; providing services in a client-centered, solution focused manner; greater system coordination of existing services and resources; and providing a range of innovative programs designed to meet specific needs of homeless individuals in accessing housing. In summary, this approach is founded on moving people into appropriate housing quickly, with the right supports, at the right time.

The Plan sets out four priority areas which will result in further development of specific aspects of the continuum of housing and related supports for individuals who experience homelessness. These include systems coordination; integrated information system and research; leadership and resources; and housing and supports.

The development and implementation of an ICM Program model is a component of the housing and supports priority. The model is designed to provide a coordinated continuum of services and supports for an estimated 160 individuals who are chronically and episodically homeless over years two to five of the Plan (2015-2019). The ICM Program model will be implemented as one
of several HF programs under the Community Plan to address a range of client needs, including Permanent Supportive Housing, Rapid Rehousing and Prevention. The improvements in service resulting from the ICM model are expected to contribute to ending chronic and episodic homelessness, which in turn will reduce pressure on shelters and public systems.

To end homelessness by 2019, the Community Plan will develop the necessary housing and supports to assist over 460 individuals – 160 of whom will be chronically and episodically homeless. This will require the coordinated efforts and resources of government, non-profit and business sectors, as well as the research and faith communities. The total cost of implementing the measures outlined in this Plan will be approximately $7.7 million. The federal HPS allocation will contribute about $3.5 million of this cost ($1.1 million for ICM, $1.1 million for HF system coordination, $0.7 million for permanent supportive housing capital and $0.6 million for rapid re-housing and homelessness prevention), but other government partners and private investors are needed to help meet the Plan’s matching resource needs. The proposed budget for the St. John’s ICM Program is provided as a separate attachment.

The implementation of the actions outlined in the Plan will result in the following outcomes:

1. End chronic and episodic homelessness.
2. Rehouse and support 460 homeless persons: of these, a minimum of 160 will be chronically and/or episodically homeless.
3. Reduce average length of stay in emergency shelters to 7 days.
4. Develop a coordinated homeless-serving system.
5. Enhance the integration of public systems to reduce exiting into homelessness
6. Align resources and funding across diverse sectors to support the St. John’s Community Plan to End Homelessness.

The following program types will be priority investment areas which will leverage HPS allocations.

<table>
<thead>
<tr>
<th>Program</th>
<th>Target Client Group</th>
<th>Total Estimated Individuals Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive Case Management</td>
<td>Chronically and episodically homeless</td>
<td>155</td>
</tr>
<tr>
<td>Permanent Supportive Housing</td>
<td>Chronically homeless</td>
<td>13</td>
</tr>
<tr>
<td>Rapid Rehousing/Prevention</td>
<td>Transitionally homeless</td>
<td>300 (approx. 200 households)</td>
</tr>
</tbody>
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ICM Projections

The following ICM projections were determined in advance of the research to develop the ICM model.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>HPS funding</td>
<td>348,712.50</td>
<td>348,712.50</td>
<td>200,170.00</td>
<td>200,170.00</td>
<td></td>
</tr>
<tr>
<td>HPS-supported</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>78</td>
</tr>
<tr>
<td>Unique New Clients Served (Turnover)</td>
<td>35</td>
<td>18</td>
<td>13</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Ongoing Capacity</td>
<td>35</td>
<td>35</td>
<td>20</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Partners</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>77</td>
</tr>
<tr>
<td>Unique New Clients Served (Turnover)</td>
<td>35</td>
<td>18</td>
<td>12</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Ongoing Capacity</td>
<td>35</td>
<td>35</td>
<td>20</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Partners’ Matching Funding</td>
<td>348,712.50</td>
<td>348,712.50</td>
<td>200,170.00</td>
<td>200,170.00</td>
<td></td>
</tr>
<tr>
<td>Combined</td>
<td>70</td>
<td>36</td>
<td>25</td>
<td>24</td>
<td>155</td>
</tr>
<tr>
<td>Total New Clients</td>
<td>70</td>
<td>36</td>
<td>25</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Total Capacity</td>
<td>70</td>
<td>70</td>
<td>40</td>
<td>40</td>
<td></td>
</tr>
</tbody>
</table>

Revised ICM projections were developed based on the following, and are presented in the table on the next page:

- A shortened year two (September, 2015 – March 31, 2016).
- The ICM model will be operationalized as a new Program – with new approaches (ICM and HF).
- There will be a new staff team (though the Program likely will be drawing on existing expertise).
- The needed level of systems support will be developed over time.
- The research identifies that it takes a minimum of six months to develop the depth of relationship with clients for the intensive case management needed to support them to move to self-sufficiency.
- Relationships will have been built with some of the clients prior to the ICM Program initiation.
- The staffing model based on a 1:15 caseload allows for 35 clients in year two (3 Intensive Case Managers) and 70 client in years three and four (based on an anticipated 5 Intensive Case Managers)
An updated budget (provided as a separate attachment)

The intent is to support 155 clients over the life of the Plan. The revised projections allow for starting with the 35 clients and allowing for less turnover in the early years as all stakeholders “learn”. It builds over years three and four as expertise is maximized – and then ramps down from year four to five as all aspects of the programs are efficient and effective and required systems are in place.

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td><strong>HPS funding</strong></td>
<td>348,712.50</td>
<td>348,712.50</td>
<td>200,170</td>
<td>200,170</td>
<td>155</td>
</tr>
<tr>
<td><strong>HPS-supported</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unique New Clients Served</td>
<td>18</td>
<td>25</td>
<td>20</td>
<td>15</td>
<td>78</td>
</tr>
<tr>
<td>Exited/Remaining Clients</td>
<td>8/10</td>
<td>20/15</td>
<td>25/10</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Partners' funding</strong></td>
<td>284,887.50</td>
<td>737,987.50</td>
<td>886,530</td>
<td>571,387</td>
<td></td>
</tr>
<tr>
<td><strong>Partner-supported</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unique New Clients Served</td>
<td>17</td>
<td>25</td>
<td>20</td>
<td>15</td>
<td>77</td>
</tr>
<tr>
<td>Exited/Remaining Clients</td>
<td>7/10</td>
<td>20/15</td>
<td>25/10</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Combined</strong></td>
<td>35</td>
<td>50</td>
<td>40</td>
<td>30</td>
<td>155</td>
</tr>
<tr>
<td><strong>Total Capacity</strong></td>
<td>35</td>
<td>70</td>
<td>70</td>
<td>50</td>
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</tbody>
</table>

**Performance targets**

EHSJ’s ICM Call for Proposals specified the expected outputs and outcomes associated with the Program, including targets in service delivery for fiscal years 2015-2016 and 2016-2017. The following presents the revised targets based on the assumptions above.

<table>
<thead>
<tr>
<th>Performance Targets</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new individuals placed in housing through an HF intervention (with HPS funds)</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>Number of new individuals placed in housing through an HF intervention (with partners' funds)</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>Percentage of HF clients who remained in housing at six months</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Percentage of HF clients who remained in housing at twelve months</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Number of days to move HF clients into permanent housing (after intake or assessment - to be determine by the community)</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Percentage of HF clients who require re-housing</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Percentage of HF clients who return to homelessness</td>
<td>15%</td>
<td>15%</td>
</tr>
</tbody>
</table>
## 2.1 Housing First

HF is a consumer-driven approach that provides immediate access to permanent housing for people experiencing homelessness, without requiring psychiatric treatment or sobriety as determinants of “housing readiness”.  

The underlying principle of HF is that people are more successful in moving forward with their lives if they are first able to access housing that meets their needs. It is a rights-based intervention rooted in the philosophy that all people deserve housing and that adequate housing is a precondition for recovery.

As a *philosophy*, the HF approach is premised on the assumption that the first and primary need of an individual who is homeless is to obtain stable, permanent housing. Once stable housing is obtained, other more enduring issues, such as addictions or mental health, can be appropriately addressed.

As an *intervention*, the HF approach involves moving individuals who are chronically or episodically homeless from the streets or homeless shelters directly into permanent housing. Permanent housing is complemented by the provision of services to assist clients to sustain their housing and work towards recovery and reintegration into the community.

The target population for the HF approach under HPS is individuals who are chronically and episodically homeless. HPS has defined these populations as follows:

- Chronically homeless refers to individuals, often with disabling conditions (e.g., chronic physical or mental illness, substance abuse problems), who are currently homeless and

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5 Canadian Housing First Toolkit – Key Questions. Available from [http://www.housingfirsttoolkit.ca/key-questions1](http://www.housingfirsttoolkit.ca/key-questions1).
have been homeless for six months or more in the past year (i.e., have spent more than 180 cumulative nights in a shelter or place not fit for human habitation).

- Episodically homeless refers to individuals, often with disabling conditions, who are currently homeless and have experienced three or more episodes of homelessness in the past year (of note, episodes are defined as periods when a person would be in a shelter or place not fit for human habitation, and after at least 30 days, would be back in the shelter or uninhabitable location).

Of note, once 90% of the target population are in housing, the St. John’s ICM Program will serve those who fit the following definitions (as adopted by the EHSJ Board from the Canadian Observatory on Homelessness):

- Chronic: Those who have either been continuously homeless for a year or more, or have had at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter.

- Episodic: A person who is homeless for less than a year and has fewer than four episodes of homelessness in the past three years.

Clear core principles have been articulated for HF in order to guide planning and implementation. From a quality assurance perspective, such principles can become necessary to ensuring fidelity to the overarching goal of HF. While a number of programs and communities have attempted to articulate core principles (and these vary somewhat in emphasis)\(^8\), the following are mandatory principles under the HPS HF approach:\(^9\)

**Rapid housing with supports** - HF involves providing clients with assistance in finding and obtaining safe, secure and permanent housing as quickly as possible. Key to the HF philosophy is that individuals and families are not required to first demonstrate that they are ‘ready’ for housing. Housing is not conditional on sobriety or abstinence. Program participation is also voluntary.\(^10\)

**Offering clients choice in housing** - HF is a rights-based, client-centred approach that emphasizes client choice in terms of housing and supports.

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\(^8\) Ibid. Pg. 5.


\(^10\) Stephen Gaetz, Fiona Scott & Tanya Gulliver (Eds.) (2013): Housing First in Canada: Supporting Communities to End Homelessness. Pg. 5.
Separating housing provision from treatment services - Acceptance of any services, including treatment, or sobriety is not a requirement for accessing or maintaining housing, but clients must be willing to accept regular visits, often weekly. There is also a commitment to rehousing clients as needed.

Providing tenancy rights and responsibilities - Clients are required to contribute a portion of their income towards rent. The preference is for the client to contribute 30% of their income, while the rest would be provided via rent subsidies. A landlord-tenant relationship must be established.

Integrating housing into the community - In order to respond to client choice, minimize stigma, and encourage client social integration, more attention should be given to scattered-site housing in the public or private rental markets.

Recovery-based and promoting self-sufficiency - The goal is to ensure clients are ready and able to access regular supports within a reasonable time frame, allowing for a successful exit from the HF program. Of note, in relation to this principle, for those with addictions challenges a recovery orientation also means access to a harm reduction environment.

3.0 Methodology

3.1 Research and jurisdictional review

To inform the St. John’s ICM Program model, comprehensive research and a literature and jurisdictional review were undertaken reviewing ICM and HF programs, policies, practices and principles.

The jurisdictional review focused on successful ICM models in other Canadian cities of similar size to St. John’s (as possible). Following discussions with the Project Advisory Committee as well as suggestions from community and government stakeholders in St. John’s and preliminary research, the following programs/services were reviewed.

1. The Infinity Project – Calgary
2. HomeBase – Calgary (A HF Program based on the HomeBase program is in the planning stages for the Halifax Regional Municipality.)
3. At Home / Chez Soi - Toronto project site (Mental Health Commission of Canada – MHCC)
4. FACT – out of the Netherlands, this model is being implemented in New Brunswick. While this is an elaboration of Assertive Community Treatment (ACT), and not an ICM, it does provide relevant learnings.

5. Moving Forward – St. John’s
6. Community Support Program – St. John’s
7. Case Management Services – The Strengths Model (Eastern Health) – St. John’s
8. Medicine Hat’s Plan to End Homelessness/HF Programs

The jurisdictional review is provided in a separate report. All of the summaries included therein were vetted by the relevant program representative in advance of being included in the report, with the exception of the FACT model. Information on this program was drawn from the program manual.

A comprehensive bibliography of sources accessed in the development of the St. John’s ICM model is found in Appendix ``A``.

### 3.2 Survey of people experiencing chronic/episodic homelessness

#### 3.2.1 Methodology

The perspectives of 23 individuals targeted for the St. John’s ICM Program, i.e., those who have significant complexities and are chronically/episodically homeless of long-term duration, were garnered to inform the ICM Program model development. The intent of the survey process was to provide the target group with an opportunity to identify how the Program could be responsive to their circumstances and realities.

To address the challenges of engaging this population, front-line staff who have established a relationship with the individuals conducted the interviews, utilizing an introduction to the survey and a short survey guide we developed. Representatives of participating organizations were communicated with in advance of implementing the surveys to ensure they understood the potential target group to be identified and the survey process itself. Each individual who participated in the survey process was provided with $10 cash or a $10 gift card at the discretion of the organizations interviewing the individuals.

A cross-section of individuals to be surveyed was ensured taking into account age and gender, as well as length of time homeless and complexity of issues. Client identifiers - gender and dates of birth – allowed us to determine that there was only one duplicate survey undertaken.
The following organizations, in no particular order, were invited to take part in this survey process:

- AIDS Committee of NL
- Choices for Youth
- Iris Kirby House
- John Howard Society of NL – St. John`s location
- Marguerite’s Place
- St. John`s Native Friendship Centre
- Stella’s Circle
- The Assertive Community Treatment (ACT) Team – Eastern Health
- The Gathering Place
- The Salvation Army New Hope Community Centre
- Thrive Community Youth Network – St. John`s

Two of the organizations were unable to connect with potential survey participants, and one had not been granted permission to participate by the time of writing this report. The 23 survey respondents were interviewed by eight organizations.

The survey tool is found in Appendix “B”.

### 3.2.2 Survey Findings

#### Demographics

Of the 23 individuals participating in the client survey, 57% were male and 44% were female and included a range of ages as noted in Table 1. Most survey respondents were between 31 and 40 years of age; 22% of the respondents also were under the age of 20.

Table 1: age range of survey respondents (n=23)

<table>
<thead>
<tr>
<th>Age range</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>22%</td>
</tr>
<tr>
<td>21-30</td>
<td>9%</td>
</tr>
<tr>
<td>31-40</td>
<td>30%</td>
</tr>
<tr>
<td>41-50</td>
<td>9%</td>
</tr>
<tr>
<td>51-60</td>
<td>17%</td>
</tr>
<tr>
<td>61-70</td>
<td>9%</td>
</tr>
<tr>
<td>No age reported</td>
<td>4%</td>
</tr>
</tbody>
</table>

### Note

11 Percentages cited in Tables may not equal 100% due to rounding.
Current living arrangements

Survey respondents were also invited to state their current living arrangements (they could provide multiple responses). This information is provided in Table 2. Just under 10% were living in:

- Hospital/medical facility
- Dwelling unfit for human habitation
- Long-term housing with supports
- Boarding/lodging home
- Addiction treatment facility
- Renting – subsidized

The majority of the respondents were living in unsubsidized/private rental arrangements (57%).

**Table 2: Current living arrangements of survey respondents (n=23)**

<table>
<thead>
<tr>
<th>Current living arrangements</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child intervention services placement</td>
<td>-</td>
</tr>
<tr>
<td>Bed and breakfast</td>
<td>-</td>
</tr>
<tr>
<td>Own home</td>
<td>-</td>
</tr>
<tr>
<td>Hotel/motel</td>
<td>-</td>
</tr>
<tr>
<td>Hospital/medical facility</td>
<td>9%</td>
</tr>
<tr>
<td>Dwelling unfit for human habitation</td>
<td>9%</td>
</tr>
<tr>
<td>Long-term housing with supports</td>
<td>9%</td>
</tr>
<tr>
<td>Boarding/lodging home</td>
<td>9%</td>
</tr>
<tr>
<td>Addiction treatment facility</td>
<td>9%</td>
</tr>
<tr>
<td>Renting – subsidized</td>
<td>9%</td>
</tr>
<tr>
<td>Transitional housing</td>
<td>13%</td>
</tr>
<tr>
<td>Correctional facility</td>
<td>17%</td>
</tr>
<tr>
<td>Emergency shelter</td>
<td>17%</td>
</tr>
<tr>
<td>Outside (rough sleeping, camping, vehicle)</td>
<td>17%</td>
</tr>
<tr>
<td>Staying with family/friends</td>
<td>22%</td>
</tr>
<tr>
<td>Renting – unsubsidized/private housing</td>
<td>57%</td>
</tr>
</tbody>
</table>

Current housing needs

The survey respondents’ current housing needs were as follows:

- Moving from a shelter to housing- 32%
End Homelessness St. John’s Intensive Case Management Program Model – Key Elements

- Rehoused\(^{12}\) from current housing situation - 35%
- Long-term housing with supports - 39%
- Housing with minimal supports - 39%
- Financial assistance to remain in their housing - 48%
- Referral for services to maintain housing - 57%

Help needed in day-to-day life

Survey respondents were asked what kind of help they needed in their day-to-day lives (they could provide multiple responses). As can be seen in Table 3, the respondents had a range of needs with transportation/bus passes being cited by the majority.

**Table 3: Help needed day-to-day**

<table>
<thead>
<tr>
<th>Day-to-day help needed</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation/bus passes</td>
<td>52%</td>
</tr>
<tr>
<td>Meal preparation/reminders to eat</td>
<td>48%</td>
</tr>
<tr>
<td>Making/keeping appointments</td>
<td>44%</td>
</tr>
<tr>
<td>Budgeting</td>
<td>39%</td>
</tr>
<tr>
<td>Socializing/money for social activities</td>
<td>35%</td>
</tr>
<tr>
<td>Reminders to take medications</td>
<td>35%</td>
</tr>
<tr>
<td>Grocery shopping</td>
<td>30%</td>
</tr>
<tr>
<td>Counseling/anger management/dealing with conflict/bad relationships</td>
<td>22%</td>
</tr>
<tr>
<td>Finding/maintaining housing</td>
<td>22%</td>
</tr>
<tr>
<td>Getting up/bathing</td>
<td>22%</td>
</tr>
<tr>
<td>More money for nutritious foods</td>
<td>22%</td>
</tr>
<tr>
<td>Household chores</td>
<td>17%</td>
</tr>
<tr>
<td>Supports with drug use/SWAP supplies/daily methadone</td>
<td>13%</td>
</tr>
<tr>
<td>Seeking employment</td>
<td>9%</td>
</tr>
<tr>
<td>Child care</td>
<td>9%</td>
</tr>
<tr>
<td>Household necessities/furniture</td>
<td>9%</td>
</tr>
<tr>
<td>Additional Income Support/day-to-day living expenses</td>
<td>9%</td>
</tr>
<tr>
<td>Encouragement/motivation</td>
<td>9%</td>
</tr>
<tr>
<td>Need a phone</td>
<td>4%</td>
</tr>
<tr>
<td>Reconnecting to school</td>
<td>4%</td>
</tr>
<tr>
<td>Navigating systems</td>
<td>4%</td>
</tr>
<tr>
<td>Home support</td>
<td>4%</td>
</tr>
</tbody>
</table>

\(^{12}\) "Rehoused" is a commonly accepted term in the homeless serving sector denoting a specific activity and context. A Rapid Rehousing Program is a goal under EHSJ’s Community Plan.
To address homelessness

Survey respondents highlighted the following issue areas as being critical for addressing homelessness: housing, funding and access to services.

- Housing
- Funding
- Access to services

3.3 Consultation and collaboration process

Following the initial stage of the research/jurisdictional review and survey, a half-day stakeholders meeting was held on May 11, 2015, in St. John’s at the Newfoundland and Labrador Housing and Homelessness Network’s (NLHHN’s) Learning Centre. This session included representation from community-based organizations and government agencies which have or could reasonably have a future role in providing supports and services to individuals who are homeless. Jaime Rogers from Medicine Hat also was present for this meeting.

The intent of the meeting was to overview the proposed St. John’s ICM Program model. Jaime Rogers described the ICM/HF model in practice.

A second and follow-up meeting was held on May 12 at the Learning Centre. The intent of this meeting was to more specifically identify those groups/agencies who were considering whether or not they could play a primary (leadership/management and/or funding) or secondary (e.g., provision of supports and services) role in the implementation and evolution of the St. John’s ICM Program. It is understood that the work of the primary service deliverers/leaders would be intensive and require the requisite skills and expertise be available within/to the organizations/agencies in question. Those who might identify to play a secondary role could provide services and supports to the clients who will be supported through the Program.

In the interim, meetings have been held with a smaller working group of community-based organizations which identified as wishing to take on leadership roles in the project and/or fine-tune the model.
THE ST. JOHN'S ICM PROGRAM

4.0 Program leadership

Strong leadership will be required to successfully implement and evolve the St. John's ICM Program. The lead organization(s)/agency(ies) must have a clear vision for the Program and plan strategically for its implementation, ensure adherence to fidelity of the model on which the Program is based and develop a collaborative culture in which partners are welcome and valued for their contributions and knowledge. Further, they must have a focus on distributing leadership - e.g., ensuring all members of the team are contributing to the strength of the Program.

It is recommended that leadership for the St. John’s ICM Program be shared between two long-standing, well-established homelessness serving organizations with significant experience with the intended target group: Choices for Youth (Choices) and Stella’s Circle.

Stella’s Circle and Choices for Youth serve hundreds of individuals a year - all of whom have challenges and complexities (e.g., poverty, mental illness, addictions and/or homelessness) which can impact their capacity and ability to be self-sufficient and independent in their lives.

Stella's Circle

Stella’s Circle’s mission is to address the impact and root causes of poverty, abuse and oppression by developing support services that promote community inclusion and by advocating for social policy changes that transform oppressive systems.

Stella’s Circle's programs and services address three essential needs:

- Real Help: counselling and support for those who are attempting to return to the community following periods of incarceration, hospitalization or other marginalization;
- Real Homes: affordable housing development and programs that ensure security and stability; and
- Real Work: training and skill development, literacy education and employment.

The organization offers a range of residential, community, and correctional-based counseling services, including the Community Support Program (CSP), employment and education programs, as well as affordable and/or supportive housing.

The CSP, which was profiled in the jurisdictional review, provides intensive assistance to people with complex mental health needs, with the goal of improving the overall quality and
stability of participants’ lives and reducing the length and number of admissions to hospitals and prisons. This program has been running an intensive case management team since the early 2000s.

Stella's Circle also operates the Brian Martin Housing Resource Centre. The home base for Stella's Circle's Supportive Housing Program, the Resource Centre staff see several hundred new people every year looking for assistance with a multitude of housing issues/challenges. They assist with a range of housing requests including finding housing, maintaining housing, system navigation and life skills support. The Resource Centre offers individuals an assessment to determine their level of support/acuity and to identify a responsive support plan based on that assessment. These services are primarily directed to individuals of low income who could not find or maintain housing without support/assistance/intervention. Once an individual has housing, staff is assigned to enhance their housing stability.

The staff at the Centre deliver elements of diversion, rapid rehousing, HF and permanent supportive housing.

**Choices for Youth**

Since 1990, Choices has worked to empower at-risk youth in St. John’s, believing that stable housing, employment and education are the three Key Life Factors for independence and healthy transitions to adulthood. Choices is based on the philosophy that everyone has a right to:

- Safe housing;
- A standard of living that promotes physical, mental, emotional, psychological and social development;
- An environment of mutual accountability, responsibility, independence, equality, dignity, peace, and respect;
- Protection from abuse; and
- Participation in any decision-making that affects their lives.

Choices strives to provide at-risk youth with programming informed by their experiences, the participants in its current programs and respected national programming and research. Each program offers unique support services and resources, which together span four areas of focus: crisis response, supportive housing, targeted supports and fostering independence.

Choices delivers the Moving Forward Program, which was profiled in the jurisdictional review. Moving Forward was established in 2009 in recognition of the fact that there was a need to address the critical gap in services (lack of an intensive support program) for youth between the ages of 16-24, with high risk behaviors and mental health needs. The program is
modeled after the CSP. The belief is that with the appropriate mix of intensive supports, youth struggling with complex mental health issues, who have exhausted services within many systems, can successfully live on their own in the community.

Moving Forward has developed an outreach service model, which provides these intensive case management supports and services through a flexible and holistic continuum of care designed to meet the needs of the target group while assisting them with learning valuable life skills, based on their individual needs.

Thus, the overarching goal of Moving Forward is to empower youth to assume control over their lives by teaching them interpersonal and practical life skills that better enable them to make good decisions and live independently. Additionally, Moving Forward is designed to increase engagement and build a sense of purpose, self-worth, and connectedness.

Of note, Choices offered a Supportive Housing Program (10 years) which reflected in many ways the ICM Program being proposed for St. John’s. Although the program is no longer funded due to changes within Child, Youth and Family Services, this program was an effective intervention due to its HF orientation. This model included portable supports (e.g., rent) that were not based on a fixed address and focused on creating housing stability. Like Stella's Circle, Choices has developed knowledge and expertise in the areas of HF and intensive case management.

Currently, Choices is leading an initiative designed to enable a provincial response to youth homelessness. One of the significant pieces of this work has been contributing to national research (published through the Homeless Hub) on the adaptation of HF to a youth context. In particular, this research highlighted that housing options and support systems must look different from those of adult systems due to a number of age/developmental factors.

A service agreement has been developed to guide the partnership arrangement between Stella’s Circle and Choices. This details the administrative arrangements for the Program, the key processes for its delivery and in general how the partners will coordinate and collaborate to ensure the needs of the target groups are met. The design of this service agreement was informed by the Memorandum of Understanding (MOU) developed for the partners for the At Home / Chez Soi site in Toronto, the MOU developed by NAVNET for information sharing between and among partner organizations and a funding service agreement used by Homeward Trust Edmonton.

It is important to state that the ICM Program is one which will serve and support the target population who are connected to many and varied organizations. Vesting the leadership in these two organizations does not in any way diminish availability of Program supports and services to the full community.
4.1 People with lived experience

Consumer choice is one of the pillars of HF. It is about helping people access what they feel they need, rather than trying to give someone a treatment or intervention that someone else thinks they need. It is important for communities to understand HF is not rigid, but rather adaptable, provided the program adheres to the [core] principles. There is flexibility in the program model to respond to the needs of unique populations. In order to respond to those needs, it is important to actively consult with members from each group who will access services to identify their needs and allow their support to be consumer-driven.13

It is important to state, as well, that those who experience homelessness can often feel powerless and/or that they are not taken seriously by those in society who hold power. The formation of advisory groups can provide a starting point for turning those dynamics around and empowering people affected. People with Lived Experience (PWLE) are a valuable asset in service programs and delivery, in that they are able to provide a unique skill set: peer support. PWLEs are able to offer support to clients from an equal “playing field” because of the common mutual lived experience that both the peer and the client share. As suggested above, forming advisory groups of PWLEs can be beneficial to informing decision-making; however, it can also provide strength to a cause – providing a forum for peers to interact, reducing their isolation and supporting both the peer and the mentee’s personal growth and leadership skills. Being involved in peer groups and solicited for their personal experience allows PWLEs to connect with others in their community, and helps them to build social relationships, thereby promoting their own societal integration.14

To that end, it is recommended that an Advisory Committee of PWLE be established for the St. John's ICM Program. A similar body (a Caucus) guided the At Home / Chez Soi study at the Toronto site. PWLE were engaged as part of the ongoing planning, development and execution of the study and provided advice and expertise during the study development process, in addition to advising on all aspects of the project, including service provision and research protocols for the duration of the study. This Caucus was one of the members of the intersectoral partnership which was leading implementation of the Toronto site’s ICM and ACT At Home / Chez Soi programs.

This Caucus helped ground the project in the lived experience of participants, enhanced project capacity to advocate for resources, and led to adaptations in housing and support services

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delivery. It is important to state, however, that engagement of this population for such an advisory body is not an easy task and requires a level of planning and ongoing commitment to their engagement.

Findings from the evaluation of the Toronto At Home / Chez Soi site presented the challenges of engaging PWLE. It was stated that facing time constraints and given little direction, the Toronto Caucus developed through a tumultuous process related to both internal and external barriers to meaningful inclusion. Despite the challenges, the Caucus contributed meaningfully to various aspects of the At Home / Chez Soi project. It was determined that it is possible to successfully integrate consumers with experience of homelessness in many aspects of research and service planning.

Suggestions emanating from this experience for other projects hoping to engage consumers included: early involvement, purposeful selection of members, clear communication of roles and responsibilities, a consumer coordinating group, space for critical dialogue throughout the process and provision of honoraria.15

The comprehensive MHCC Toronto Site Caucus Protocol (October 2010) which “outlines the roles and responsibilities of the Caucus in relation to the meaningful engagement of PWLE in all aspects of the MHCC At Home / Chez Soi project, Toronto Site” is found at http://www.housingfirsttoolkit.ca/sites/default/files/Caucus%20Protocol.pdf. A sample Terms of Reference for a consumer advisory committee of PWLE from Wesley Urban Ministries' Transitions to Home in Hamilton is found in Appendix “C”.

4.2 Governance16

In addition to strong leadership, a complex initiative such as the St. John’s ICM Program will require strong effective governance. It is recommended that an Advisory Committee be established to provide strategic advice on and expertise to the Program’s leadership and on specific initiatives, projects and key priority areas. This Committee should be comprised of representatives from the lead organizations – who would undertake the Chairperson’s role, and critical service delivery and funding partners to a maximum of 8 to 10 members.


This Committee would:

- Support the intent and outcomes of the Program;
- Provide strategic advice and direction as requested by Program leadership;
- Reflect on and offer solutions to issues brought for discussion;
- Ensure the Program is being implemented with fidelity to the HF ICM program approach;
- Communicate on behalf of the Program leadership by accepting appropriate opportunities to discuss the Program (e.g., media, speeches, workshops and conferences); and
- Guide evaluation processes for the Program/ensure fidelity to the HF scale.

This Advisory Committee must have a clear and concise Terms of Reference which would include the process by which members are chosen, terms of office/continuity of membership, roles and responsibilities, decision-making processes and accountabilities.

5.0 Philosophy and Guiding Principles

The St. John’s ICM Program will operate within the following philosophical framework:

*Each individual person has unique talents, abilities and potential. In order to reach their fullest potential, every individual requires, and has a right to, basic safety, support, care and housing. The St. John’s ICM Program endeavors to provide the right combination of supports to enable individuals to live successfully in the community. The key element to achieving this is relationship-building.*

*Each person has the right to make their own decisions about what they require, in an atmosphere of dignity and respect. Support should be provided in a manner that draws upon the strengths and abilities of the individual which means, wherever possible, ‘doing with’ versus ‘doing for’.*

It espouses the following core values:

- Act with empathy, compassion and kindness.
- Choose to see the potential.
- Cultivate safe, inclusive spaces and promote diversity.

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17 Adapted from the Community Support Program - Stella’s Circle.
18 Adopted from Choices for Youth.
• Work hard, with boundless ambition and strategic excellence.
• Inspire hope, and create opportunities that empower.

It adheres to the following HF Principles\textsuperscript{19}
• Rapid housing with supports
• Offering clients choice in housing
• Separating housing provision from treatment services
• Providing tenancy rights and responsibilities
• Integrating housing into the community
• Recovery-based and promoting self-sufficiency.

Its service provision and practice are built upon the following values and principles:\textsuperscript{20}

\textit{Service Delivery}

• Accessible services: clients will access needed disability-related supports.
• Accountability: requires critical thinking skills and ongoing reflection on practice.
• Building on strengths: focuses on strengths as the basis for making changes.
• Client-centred service: clients are key players and have an active voice in shaping services that will support them.
• Collaboration: based on a team approach to creating and implementing individual service plans; drawing on the experiences and knowledge of one another.
• Consistency: consistent in its services - what is written on paper is what occurs in practice.
• Continuity: based on a team approach to creating and implementing a service plan that provides clients with a sense of continuity.
• Evidence-based and evidence-informed: program and service decisions are supported by evidence-based or evidence-informed research appropriate to particular client circumstances.

\textsuperscript{19} Employment and Social Development Canada. Housing First Approach.
- Harm reduction: operates on harm reduction principles and practices.
- Holistic approach: provides a comprehensive approach to a client’s circumstances and needs.
- Knowledge exchange: supports knowledge exchange designed to improve on service delivery and client outcomes.
- Least intrusive and intensive intervention: enables services to be provided before difficulties develop into crises and to minimize the number, intensity, duration and restriction of the interventions.
- Mutual respect: a shared learning experience for all team members and one in which all clients make unique and valuable contributions.
- Recognizing diversity: relies on multiple perspectives.
- Responsive programming: programs and services meet the needs of the clients, promote flexibility and innovative responses, are recovery-focused and designed and evaluated in partnership with the clients.
- Solutions focused: assists clients to identify problems for the purpose of seeking solutions, and remains free of judgment relating to the details of the problems that are a part of the lives of the clients they serve.
- Sustainability: focused on identifying sustainable practices and approaches, in particular through partnerships and collaborations.

Clients

- Have a right to safe, affordable and appropriate housing, protection from abuse and a standard of living that promotes physical, mental, emotional, psychological and social development.
- Will be afforded respect and dignity.
- Will have choice, a voice and control over where and how they live and the support they receive.
- Will be directly involved in the participation and decision-making that affects their lives; they will be empowered in decision-making through the provision of informed consent, informed choice and self-determination.
- Will be empowered and equipped to be self-advocates and to enhance self-efficacy.
- Can recover, reclaim and transform their lives.
Goals of the St. John’s ICM Program\(^{21}\):

- Clients will remain in stable housing.
- Clients will reduce justice, legal and health services usage.
- Clients will improve self-sufficiency.
- Clients will engage in mainstream services (e.g., improve social networks, access community resources).
- Clients will have their needs met and experience improved quality of life.

5.1 Code of Ethics and Conduct\(^{22}\)

The St. John’s ICM Program provides a service to vulnerable members of our society. As such, there can sometimes be an imbalance of power between staff and clients. Therefore, clear standards of conduct must be established so that all clients are treated equally and fairly. All staff will maintain the highest standard of conduct and judgment, and adopt and maintain a thoughtful, sensitive approach to their work with clients. Specifically, all staff are expected to:

- Act ethically and uphold professional standards in all dealings with clients.
- Respect and honour the rights, dignity, wellbeing and privacy of all clients.
- Respect clients regardless of race, religion, culture, sexual orientation, gender, age, ability, state of health and/or life circumstances.
- Protect all clients from any form of abuse, neglect or exploitation.
- Maintain the highest level of client confidentiality at all times.
- Respect and protect the emotional vulnerability of all clients and refrain from encouraging, developing, fostering or maintaining intimate or inappropriate personal relationships with them.
- Never borrow from or lend personal money/materials to clients or enter into any financial dealings with them.


\(^{22}\) Adapted from Stella’s Circle’s Community Support Program - Policy and Procedure Manual. 2014.
6.0 An Integrated Approach to Service Delivery

Adopting an integrated service approach that provides both clinical and housing supports will strengthen the St. John's ICM Program service delivery model. This was demonstrated through the At Home / Chez Soi projects as stakeholders reported that diverse clinical and social supports offered through the project were critical to its success. These services were described as being wide-ranging, client-focused and oriented toward prevention and recovery. The type of assistance offered to participants included access to a psychiatrist or primary care physician, as well as support with cooking, laundry, grocery shopping, paying bills, scheduling, organization, budgeting, family relations, social networks, employment and volunteering.

As HF is more than just housing, the St. John's ICM Program staff will be providing three types of support including:

**Housing Supports:**
- Helping the client search for and identify appropriate housing;
- Building and maintaining relationships with landlords;
- Negotiating with the landlord or accessing social housing or permanent supportive housing;
- Applying for and managing rent subsidies; and
- Providing assistance in setting up apartments, including acquiring furniture and supplies.

**Clinical supports**

This includes a range of client-driven supports designed to enhance the health, mental health and social care of the client and ultimately improve his/her quality of life and foster self-sufficiency. To determine the appropriate services demands a comprehensive assessment of client goals, interests and needs.

**Complementary supports**

Housing stabilization usually requires a broader range of supports beyond housing and clinical supports. Such supports are intended to help individuals and families improve their quality of life, integrate into the community and potentially achieve self-sufficiency. Complementary supports may include:

- Life skills – skills for maintaining housing, establishing and maintaining relationships (including conflict resolution) and engagement in meaningful activities.
• Income Supports for those entitled to them.
• Assistance with finding employment, enrolling in education, volunteer work and accessing training.
• Community engagement.\textsuperscript{23}

Services should be focused in the community and managed in a manner that responds to fluctuations/variations in consumer need.

7.0 Multi-Disciplinary Teams

Multidisciplinary team make-up was highlighted through the jurisdictional review and research as being critical for adequately responding to the wide-ranging, complex needs of participants. This approach provides for a range of staff members with different professional backgrounds who collectively are better able to meet these needs. All members of the team should be outcome-driven, results-focused and solution-minded in their efforts and engagement with clients.

Multidisciplinary teams providing for a quality case management relationship with clients have been proven to deliver reduced homelessness and more client satisfaction at no extra total system cost than office-based services for clients requiring a complex service response. Furthermore, one study found that such teams also experience significantly higher job satisfaction and lower burnout rates and provided some evidence that it was the access to relevant professional colleagues rather than the caseload size that had the positive effect on worker experience (Boyer and Bond, 1999).\textsuperscript{24}

7.1 Experience from the jurisdictional reviews

The exact make-up of each multi-disciplinary team per jurisdictional program reviewed varied depending on, for example, the needs of the potential target group, available services/supports and resources (funding/human resources). There were commonalities in relation to the availability of program managers and/or team leads, as well as case managers and/or front-line workers (e.g., community mental health workers, housing support workers/specialists).

\textsuperscript{23} Stephen Gaetz, Fiona Scott & Tanya Gulliver (Eds.) (2013): Housing First in Canada: Supporting Communities to End Homelessness.

7.2 Proposed Staff Structure for the St. John's ICM Program

Based on a review of staff structures for several ICM programs, findings from the literature review, learnings from the Medicine Hat model, an understanding of the needs of the target group, the anticipated caseload for the St. John’s ICM Program, discussions with local leaders in the homelessness services sector and overall program goals, the following staff composition is proposed:

- A half-time Program Manager (in-kind) [This position will be shared between Choices and Stella's Circle, each of whom will contribute a .25 full-time equivalent senior staff to the position.]
- One full-time Team Lead (new position)
- Five full-time Intensive Case Managers (new positions)
- Two full-time Community Mental Health and Housing Workers (new positions)

It is important to reflect on the fact that, as noted previously, the programming is targeting individuals who are chronically and episodically homeless and for whom the ICM Program can provide appropriate levels of support. It must be noted that under the context of HPS funding, provision of direct medical/clinical services to clients is constrained.

7.2.1 Program Managers

The Program Managers will be responsible for all aspects of the operation of the St. John's ICM Program. They will ensure that all aspects of the Program are effectively implemented - ensuring fidelity to the HF ICM intervention, and that the Program is effectively integrated within EHSJ’s continuum of programs. The Managers will ensure that services are provided professionally and in accordance with current thought and practice in successful ICM programs. They will stay abreast of trends and developments in the sector and work collaboratively with the other partners.

It will be critical that the Program Managers have a shared vision and goals for the Program and a shared understanding of key Program concepts and language. They must work closely together from the outset of Program implementation and have clear, open and honest lines of communication.

*Duties include:*

- Ensuring the ICM Program’s philosophy, goals and objectives and EHSJ’s performance targets are being met.
- Ensuring financial accountability for Program funds.
• Overseeing the ICM Program budget, including the monitoring of administration and staff development costs.
• Working with EHSJ to develop and administer housing supports for the ICM Program (e.g., rent assistance, furnishings).
• Identifying gaps in service and holding discussions with the appropriate government or agency level to effect change.
• Supporting Program Team efforts to identify safe appropriate housing for clients.
• Supporting development of the private landlord market for potential rentals.
• Supporting clients to maintain housing/achieve housing stability.
• Undertaking the recruitment, screening, hiring and overall oversight of ICM staff.
• Conducting annual staff performance reviews on the Team Lead.
• Providing staff members with support and encouragement for professional growth.
• Ensuring the involvement of service users in program development and program delivery.
• Completing reports required by the funders and EHSJ.
• Ensuring collection of relevant data for stakeholders and that Program evaluation is undertaken.
• Ensuring the Program meets all legislative, regulatory and professional standards.
• Attending relevant internal/external meetings and networking, as necessary.
• Engaging in strategic planning for the Program, as required.
• Overall accountability to all Program stakeholders.

**Qualifications:**

• A minimum of an undergraduate degree, and preferably a master’s degree, in social work.
• Knowledge, understanding and commitment to the HF model and philosophy.
• Knowledge, understanding and commitment to the Recovery Model/Philosophy.
• Clinical knowledge and understanding of the issues of people experiencing homelessness and mental health and/or addictions.
• A minimum of five years supervisory experience in mental health and addictions for adults and with homeless populations.
• Understanding of the concepts of a client-centred relationship.
• Creative in developing services that foster healing, growth and empowerment.
• Understands holistic approaches to mental health.
• Demonstrated experience in developing, implementing and evaluating programs and services.
• Demonstrated experience in community development.
• Excellent communication, interpersonal, organizing, computer and leadership skills.
• Superior presentation, facilitation and public speaking skills.

**Reporting relationship:**
The Program Manager is accountable to the ICM Program Advisory Committee.

**Salary:** $80,000 + benefits ~ $92,000

As noted above, this position will be shared between Stella’s Circle and Choices for Youth – each providing a .25 full-time equivalent staff position. The estimated funding provided in-kind is $45,000.

### 7.2.2 Team Lead

The Team Lead will provide day-to-day leadership, mentoring and support to the St. John’s ICM Program staff, ensuring that the team works effectively together and delivers high-quality services to clients. The Team Lead will supervise the Intensive Case Managers and Community Mental Health and Housing Workers (CMHHWs). Depending on the number and complexity of clients and availability of staff, he/she might have a small caseload. This staff will work in collaboration with the Program Managers.

**Duties include:**

• Working in collaboration with the Program Managers and ICM Program staff team to further the goals and objectives of the Program and ensure the EHSJ’s performance targets are being met.
• Ensuring fidelity to the HF ICM program intervention.
• Working with the Program Managers to inform the development of policies and procedures relevant to the staff team and delivery of services.
• Assisting with the recruitment, screening and hiring of the Intensive Case Managers and CMHHWs in collaboration with the Program Managers.
• Providing ongoing leadership, mentorship and support to the Intensive Case Managers and CMHHWs.

• Receiving client referrals and conducting assessments for individuals who fit the Program criteria; assigning Intensive Case Managers to clients with attention to balancing caseload and client complexity.

• Assisting participants in the search for safe, affordable housing and selection of housing that best meets their individual needs and personal preferences, with no conditions of housing readiness.

• Supporting development of the private landlord market for potential rentals.

• Supporting clients to maintain housing/achieve housing stability.

• Initiating appropriate community referrals and/or collaborating with others as required for out-referrals for clients who do not meet the Program criteria.

• Ensuring case conferences are held and reports and service plans are completed within the required timelines.

• Working at least one full day every two months “in the field” with each Intensive Case Manager to monitor service delivery and inform appropriate coaching and training opportunities.

• Ensuring all crisis situations are debriefed and documentation is received by appropriate parties within 24 hours.

• Being available to each Program client to address concerns regarding ICM Program supports and services.

• Ensuring all due diligence has been completed prior to a client exiting from the program.

• Ensuring orientation, assessment of skills, training and professional development of all staff.

• Setting up and maintaining staff scheduling (including vacation requests, leaves of absence and time sheets).

• Planning and leading bi-weekly staff meetings, as well as other team meetings, as required.

• Conducting performance appraisals.

• Administering program funds and budget.

• Overseeing/Managing Program information systems including submitting program data/information for program evaluation and improvement. On an ongoing basis, the
Team Lead shall review internal data to detect trends in service delivery and the clients being served.

**Qualifications:**

- A minimum of an undergraduate degree in social work or a diploma or course in an area related to community social services such as criminology or mental health or an equivalent combination of education, training and experience.
- A minimum of five years’ experience in a mental health setting (work and/or volunteer) including working with the target population.
- A minimum of three years of supervisory and program development experience.
- Knowledge, understanding and commitment to the HF model and philosophy.
- Knowledge, understanding and commitment to the Recovery Model/Philosophy.
- Extensive knowledge and experience in such areas as housing, homelessness, mental health and addictions, trauma, conflict resolution and crisis intervention.
- Experience in partnership-based programs and services.
- Excellent knowledge of resources available to the target population.
- Excellent conflict resolutions skills.
- Skilled in negotiation and relationship-building.
- Exceptional facilitation, communication and interpersonal skills.
- Excellent analytical and problem-solving skills.
- Demonstrated ability to work independently, cooperatively and constructively within a multidisciplinary team environment.
- Proficiency in Microsoft Office.

The successful applicant must be able to provide a Certificate of Conduct and have current First Aid/CPR, Applied Suicide Intervention Skills Training (ASIST), a valid driver’s license and access to a reliable, safe vehicle for work.

**Reporting Relationship:**

Reports to the Program Manager

**Salary range:** $70,000 – $75,000 + benefits: ~ $80,500 - $86,250 based on a 37.5 hour work week.
7.2.3 **Intensive Case Manager**

Using a strengths-based approach, the Intensive Case Manager will provide individualized support services to persons who have been referred to and accepted under the criteria for the ICM Program in order to promote recovery, stability and independent living. This role requires significant relationship building/engagement skills, the ability to meet clients where they are and to support them to develop and implement goals in an effort to make positive changes in their lives. This position requires a dynamic individual with skills in the areas of advocacy, crisis intervention and conflict resolution.

This position will require a flexible approach to hours of work and a willingness to be creative in motivating/inspiring clients. Some on-call will be required.

*Duties include:*

- Provide intensive assertive case management to Program clients.
- Provide ongoing emotional support, encouragement and unconditional acceptance to clients.
- Build a working relationship with each client, getting to know them as a unique individual and clarifying the role of the Intensive Case Manager.
- Meet with clients at a minimum and as possible (depending on the consent of the client) on a weekly basis, as per the HF expectation.
- Identification of client needs and development of an individualized service plan in conjunction with the client and the CMHHWs. The individual plan shall be holistic in nature and reflect a strong commitment to client self-determination and empowerment principles.
- Conduct risk assessments and establish safety plans with clients.
- Assist clients in meeting their basic needs, including the search for decent, affordable housing and adequate financial resources.
- In concert with the CMHHWs, help clients move to their housing and, as needed, from one location to the next (e.g., packing up clients' belongings, tidying and cleaning apartments, contacting agencies for donations for required items).
- Assist tenants in developing landlord-tenant agreements.
- Help the client recognize, develop and utilize the support networks in his/her life.
- Initiation of appropriate community referrals and/or collaboration with others as required and with the agreement of the client.
• Schedule support services for clients.

• Oversee the transportation of clients in personal vehicles to assist with medical appointments, probation appointments and various activities of daily living such as grocery shopping/food bank.

• Be a liaison between families, social service agencies, school representatives, doctors and other professionals involved with the client with a view to ensuring clients’ overall health and stability.

• Consultations with therapeutic staff, correctional officers, client services officers, Health and Community Services and other community-based/government services as necessary and as agreed to by the client.

• Focus on crisis-prevention through problem-solving and planning with clients.

• Management of crisis situations which do occur and implementation of appropriate action plans to resolve the incidents in a satisfactory, safe manner that includes follow up. Mediation of conflict, where necessary, between clients and others.

• Implement an Eviction Prevention Program – providing direct support to tenants regarding housing retention, mediation and conflict resolution.

• Seek out and develop private landlord market for potential rentals.

• Support clients to maintain housing/achieve housing stability.

• Participate in program and policy development/improvement by continuously re-evaluating forms and processes of everyday tasks and conveying any concerns to the Team Lead.

• Ensure all documentation, case management reports and outcome measures for each client on the caseload are current and complete.

• Participate in bi-weekly staff meetings, as well as other scheduled team meetings.

**Qualifications:**

• A minimum of an undergraduate degree in social work or a diploma or course in an area related to community social services such as criminology or mental health or an equivalent combination of education, training and experience.

• Three years direct experience (including community work experience and/or volunteer work) assessed as being relevant to the target population being served.

• Knowledge, understanding and commitment to the HF model and philosophy.

• Knowledge, understanding and commitment to the Recovery Model/Philosophy.
• In-depth knowledge and experience in such areas as housing, homelessness, mental health and addictions, trauma, conflict resolution and crisis intervention.
• In-depth knowledge of local community resources.
• Excellent clinical, analytical and problem solving skills.
• Program development experience.
• Demonstrated ability to work independently, cooperatively and constructively within a multidisciplinary team environment.
• Adaptable to working in varied environments (e.g., correctional settings, community).
• Ability to develop and maintain good working relationships with agencies and systems.
• Demonstrated excellent documentation and time management skills.
• Excellent communication skills.
• Strong organizational skills and attention to detail.
• Strong interpersonal skills.
• Ability to work flexible hours.
• Excellent computer skills (e.g., Microsoft Word, Excel and Outlook).
• Must have a Certificate of Conduct, a valid First Aid/CPR certificate and ASIST.
• Must have a valid driver’s license and access to a safe vehicle for work

**Reporting Relationship:**
Reports to the Team Lead

**Salary range:** $60,000 – $65,000 + benefits: ~ $68,000 - $75,000 based on a 37.5 hour work week

**7.2.4 Community Mental Health and Housing Worker**

The Community Mental Health and Housing Worker (CMHHW) will provide outreach services to all Program clients using a strength-based approach. They will collaborate with clients and Intensive Case Managers to assist in the development and implementation of a client’s individualized service plan and in finding housing for each client and supporting these clients to maintain their housing.

This role requires significant relationship building/engagement skills, the ability to meet clients where they are and to support them to implement goals in an effort to make positive changes in
their lives. This position requires a dynamic individual with skills in the areas of advocacy, crisis intervention and conflict resolution.

This position will require a flexible approach to hours of work (some evening and weekend hours) and a willingness to be creative in motivating/inspiring clients.

Duties include:

- Provide ongoing support, encouragement and unconditional acceptance to the clients.
- Support the Intensive Case Managers in provision of outreach services to clients through weekly visits to their homes.
- Build a working relationship with each client, getting to know them as a unique individual and clarifying the role of the CMHHW.
- Work with and support the Intensive Case Managers to ensure individualized service plans are implemented.
- Support clients to maintain housing/achieve housing stability.
- Provide information to the Intensive Case Managers to assist with ongoing risk assessment regarding the client’s personal safety, the safety of the staff and the need for intervention.
- Complete shift reports and/or daily logs and submit in a timely manner.
- Participate in bi-weekly staff meetings as well as other scheduled team meetings.
- Collect and report on data as required for Program accountability.

Housing-related duties

The CMHHW will coordinate housing and tenant-related services:

- Assist participants in the search for safe, affordable housing and selection of housing that best meets their individual needs and personal preferences, with no conditions of housing readiness.
- Support consumers in all aspects of moving into housing / re-housing including acquiring furnishing.
- Act as the liaison with NL Housing, as well as with any other relevant housing programs to access funding as required for clients.
- Provide individualized housing support tailored to each client’s unique needs and preferences.
- Support clients to maintain housing.
• Provide tenant's rights education to clients.
• Provide crisis intervention, conflict resolution and meeting facilitation with tenants regarding housing-related issues.
• Seek out and develop private landlord market for potential rentals.
• Provide direct support and education to private landlords who rent to clients.
• Implement an Eviction Prevention Program – providing direct support to tenants regarding housing retention, mediation and conflict resolution.

Qualifications/Requirements:

• A combination of a post-secondary degree/diploma in a related field and 2 years direct experience (including community work experience and/or volunteer work), assessed as being relevant to the target population being served.
• Knowledge, understanding and commitment to the HF model and philosophy.
• Knowledge, understanding and commitment to the Recovery Model/Philosophy.
• Knowledge of community resources, in particular the housing market.
• Experience working in a community agency.
• Ability to develop and maintain good working relationships with agencies and systems.
• Adaptable to working in varied environments (e.g., correctional settings, community).
• Demonstrated ability to work independently, cooperatively and constructively within a multidisciplinary team environment.
• Proficient written and oral communication skills.
• Excellent computer skills (e.g., Microsoft Word, Excel and Outlook).
• Must have a Certificate of Conduct, a valid First Aid/CPR certificate and ASIST.
• Must have a valid driver’s license and access to a reliable, safe vehicle for work.

Reporting Relationship:

Reports to the Team Lead

Salary range: $45,000 – $50,000 + benefits: ~ $51,000 – $57,500 based on a 37.5 hour work week.
Of note, it is understood that the extent to which the full complement of staff is implemented will depend on the funding available. At the time of writing of this report, support from partners has not yet been confirmed and/or finalized. It is recommended that the key staff position of Team Lead be implemented regardless of the level of funding ultimately available to support the Program.

### 7.2.5 Allocation of staff

The allocation of St. John’s ICM Program staff is as follows:

**Year one (September 1, 2015 to March 31, 2016)**
- **Choices**: one Intensive Case Manager; one Community Mental Health and Housing Worker
- **Stella’s Circle**: the Team Lead; one Intensive Case Manager; one Community Mental Health and Housing Worker
- **Iris Kirby House**: one Intensive Case Manager

**Year two (April 1, 2016 to March 31, 2017)**
- **Choices**: two Intensive Case Managers; one Community Mental Health and Housing Worker
- **Stella’s Circle**: the Team Lead (to be called the Program Coordinator); **two** Intensive Case Managers; one Community Mental Health and Housing Worker
- **Iris Kirby House**: one Intensive Case Manager

As can be seen from this staffing arrangement, in addition to staff being allocated to Choices and Stella’s Circle, an Intensive Case Manager will be allocated to Iris Kirby House (IKH) with the funding for the staff position being provided to this agency. IKH was a member to the small working group referenced above which supported the consultant in the design of the model and they sought to have this ICM position on-site.

**Iris Kirby House**

IKH provides shelter to women with or without children who are experiencing relationship abuse (physical, psychological, emotional, sexual and economic). Since opening its doors, IKH has provided shelter to thousands of women and children and has been a strong advocate for domestic violence and homelessness issues at municipal, provincial and federal levels.
In moving forward to meet the demands of a changing society, the organization has seen rapid growth in its facilities as well as services in the last six years. The facility located on Waterford Bridge Road has been significantly expanded and programs have been revamped and enhanced to meet the needs of clients requiring services and support. The number of available emergency beds at IKH has increased from 21 to 47. A second emergency shelter, O’Shaughnessy House, was opened in Carbonear and it provides 15 emergency beds. Both sites function as a fully staffed, 24/7 service agency, including a 24/7 distress line.

In addition to the emergency beds, IKH operates second-stage housing units in the St. John’s, Mount Pearl and Carbonear areas. The available housing units increased from seven to 30, and there are four self-contained supportive housing units attached to the emergency shelter at the St. John’s site, available for women to access - the first provision of its kind in the province.

Along with the physical space provided, there are numerous programs and services provided to help women and children adjust to their situations and begin a new chapter in their lives. For example, IKH runs a Mental Health Program and employs a full time Mental Health Nurse who provides intensive case management to in-house clients, as well as women living in the second stage housing. This staff could be a resource to the St. John’s ICM Program.

Complementing the Mental Health Program, IKH employs a full-time Director of Community Outreach and Mental Health who also could be a resource to the Program and to the Intensive Case Manager housed at IKH.

In recent months, IKH has enhanced its programs and services to further meet the needs of the women and children who use the shelter. These changes include new empowerment and economic support programs as well as a new youth support program and a children’s services program. To support the new programs, additional staff have been retained including the management position of Child Services Coordinator.

The new model of service provision to children and youth at IKH is designed to serve the broader population of young people witnessing or at risk of experiencing violence. Groups offered at IKH are open to children and youth living in the shelter and those in the community referred from outside services. This unique service would be accessible to the broader client base of the ICM Program.

**Women and Homelessness**

All women requesting shelter are categorized as homeless, with the primary cause of this homelessness being violence and abuse; however, the perpetrators are not always intimate or current partners. Women’s homelessness is often hidden - with women living in substandard and
dangerous environments as opposed to sleeping on the streets. Families also do not likely transition into street homelessness but, rather, flee abuse and violence by staying with family, friends or in hotels. Many move to different provinces if they have the resources and, as well, many access shelters specializing in responding to their needs.

**Client Base**

From April 2013 to March 31, 2015, IKH received more than 1400 distress calls related to abuse and violence. The women and families accessing services at IKH are presenting with more and increasingly complex needs including, for example, higher rates of addiction to prescription medication and illicit street drugs, experience with the criminal justice system and serious mental and physical health issues. These complexities are most often a direct result of the trauma and violence which they have experienced and that constrain their options for and access to safe, affordable and supportive housing.

### 7.3 Training

The St. John’s ICM Program leadership must support and promote the attainment, maintenance and upgrading of staff qualifications through training and development to build professional capacity and proficiency in evidence-based practice. The jurisdictional review and research identified core skills and/or training which ICM Program staff should have and/or acquire including, but not limited, to the following:

- A strong working knowledge of the existing community-based and government services and supports and how to access them (systems navigation)
- Activities and processes of ICM
- Administering and analyzing a variety of assessment tools
- ASIST/Suicide prevention
- Case notes and record keeping
- Client engagement techniques
- Data collection processes
- Disease education and prevention e.g., HIV/AIDS
- Domestic violence
- Ethics/boundaries
- Family dynamics
- Fetal Alcohol Spectrum Disorder
- First Aid/CPR
- Freedom of Information/Privacy legislation
- Harm reduction approaches
- Hoarding
- Home visit 101
- Homelessness and its layers
- Housing First
- Inclusion/multicultural sensitivity
- Individual Service Plans
- LGBTQ2s* awareness
- Mental health/addictions, in particular as it relates to sub-populations
- Mental Health First Aid
- Motivational interviewing
- Non-violent crisis intervention
- Psycho-social rehabilitation
- Stages of change
- Strength-based approaches
- Theory and practice of ICM in HF
- Universal precautions
- WHIMIS/Assessing the environment
- Work-life balance and stress management including burnout avoidance

Staff must be vigilant in remaining current, relevant and constant in their approaches to working with and supporting clients.

Of note, currently EHSJ is mapping out a long-term training plan, in conjunction with the Frontline Members’ Forum and the NLHHN (as a potential provider). This plan would consider the training needs for the ICM Program staff team.
8.0 Caseloads

Determination of caseloads for Case Managers varied widely across the jurisdictional programs reviewed as well as the literature. However, a standard did appear to be between 1:10 and 1:20.

To maximize provision of services to clients, providing care that is regular and frequent, building relationships with participants, and offering individualized, flexible support, it is recommended that the caseload not exceed 1:15 for the St. John’s ICM Program.

Efforts must be made to ensure that all caseloads are balanced in terms of acuity and level of need. Consideration for smaller caseloads should be given for Intensive Case Managers working with youth given the findings of the Infinity Project and the experience identified through Choices Moving Forward Program.

The stipulation for the 1:15 staff/client ratio is that the Intensive Case Managers are supported by the CMHHWs. Should it be determined over time that their duties are better integrated into the work of the Intensive Case Managers, consideration should be given to lowering the staff/client ratio from 1:15.

8.1 Managing the caseload

An intentional process and tool will be identified to facilitate assigning caseloads for the St. John’s ICM Program to ensure appropriate allocation of staff time to meet client needs. Such a process will enable better caseload planning, monitoring of progress and resource allocation.

9.0 Hours of operation

Many of the programs reviewed provided service outside of regular business hours. This includes both Moving Forward and the Community Support Program – local, long established and evidence-based programs that will have experience with some of the potential clients for the St. John’s ICM Program.

- The CSP staff work Monday to Friday with the hours being dependent on the needs of the clients with whom they are working. At the time of writing this report, for example, support is being provided up to 10:30 at night. In the past, the program has provided up to 24-hour support if an individual’s circumstances/needs require it. However, it is important to note that this situation stretched the capacity of the program.
Each of the case managers is on-call for one week. If issues arise after hours/on weekends, the individuals can call Emmanuel House and a message will be relayed to the on-call Case Manager.

- Moving Forward operates seven days a week: Monday to Friday - 8:30 a.m. – 9:00 p.m.; Saturday and Sunday 11 a.m. - 7 p.m. Staff work one weekend on and one weekend off. To assist with staff retention, Moving Forward tries to have a regular and predictable schedule.

Discussions with jurisdictional informants, as well as the research, revealed that hours of delivery must be flexible and able to be extended or modified based on the needs of the clients.

Given the experience here and in other jurisdictions, it is suggested that for the St. John’s ICM Program there be staff coverage Monday to Friday, 8:30 a.m. – 4:30 p.m., with some evening and weekend coverage at the outset by the CMHHW's with access to on-call Intensive Case Managers, and processes put in place to ensure these hours are responsive to the needs of the clients. Of note, weekend and evening support should be closely monitored to identify the ongoing need. The At Home / Chez Soi site in Toronto, for example, found in the early months of program implementation that this demand was not as thought and so reduced its hours of operation – but provided access to off-service hours, if this need was identified.

Clients of the St. John’s ICM Program must be provided access to services/supports in off-service hours as part of emergency/crisis planning – either through the Program or other established and reliable services. Emergency/crisis provisions will be written into the clients’ individual service plans.

10.0 Coordinated Access and Assessment

For communities that have demonstrated progress in ending homelessness, the development of a coordinated access and common assessment approach has been an essential component of their success.

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10.1 Coordinated access

Coordinated access is a single place or process that ensures that all people experiencing a housing crisis in a defined geographic area have fair and equal access, and are quickly identified, assessed for, referred and connected to housing and homeless assistance and support services based on their needs and strengths, no matter where or when they present for services. It is a system-wide program designed to meet the needs of the most vulnerable and highest acuity first (triaging), while ensuring all people who come into contact with the homeless system are assessed and provided with appropriate supports to exit homelessness. In short, it is a single place and/or process for people experiencing homelessness to access housing and support services.

Without a coordinated entry and assessment process to determine client acuity, individual agencies have historically and independently determined which clients they accepted into their programs through agency-specific eligibility requirements and program entry. This often has led to multiple system issues and obstructions.

In the absence of a coordinated approach, individuals/families experiencing homelessness are often faced with the daunting task of finding help in a fragmented system. Imposing complicated system navigation on high-acuity individuals leads to low utilization of services for those with the most needs.

A coordinated access and assessment process, however, allows agencies/organizations to work together with a common language, assessment tool, processes and policies. With coordinated and efficient intake processes, clients can access appropriate housing services quicker and with better accuracy, minimizing stress and respecting client dignity. This approach provides for more consistent, harmonized processes across the sector, regardless of where or how an individual enters the continuum of care.

This approach also eliminates a common outcome of agency-centric systems of care whereby clients could apply for entry into multiple programs at the same time to increase their likelihood of acceptance. This resulted in a system with multiple waitlists and no way of knowing if the same client waited on numerous lists. An effective coordinated access and assessment process will allow for more accurate identification of the needs of the target population and guide interventions and funding towards the program types most in demand.

This standardized, coordinated and accessible approach then paves the way for a more efficient homeless serving system by:

- Leveraging the strengths of individual service providers
• Improving consumer access to the right housing and support options to meet their needs (shortening the pathway from homeless to housing with supports)

• Reducing new entries into homelessness (by consistently offering prevention and diversion resources upfront, reducing the number of people entering the system unnecessarily), and

• Improving data on needs, strengths, opportunities and appropriate approaches to end homelessness.

To be an effective process it must:

• Be person-centred, inclusive and sensitive to lived experiences

• Be low-barrier

• Prioritize based on criteria not preferences; no “side” doors

• Ensure what is written on paper is what occurs in practice

• Use standard forms and assessment processes for every client for every program

• Ensure a coordinated referral process across the organizations and agencies

• Have accessible information about available housing and service interventions in the area.

10.2 Models of Coordinated Access

There are two general models for coordinated entry systems – centralized and decentralized. A geographically centralized "front door" has one distinct location where every individual/family can go to access intake and assessment, while a decentralized, coordinated entry system offers multiple sites for intake and assessment. A virtual or telephone-based centralized intake provides one number that consumers can call to access intake and get referrals.

Regardless of the model, intake staff should be able to help individuals and families access prevention, diversion and rapid re-housing resources; use an effective assessment tool; and provide information about local homeless assistance programs, housing resources and community-based mainstream services.

□ The centralized intake model offers those seeking services one location – physical or virtual – where they can enter the homeless system. For this reason, the physically centralized intake model is considered most appropriate for those areas that are small and/or have a reliable and comprehensive mass transit system. The advantages of this model are that the same staff person or people will deliver the assessment to every person requesting services, ensuring consistency and efficiency in assessment administration and data collection. For centralized
intake to work, providers must be confident that they will receive quality referrals as a result of the intake process. Transparency and collaboration go a long way toward creating this kind of trust.

Some communities may have separate intake centers for different populations (e.g., singles and families). This kind of set-up would still be an example of a centralized approach.

The decentralized intake model offers individuals/families multiple locations/regional hubs from which they can access services or shelter. It is termed the "no wrong door" approach. The coordinated aspect of this model comes from the fact that each agency doing intake uses the same set of agreed-upon assessment and targeting tools, makes referrals using the same criteria and has access to the same set of resources. Larger communities, or communities without a transit system to support everyone coming to one centralized location, may find the decentralized approach easier to implement. However, an increase in the number of organizations a community has participating in the system entry process may increase the likelihood of variation in terms of how assessments and referrals are handled. This particular issue may make the decentralized model less desirable for some communities than a centralized model that uses staff from only one organization. ²⁶

10.3 The St. John's ICM Program approach

The St. John’s ICM Program will establish the centralized model of access, intake and assessment.

10.3.1 Referral process

Referrals will come from any community-based homeless serving organization or public system serving individuals who are homeless. Referrals (either through organizations or self-referral) will be based on the answers to a concise set of clear relevant questions, which will be provided as a standardized referral form to the organizations/systems referenced above. These referrals will come to the Team Lead who will be responsible for intake and assessment.

It will be critical to ensure there is wide-spread awareness of the ICM Program and its target population to support the referral process.

### Referral to the St. John's ICM Program

(Please note that the yellow highlights below represent items which need to defined by the ICM Program Team and approved by the St. John’s ICM Program Advisory Committee.)

**Question #1 - XXX**

**Question #2 - XXX**

**Question #3 - XXX**

**Question #4 - XXX**

*If the individual is eligible for referral,* please contact [name] Team Lead for the St. John’s ICM Program at [contact information]. The following information will be required:

- Name of client
- Contact information for the client (if the client does not have a phone, please ask him/her if it is alright for us to provide information to you, which you can then provide to the client).

Please let the client know that they will be seen within three days.

Please ensure that you provide the individual with options for shelter/housing in the interim. If it is within your mandate to support the individual in this regard, please do so. If not, please call **XX**.

*If the individual is not eligible for the Program* based on their responses, then please determine with the client whether your services can address their needs and/or whether a referral to other services is required.

Please ensure that you provide the individual with options for shelter/housing in the interim. If it is within your mandate to support the individual in this regard, please do so. If not, please call **XX**.

### 10.3.2 Receiving referrals

If a client referred from another agency/organization/program or by self-referral is deemed ineligible for the ICM Program on review by the Team Lead, this staff will provide them a minimum of three referrals to other agencies/organizations which match their needs and which are agreed to by the client. Reasons for ineligibility might include that the individual, although being episodically or chronically homeless, requires intensive and extensive clinical support which exceeds the support which the Program is designed to provide within the context of the HPS funding.
Of note, the individual will not be left without housing and so, as required, the Team Lead will connect with the appropriate services/programs to secure housing and/or use Program funds to ensure access to emergency housing with a view to connecting the individual within 24 hours to an appropriate program. These linkages must be defined early in the Program implementation to ensure Program participants' access to appropriate and stable housing is facilitated.

10.3.3 The assessment process

While diverse services may exist in the homeless-serving system, it is essential to develop processes to effectively match client needs to the right service. When a client’s complexity is not assessed, or when the programmatic intervention chosen does not match their risk and resiliency factors, there is a higher likelihood of poor outcomes. The programs that have typically faltered are those that have aimed to assist chronically homeless, complex clients with supports that were more appropriate for the more resilient, transitionally homeless population. This confirms the critical role that comprehensive assessments play in ensuring that interventions are appropriately targeted to client needs.

Assessment tools measure a variety of aspects (e.g., health, mental health, addictions, system interactions) and should be strategically assessed and selected to meet community needs as some modifications of these tools may be necessary. Whichever tool is chosen, it is important that it is used consistently across services to ensure a common understanding of need is in place and enable system-level assessments of program success and accurate matching of client needs.

Ultimately, ensuring clients have ready access to the right program at the right time leads to better outcomes for them and the system as a whole.

Selecting an assessment tool

In selecting an assessment tool, one must know where in the process it is to be used, with whom and why. It is critical to remember that assessments inform choices that people can make; these tools do not make choices for people. The assessment or assessment instrument should not override the decisions made by the provider and the client about the best course of action for that client.
In choosing assessment tools, considerations include the following:  

- The tools should be based on a clear understanding of their purpose, whether that is matching clients to services, prioritizing the allocation of available assistance or both.

- Assessments should be tailored to the services that providers can offer. For example, asking about diabetes in an assessment is unnecessary if no services will be offered to directly treat the condition.

- The tools should be used in ways that take client preferences and choices into account.

Across the programs reviewed for the jurisdictional scan, many and varied assessment tools were used including those developed for and unique to programs. It is important to note that the Canadian Observatory on Homelessness is working on developing a set of tools specific for the Canadian context and is currently assessing available tools against best practices, in collaboration with research and clinical experts. The time frame for releasing this analysis is within this year (2015).

The final assessment tool(s) to be used/developed for the St. John’s ICM Program will be determined by the lead organizations implementing the Program. The tool(s) will be chosen so as to determine the appropriate level, intensity and frequency of supports.

### 11.0 Accessing housing

A critical focus of HF is moving people as quickly as possible from a state of homelessness to housing. The performance target established for HPS will be the one which the Program strives to achieve:

<table>
<thead>
<tr>
<th>Performance Target</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of days to move HF clients into permanent housing (after intake or assessment - to be determine by the community)</td>
<td>14</td>
<td>12</td>
</tr>
</tbody>
</table>

Of note, “permanent housing” in the context of this performance target, is understood to mean the client is no longer homeless and/or in an emergency shelter.

The HF fidelity standard which speaks to ensuring clients move into housing of their choice within one month of intake into the Program also will be ensured (see section 18.2).  

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It is well understood by community-based homeless serving organizations and public systems serving individuals who are homeless/experiencing housing instability that there are challenges to finding safe, affordable and appropriate housing for those in need of same. As detailed in section 22.2, challenges include limited availability and restrictive housing policies.

Efforts to secure housing for Program clients will be led by the Program staff team but they must work in collaboration with key and critical stakeholders including EHSJ, the City of St. John's and NL Housing. Further, and as detailed in section 23.5, landlord education and engagement will be an integral aspect of the ICM Program.

### 12.0 Client handbook

Consideration should be given to developing a client handbook for Program clients. Examples from which to draw are:

→ The Infinity Project has developed a youth manual which "welcomes them", provides program guidelines and explains what they can expect from the project. It includes names of staff/contact information, guiding beliefs, forms they should sign and expectations on, for example, keeping their space clean, visitors and noise. It also has detailed information on safety.

→ NAVNET has a client handbook which provides a clear and plain language presentation on the program and how it works for the client, including what the client does and does not have to do if they agree to become involved in the initiative.

→ Moving Forward has a client handbook which provides a clear and plain language presentation on the support provided through the program, the intent of and guidelines for the scheduled “visits” with the client and a list of staff contact numbers.

### 13.0 Individual planning

An integral component in service delivery will be the individual service plans developed with and for each client. This plan is client-centred and driven and reflects the individuals’ needs,

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strengths and goals, as well as activities to achieve these goals. Working with the client and based on assessment results, the Intensive Case Manager determines, for example,

- Daily living needs
- Health care needs
- Formal and informal support systems
- Financial, education and employment needs
- Cultural and religious preferences
- Issues or trigger points and strategies for dealing with them when they emerge
- Leisure and recreational interests/needs.

The client’s goals and priorities should be documented to help the Intensive Case Manager identify their progress, as well as determine resources that are available to support goal achievement. The service plan should include the activities to be conducted by both the client and the Intensive Case Manager and other service providers that will support goal attainment and articulate a vision for the client's future.

It is imperative that individualized safety plans to reduce identified risks also be developed. Such a plan would be interactive, practical, relevant and frequently reviewed. Plans will change as life circumstances change and they should be reviewed and edited when things change to ensure safety. The safety plan should guide case management activities to ensure appropriate mainstream services and clinical supports are in place to meet client needs.

### 13.1 Client consent forms for sharing information

It is imperative that there be a client consent form for sharing information, which details in plain language the protection of privacy and confidentiality of client information. Forms must be signed by the client before initiation of services and a copy kept in client files. Consent forms should include:

- Purpose of the information being collected
- Reason for collection of information
- Use of information
- Access to information
- Secure storage of information
- Length of time information will be stored

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29 Ibid. Pg. 66.
It is suggested that there be forms for information-sharing internal to the Program and external to/from other service providers.

- **Release of Information Form (internal):** Each client would sign a Release of Information Form which permits the Intensive Case Managers to collect and share necessary information between and among the ICM Program staff and enter information into the Program database. This form will be valid for the duration of time the client is in the Program, but will be reviewed with the client on an annual basis. This form will be maintained in the primary client file with copies provided to the client.

- **Release of Information Form (external):** Each client would sign a Release of Information Form which permits Intensive Case Managers to collect and share necessary information from community sources/other service providers and to enter information into the Program database. A form would be signed each time information is requested and/or shared with each community source/service provider. These forms are maintained in the primary client file with copies to the client.

Copies of these forms could be included in the client manual.

Of note, there are many examples of information-sharing and confidentiality forms currently in use by homeless-serving organizations which could be used for the St. John’s ICM Program.

If an individual chooses not to sign the information-sharing forms, this will not impact their entry into the Program or the services to be received.

**14.0 Peer Support**

Research has demonstrated the positive impacts of peer support for people with complex mental health issues. In the MHCC’s report, *Making the Case for Peer Support*, it details that people with lived experience of mental health challenges can offer huge benefits to each other. The development of personal resourcefulness and self-belief, which is the foundation of peer support, not only improve people’s lives but can also reduce the use of formal mental health, medical and social services.

A robust and growing research evidence-base shows peer support is associated with:

- Reductions in hospitalizations for mental health issues,
- Reductions in ‘symptom’ distress,
- Improvements in social support, and
• Improvements in people’s quality of life.

Research shows that the values and processes of peer support – among them, recovery, empowerment and hope – help individuals develop the skills they need to take charge of their lives and help change mental health services so that they can better contribute to the recovery process.  

The St. John’s ICM Program should endeavour to avail of existing peer support groups/networks/resources in the City and if required, develop its own.

### 15.0 Exiting an ICM Program

About half of the programs reviewed for the jurisdictional study have a time frame (based on age, program policy and/or readiness) for clients to exit their programs. For programs which have a specific policy/program expectation regarding the maximum time which a client can access services, informants stated that this is not set in stone. Criteria for exiting and post-program support varied depending on the program; most provided rapid re-entry to their programs for those who had exited, but who were once again in need of the same level of support.

The other jurisdictional programs reviewed do not have specific requirements for clients to exit their programs, although it is recognized that some clients may choose to exit.

Research details the need for relationships with clients to be persistent and reliable. The finding of persistence and reliability does not imply that everybody needs a long period of case management. Rather, it implies that case management durations must be individually negotiated with reference to the person receiving assistance and a realistic level of self-care as an outcome goal. Reliability and persistence is an acknowledgement that sustainable change is never made quickly, nor are the required resources ever completely and instantly available.

The research also has shown that case management programs designed as short-term crisis responses, or as high caseload, office-based brokerage and referral services, do not allow case management to function effectively because a relationship cannot be developed or maintained. Available evidence indicates that six months may be the minimum required duration to establish a working relationship with people experiencing homelessness and mental illness, and more than

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six months will be required for the most disengaged clients. Arbitrarily imposed case management durations may be inefficient if they end the relationship prematurely. Not only will this compromise the outcomes, but the initial investment in the relationship will be lost.

15.1 Exiting the St. John's ICM program

It is recommended that the St. John’s ICM Program not establish a time frame for which clients can be engaged in the Program as, given the unique needs, experiences and backgrounds of the clients, it would to some degree be an arbitrary figure. However, it must work from the premise that transition planning for clients begins on the day of intake – this will require that there be a vision for the future for each client and that planning is long-term and not focused on short-term one-of activities. The intent is to move the clients along a spectrum, as possible, from intensive case management and supports to less intensive supports and onto independent living.

The St. John’s ICM Program must develop clear criteria for clients’ planned and unplanned exit from the Program. It also must detail the type and level of support that will be available to clients who have exited, should their status change and they once more require assistance to maintain their housing and/or health; re-entry into the Program must be an option. The Program also must be founded on the principle that there will be zero exits into homelessness.

An effective practice identified in relation to exit planning is to have peer support programs/networks in place. As previously noted, establishing/availing of existing peer support programs will be a focus of the ICM Program.

It must be acknowledged that reduction in supports for the target population may be a challenging and time-consuming process – as it might require several approaches. However, if the Program is to service the full spectrum of the target population within finite resources and a context of sustainability, the return on investment is clear.

15.2 Client Exit Planning Process


All efforts should be made to keep individuals engaged in services until final assessments show readiness to disengage (planned exits). The case management relationship may end upon successful completion of the identified goals (planned), or conclude with the goals unfulfilled if the client decides not to continue with the service and/or if the service is unable to meet their service needs (unplanned).
Discussion of criteria for planned and unplanned exits is initially done during the intake and assessment process. This discussion is revisited during the case management relationship if issues emerge.

To prepare for exiting the program, from the outset of the case management relationship, the Intensive Case Manager is expected to support people to develop self-advocacy skills to maximize independence. As well, they must provide them with information or links to other available services and support them in securing such resources, address any concerns the person may have about the ending of the relationship prior to ending it and provide contact information for re-accessing services or support.

15.2.1 Planned Exits

Planned exiting is the process whereby clients transition out of the formal case managed relationship because goals have been reached and assessments show readiness to disengage. Clients should be provided with contact information for follow-up questions and/or for re-engagement with the program if necessary. Referrals can be made to other services if assessment shows additional supports or time is needed.

Final Plan Review

A final review of the service plan should occur 30 days before the end of the formal relationship for planned exits.

Post-Measurement

Using the same evidence-based measurement tool as at intake, a post-measurement should be completed within 10 days before planned exits.

15.2.2 Unplanned Exits

Several steps should be in place and documented to ensure all available means were utilized to avoid unplanned exits from a program. Criteria for unplanned exits include but are not exclusive to:

1. Habitual non-compliance with the terms of case management agreement
2. Threats to assault another individual in the program or program staff
3. Physical assault of another individual in the program or program staff
4. Endangering the safety of others
Intensive Case Managers are expected to reduce the likelihood of unplanned exits by, for example:

- Regular meetings to address issues
- Flexible options for payment of arrears
- Advocating with landlords/building operators on a client’s behalf
- Mediation and conflict resolution
- Supporting clients to transfer to different housing if negotiations and accommodations cannot be made with existing landlords/building operators.

There are two kinds of unplanned exits - foreseen and unforeseen.

**Foreseen unplanned exits** can occur over several weeks for behavioural issues or over 24 hours for safety/dangerous situations that threaten harm. In the event of a foreseen unplanned exit, the Intensive Case Manager must make every effort to ensure the successful transition to another program by ensuring:

- Appropriate referral to a minimum of three programs in which the client could enroll, with client consent. The focus of these referrals should be housing stability. If there are not three programs available, (i.e., inappropriate client/program eligibility match) this should be documented, including what the Intensive Case Manager did to facilitate the referrals.

- If a client is unwilling to take a transfer, it is important that he/she be supported in their right to choose. Once presented with the appropriate options, and they refuse all, the client may exit the Program.

- Only when no reasonable alternative is available should a return to emergency shelter be an option, for example, if a woman/family fleeing violence requires the additional security of a women’s shelter while alternate housing plans are made. This should be documented in the case file.

- The agency receiving the referral should consider program fit, wait list and capacity to accept the client. If referral is not appropriate, the agency should communicate to the Program with the reason for refusal.

- Transfer of client information if appropriate and with consent can include their service plan, referral history and case notes.

- Provision of contact information for re-engagement in the Program. (Note: if a Program exit occurred due to threats of violence against program staff, the Program management can use discretion for allowing re-entry; if the decision is not to accept the client back,
this should be documented including the reasons, e.g., the clients’ clinical needs exceed the level of support available from the Program.)

- Provision of program grievance and appeals procedures.

All efforts should be documented and kept in the client file.

*Unforeseen, Unplanned Exits* - In the case of unforeseen, unplanned exits, that is immediate and cannot be predicted (client leaves without prior discussion with the Intensive Case Manager), staff must complete an exit summary that contains information related to efforts to resolve issues and keep clients engaged. This should be documented in the client file.

### 15.3 Re-Accessing Services after planned or unplanned exits

At the point of exiting the Program, the client is advised how to re-access the service if necessary in the future. If re-access occurs within three months of exiting the Program, the client file can be re-opened and an updated plan developed. If re-access occurs after three months, the case management process begins with a new intake.

### 15.4 Exit Resource Package

Moving Forward has developed an exit package/binder which is provided to each youth who exits the program. It contains critical information on a youth’s transition plan, health care, education/programs, resumes and contact numbers:

**Transition plan**

- Copy of Transition Plan
- Long-term and Short-term goals

**Identification**

- Original Birth Certificate
- Photocopy of Birth Certificate
- Original MCP Card
- Photocopy of MCP Card
- Original Hospital Card
- Photocopy of Hospital Card
- Original Photo Identification
• Photocopy of Photo Identification
• Original Social Insurance Card
• Photocopy of Social Insurance Card
• Bank Card
• Photocopy of Bank Card

Health Care
• All blister pack medications provided
• Contact information for previous and current pharmacy
• Three-month prescription for current medications
• Copy of Immunization records
• Annual medical, optical, dental appointment due dates

Education/Program
• Copy of Transcript
• Copy of Referrals
• Application for Advanced Education and Skills

Resumes
• Updated resume
• 10 photocopies of resume

Contact numbers
• Youth Services
• Moving Forward
• Personal health care contacts
• General supports and services in area
• 24 hours/after-hour support
• Community resources

It is recommended that the St. John’s ICM Program review this exit package with a view to developing a similar package.
16.0 Policies and Procedures

Policies and procedures are the strategic link between the vision of the St. John’s ICM Program and its day-to-day operations. Well-written policies and procedures will:

- Provide staff with information that allows them to clearly understand their roles and responsibilities, freedom to carry out their job and make decisions within defined boundaries/predefined limits;
- Allow staff to understand the constraints of their job without using a ‘trial and error’ approach, as key points are visible in well-written policies and procedures;
- Enable staff to clearly understand individual and team responsibilities/expectations, thus saving time and resources. Everyone is working from the same page; employees can get the “official” word on how they should go about their tasks quickly and easily;
- Allow managers to guide operations without constant management intervention/micro-management; and
- Enable accountability in the eyes of internal and external stakeholders.32

The St. John’s ICM Program must have a comprehensive set of policies and procedures which minimally identifies acceptable practices relating to:

Staff

- Job descriptions
- Hiring
- Probationary period and orientation
- Resignations
- Termination
- Staff training and development
- Staff meetings
- Time sheet/shift report submission
- Annual leave/leave request
- Shift change/cancellation
- Statutory holidays

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- Adverse weather conditions
- Overtime
- Promotion of self-care and professional development

**Administration**

- Prudent use of public funds according to contract schedules
- Expenses
- Data collection and reporting; maintaining data; access to data
- Protection of confidential information
- Internal grievance processes
- Performance management
- Disciplinary processes

**Ethics and conduct**

- Professional/ethical conduct
- Use of email and internet/social media
- Use of cell phone
- Avoiding personal, financial and professional conflict of interest
- Privacy and protection of client information relating to legislative requirements (e.g., Access to Information and Protection of Privacy Act), codes of confidentiality and processes to deal with breaches of privacy
- Complaint processes for community members, clients, staff, landlords and other parties relevant to the ICM Program including an appeal process
- Addressing allegations of client abuse.

### 16.1 Risk Management/staff safety

The complexities of people who have experienced homelessness, many of whom have addiction and mental health issues and could have justice histories/involvement, can sometimes result in difficult, if not unsafe situations, including for example, physical violence, drugs, fires and other
harmful behaviour. The St. John’s ICM Program must prioritize risk management and staff safety with clear policies and procedures for same articulated in the Program policy framework.\textsuperscript{33} 

Staff must be informed and educated on both the risks associated with their position and measures to mitigate the identified risks. Relevant policies include:

- Staff safety, including working alone
- Universal precautions
- Medication and dispensing
- Injury in the workplace
- Incident reporting, including critical incidents such as client death, fire, and management of communicable disease, threats of violence or violence towards staff
- Risk management
- Use of personal vehicles for transporting clients.

In relation to considering policies and procedures for risk management and staff safety, the following information from the Calgary Homeless Foundation will be instructive.


1. Programs should have clearly written policies, procedures and protocols which take into account staff safety and security. Program protocols include staff check-ins at predetermined intervals, staff access to cell phones, staff attend home visits in pairs where safety may be an issue, safety is an ongoing part of staff supervision, safety concerns are reflected in case plans, staff teams regularly discuss safety concerns and staff receive safety training.

2. It is important for programs to maintain detailed documentation in the client file. The documentation should provide adequate details with respect to safety concerns, case management support and interventions relating to the safety concerns and ongoing monitoring and reporting of safety concerns.

3. With frequent exposure to expressions and/or acts of aggression and violence in our sector, it is important for staff and supervisors to be aware of adverse emotional and psychological impact. The impact may also result in increased tolerance or desensitivities.

\textsuperscript{33} Stephen Gaetz, Fiona Scott, Tanya Gulliver, Housing First in Canada: Supporting Communities to End Homelessness. 2013.
to acts of client aggression and violence, which may put both staff and clients at risk. This is a particular concern in housing couples and families whose history of discord is intensified due to mental health, addictions and/or financial stressors.

4. The capacity of a program to mitigate risk with respect to client and staff safety is largely determined by program structure and staffing resources. In other words, some programs may not have the program structure and/or staffing resources to provide the level of clinical support or monitoring which some higher acuity clients require. It is important that eligibility criteria and screening processes of programs are aligned with the target population that the program is designed to serve.

5. It is important that programs have tools and/or processes in place to assess behavior that may put the client or staff at risk. The assessment of risk should minimally include assessment of a client’s criminal background and presence of domestic violence prior to intake into the program. It is essential in this process that programs develop working relationships and communication protocols with partners […] to gather information to complete a full assessment.

6. It is important for programs to develop safety plans with clients who may be at risk.

### 16.2 Sample policies

It is anticipated that the organizations taking on the leadership roles for implementation and evolution of the St. John’s ICM Program have their own compendium of policies and procedures. A few sample policies are provided in Appendix “D” including:

- Confidentiality
- Codes of Ethics and Conduct
- Universal Precautions
- Medication and dispensing
- Safety/Working alone
- Safety and Critical Incidents (Calgary Homeless Foundation)
- Serious Incident Reporting form
- Safety and Critical Incidents (Community Support Program)
- Critical Incident Report form
Other sources for review, comparison and/or adoption of relevant policies include:


17.0 Protocols for service delivery

It is suggested that, as possible, protocols be developed for the St. John's ICM Program to establish roles and responsibilities and guide program delivery. Examples of protocols are available from the At Home / Chez Soi Toronto project site and as well from the Calgary Homeless Foundation’s Standards of Practice - Accreditation Process and Standards Manual (2011). These include, for example, protocols for intake, assessment, identifying and securing housing, developing individual service plans, eviction prevention, planned and unplanned exiting from the Program and a complaint process for clients, their families and external stakeholders/partners.

The following is an example of a “Housing Protocol” from Homeward Trust Edmonton's Housing First Service Manual.34

Housing Protocol

- Clients will be presented a minimum of two housing choices based upon their needs and preferences, which are of good quality, affordable and actionable.

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• Clients shall be informed of any particular rules or regulations or program protocols that they are agreeing to with any specific type of housing that they are choosing.

Orientation, furniture and move-in support

• Clients shall be provided an orientation to their new building at move in, including but not limited to:
  ▪ Fire exits
  ▪ Mail service
  ▪ Laundry
  ▪ Access (e.g., buzzer, lock)
  ▪ Location and contact details for superintendent/landlord
  ▪ Garbage/location
  ▪ Storage

• Clients will be encouraged, during the orientation, to introduce themselves to their most immediate neighbours.
• Clients will have access to the furniture bank to furnish their apartment.
• Arrangements will be made for the delivery of those belongings on the day of move-in or as shortly thereafter as possible.
• Clients will be assisted in moving furnishings and belongings into their apartment.
• Housing First staff will assist clients setting up their apartment.
• Housing First staff will accompany clients on day of move-in to the apartment.

Core items for re-housed tenants

Further, the Housing First Service Manual provides a detailed list of what items will be purchased or acquired with the client at the time of move-in or as soon as possible after move in (with some items coming from a furniture bank).

• Shower curtain and hooks / Bath mat
• Two towels
• Hygiene supplies
• Couch / Television / Table / Lamp (all from the furniture bank)
• Curtains for each window
• Picture for the wall (furniture bank)
• Two plates / Two cereal bowls / Two glasses / Two mugs / Two place settings of cutlery
- Coffee maker / Kettle
- Toaster
- Pots and pans set / Frying pan
- Egg flipper / Potato masher / Slotted spoon
- Mixing bowl / Cookie sheet
- Microwave
- Four tea towels / Four dish clothes
- Dish rack
- Cutting board
- Strainer/colander
- Bed - single one per individual, double for couples enrolled in the program (furniture bank)
- Sheets / Blanket / Comforter / Pillow
- Dresser (furniture bank)
- Clothes hangers (24)
- Pail / Mop
- All purpose cleaner / Toiler cleaner
- Broom / dustpan
- Vacuum cleaner
- Toilet bowl brush
- Dish soap

### 18.0 Evaluation and Performance Management

In advance of its implementation in September 2015, an evaluation framework will be developed for the St. John's ICM Program. This will include a logic model and evaluation matrix detailing the evaluation issues/questions and sources of evidence.

As detailed in the ICM standards for the Program (see section 18.1), an external evaluator should be engaged at the outset of the implementation of the Program and a formative review completed at the end of the project in March 2017. The evaluation over the course of the September 2015 – March 31, 2017 would include:

- Initial guidance regarding data collection (Early Fall 2015)
- Client surveys (March 2016)
- Focused interviews with two or three key partners; focus group with Program staff (March 2016)
- High level data review (March 2016)
- Summary findings report of this preliminary evaluation activity (May 2016)
- Formative evaluation – to include for example, key informants interviews, data review, focus groups, and client surveys (March – May 2017)
- Formative evaluation report (June 2017)

It is anticipated that this overall evaluation activity would cost from $25,000 – $30,000 +HST: $10,000+HST in year one of the Program; up to $20,000+HST in year two.

Should the project be renewed to 2019, evaluation should be ongoing with a summative evaluation completed for March 2019. Should the Program continue beyond 2019, it is recommended that an external evaluation be undertaken every three to five years.

### 18.1 ICM standards

Critical functions of an ICM program can include:\[35\]:

- Outreach and Consumer Identification
- Assessment and Planning
- Direct Service Provision/Intervention
- Monitoring, Evaluation and Follow-up
- Information, Liaison, Advocacy, Consultation and Collaboration

Given the St. John's ICM Program will be referral-based and founded on HF principles, the following provides a suggested set of standards and functions relevant to the Program.

<table>
<thead>
<tr>
<th>Function</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to the Program / Intake and Assessment/ Housing</td>
<td>▪ Agency referrals to the St. John's ICM Program will be based on a consistent set of criteria and a standardized form.</td>
</tr>
<tr>
<td></td>
<td>▪ The intake and assessment process will be initiated within three working days.</td>
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</tbody>
</table>

### Function

<table>
<thead>
<tr>
<th>Standards</th>
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<tbody>
<tr>
<td>Options</td>
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<tr>
<td>- days after an initial referral to the Program.</td>
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<tr>
<td>- If diversion to another service is recommended, the referral will be developed in consultation with the client.</td>
</tr>
<tr>
<td>- Once a client has been approved for entry into the Program, at a minimum, they will be provided information on their rights and responsibilities, the services and supports they can expect, the expectation that they will meet with their Intensive Case Manager a minimum of three times a month, the grievance process should they not be satisfied with programs/services and the exit process.</td>
</tr>
<tr>
<td>- Release of Information Form (internal): Each client signs a Release of Information Form which permits the Intensive Case Managers to collect and share necessary information between and among the ICM Program staff and enter information into the Program database. This form will be valid for the duration of time the client is in the Program, but will be reviewed with the client on an annual basis. This form will be maintained in the primary client file with copies to the client.</td>
</tr>
<tr>
<td>- If a client chooses not to sign this form, this will not impact their entry into the Program or access to services.</td>
</tr>
<tr>
<td>- Release of Information Form (external): Each client signs a Release of Information Form which permits Case Managers to collect and share necessary information from community sources/other service providers and to enter information into the Program database. A form must be signed each time information is requested and/or shared with each community source/service provider. These forms are maintained in the primary client file with copies to the client.</td>
</tr>
<tr>
<td>- If a client chooses not to sign this form, this will not impact their entry into the Program or access to services.</td>
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<tr>
<td>- Clients will be provided the Program handbook.</td>
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<tr>
<td>- The Program staff team will work in collaboration with key and critical stakeholders including EHSJ, the City of St. John’s and NL Housing to secure housing for Program clients.</td>
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<tr>
<td>- Landlord education and engagement will be an integral aspect of the ICM Program.</td>
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<tr>
<td>- Clients will have appropriate and responsive housing options.</td>
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<tr>
<td>Function</td>
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<tr>
<td>--------------------------------</td>
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<tr>
<td><strong>Service Planning</strong></td>
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<td></td>
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<tr>
<td><strong>Direct Service Provision/ Intervention</strong></td>
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</tr>
<tr>
<td><strong>Monitoring, Evaluation and Follow-up</strong></td>
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</tbody>
</table>
### Function | Standard
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- | A written exit plan will be developed for clients exiting from the service that would include criteria for follow-up, re-entry and linkage with other services.
- | Written protocols will be developed for a complaint process to receive and act upon the concerns of clients, families and stakeholders/partners. Clients must be informed of this process.
- | Program evaluation will be ongoing - through feedback from Program staff, clients and partner agencies and ongoing review of data.
- | An external evaluator will be engaged at the outset of Program implementation to ensure ongoing monitoring of design and implementation; a preliminary review will be completed in March 2016; a formative review will be completed at the end of the project in March 2017. Should the project be renewed to 2019, evaluation would be ongoing with a summative evaluation completed for March 2019. On an ongoing basis, an external evaluation would be undertaken every three to five years.

### Information, Liaison, Advocacy, Consultation and Collaboration
- | The lead agencies for the St. John’s ICM Program develop partnerships with other community services/government agencies and primary care providers to ensure continuity of service provision to clients.
- | The Intensive Case Managers will have in-depth knowledge about services that are accessible and relevant to client interests in order to provide up-to-date information.
- | The Intensive Case Manager advocates on behalf of clients for services that are accessible and relevant to the client’s needs.

### 18.2 Fidelity and Housing First

Information for this section was primarily drawn from the following sources:


Fidelity assesses the extent to which implementation reflects the actual ideas, principles and practice/methods of a model/program/initiative, i.e., how “true” the sound is to the actual recording and high fidelity represents the least amount of distortion. The fidelity domains and standards for HF include:

→Housing Choice and Structure
Standards focusing on the provision of housing to clients (e.g., housing choice, housing availability, integrated housing)

→Separation of Housing and Services
Standards focusing on the relationship between housing and support provided by the program (e.g., no housing readiness, standard tenant agreement, commitment to re-house)

→Service Philosophy
Standards focusing on the principles and values guiding the delivery of services (e.g., service choice, harm reduction, assertive engagement, person-centered planning)

→Service Array
Standards focusing on the range of services available to clients (e.g., psychiatric services, integrated substance abuse treatment, nursing services, supported employment services)

→Program Structure
Standards focusing on service delivery characteristics (e.g., frequency of contact with clients, client/staff ratio, team approach, peer specialist on staff)

Fidelity is important to ensure, for example, that the following principles are clear:

• Housing First is not “Housing Only”
• Housing First is not “Housing is the first thing after they…”
• Choice is not laissez-faire
• Assertive engagement is not coercion
As an example, for “Service Philosophy”:

Low Fidelity

“…what we're really saying is, 'How do I see something from their perspective to get their buy-in and reframe it?' That's all it is - re-framing it in a way that's digestible and palatable for them. And so, yeah it's manipulation, yes, but we believe that we're doing it with the best intentions.”

High Fidelity

"I spend a lot of time helping people [staff] look at the perspective of the member [client], and then helping them move that way instead of what we think is the best thing for them..."

As another example, in relation to client decision-making:

Low: Clinically-centered, make decisions for clients.

Medium: Client-centered, take into account client’s different needs

High: Client-driven, truly collaborative – “Do you have any goals, hopes, dreams? What would you do if you had a home?"

A number of issues can impact fidelity and these would need to be considered when measuring the degree to which the St. John’s ICM Program has adhered to the HF fidelity scale: the agency implementing the Program, availability of housing/Program staff, local policy, social context, available funding and the needs of the clients.

A HF fidelity scale\(^{36}\) with versions for ACT and ICM program types was developed for the At Home/ Chez Soi study and used to rate programs on 38 items. The table below presents the fidelity scale for an ICM approach. This can be used to track fidelity to the St. John’s ICM Program, with adaptation as required once the model is finalized.

### HOUSING CHOICE AND STRUCTURE

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<tr>
<td><strong>1.</strong></td>
<td>Housing Choice.</td>
<td>Participants have no choice in the location, decorating, furnishing, or other features of their housing.</td>
<td>Participants have some choice in location, decorating, furnishing, and other features of their housing.</td>
<td>Participants have little choice in location, decorating, furnishing, and other features of their housing.</td>
<td>Participants have much choice in location, decorating, furnishing, and other features of their housing.</td>
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<tr>
<td><strong>2.</strong></td>
<td>Housing Availability.</td>
<td>Less than 54% of program participants move into a unit of their choosing within 1 month.</td>
<td>55 - 69% of program participants move into a unit of their choosing within 1 month.</td>
<td>70 - 84% of program participants move into a unit of their choosing within 1 month.</td>
<td>85% or more of program participants move into a unit of their choosing within 1 month.</td>
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<td><strong>3.</strong></td>
<td>Permanent Housing Tenure.</td>
<td>There are rigid time limits on the length of stay in housing such that participants are expected to move by a certain date or the housing is considered emergency, short-term, or transitional.</td>
<td>There are standardized time limits on housing tenure, such that participants are expected to move when standardized criteria are met.</td>
<td>There are individualized time limits on housing tenure, such that participants can stay as long as necessary, but are expected to move when certain criteria are met.</td>
<td>There are no expected time limits on housing tenure, although the lease agreement may need to be renewed periodically.</td>
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<td><strong>4.</strong></td>
<td>Affordable Housing.</td>
<td>Participants pay 61% or more of their income for housing costs.</td>
<td>Participants pay 46-60% of their income for housing costs.</td>
<td>Participants pay 31-45% of their income for housing costs.</td>
<td>Participants pay 30% or less of their income for housing costs.</td>
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<td><strong>5.</strong></td>
<td>Integrated Housing.</td>
<td>Participants do not live in private market housing; access is determined by disability; and 100% of the units in a building are leased by the program.</td>
<td>Participants live in private market housing where access may or may not be determined by disability, and more than 40% of the units in a building are leased by the program.</td>
<td>Participants live in private market housing where access is not determined by disability and 21 - 40% of the units in a building are leased by the program.</td>
<td>Participants live in private market housing where access is not determined by disability and less than 20% of the units in a building are leased by the program.</td>
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<td><strong>6.</strong></td>
<td>Privacy.</td>
<td>Participants are expected to share all living areas with other tenants, including a bedroom.</td>
<td>Participants have their own bedroom, but are expected to share living areas such as bathroom, kitchen, dining room and living room with other tenants.</td>
<td>Participants have their own bedroom and bathroom, but are expected to share living areas such as a kitchen, dining room, and living room with other tenants.</td>
<td>Participants are not expected to share any living areas with other tenants.</td>
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Note that this standard was changed from three months to one month for the St. John’s ICM Program.
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<td><strong>SEPARATION OF HOUSING &amp; SERVICES</strong></td>
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<td>7.</td>
<td><strong>No Housing Readiness.</strong> Extent to which program participants are not required to demonstrate housing readiness to gain access to housing units.</td>
<td>Participants have access to housing only if they have successfully completed a period of time in transitional housing or outpatient/inpatient/residential treatment.</td>
<td>Participants have access to housing only if they meet many readiness requirements such as sobriety, abstinence from drugs, medication compliance, symptom stability, or no history of violent behavior or involvement in the criminal justice system.</td>
<td>Participants have access to housing with minimal readiness requirements, such as willingness to comply with program rules or a treatment plan that addresses sobriety, abstinence and medication compliance.</td>
<td>Participants have access to housing with no requirements to demonstrate readiness, other than agreeing to meet with staff face-to-face three times a month.</td>
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<td>8.</td>
<td><strong>No Program Contingencies of Tenancy.</strong> Extent to which continued tenancy is not linked in any way with adherence to clinical, treatment, or service provisions.</td>
<td>Participants can keep housing only by meeting many requirements for continued tenancy, such as sobriety, abstinence from drugs, medication compliance, symptom stability, no violent behavior or involvement in the criminal justice system.</td>
<td>Participants can keep housing with minimal requirements for continued tenancy, such as participation in formal services or treatment activities (attending groups, seeing a psychiatrist).</td>
<td>Participants can keep their housing with no requirements for continued tenancy, other than adhering to a standard lease and seeing staff for a face-to-face visit 3 times a month.</td>
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<td>9.</td>
<td><strong>Standard Tenant Agreement.</strong> Extent to which program participants have legal rights to the unit with no special provisions added to the lease or occupancy agreement.</td>
<td>Participants have no written agreement specifying the rights and responsibilities of tenancy and have no legal recourse if asked to leave their housing.</td>
<td>Participants have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of tenancy, but contains special provisions regarding adherence to clinical provisions (e.g., medication compliance, sobriety, treatment plan).</td>
<td>Participants have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of tenancy, but contains special provisions regarding adherence to program rules (e.g., requirements for being in housing at certain times, no overnight visitors).</td>
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<td>10.</td>
<td><strong>Commitment to Re-House.</strong> Extent to which the program offers participants who have lost their housing access to a new housing unit.</td>
<td>Program does not offer participants who have lost their housing a new unit, but assists them to find housing outside the program.</td>
<td>Program does not offer participants who have lost housing a new unit, but only if they meet readiness requirements, complete a period of time in more supervised housing, or the program has set limits on the number of relocations.</td>
<td>Program offers participants who have lost their housing a new unit without requiring them to demonstrate readiness and has no set limits on the number of possible relocations.</td>
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<td>11.</td>
<td>Services Continue Through Housing Loss. Extent to which program participants continue receiving services even if they lose housing.</td>
<td>Participants are exited from program services if they lose housing for any reason. (Services are contingent on staying in housing.)</td>
<td>Participants are exited from services if they lose housing, but there are explicit criteria specifying options for re-enrollment, such as completing a period of time in inpatient treatment.</td>
<td>Participants continue to receive program services if they lose housing, but may be exited if they do not meet “housing readiness” criteria.</td>
<td>Participants continue to receive program services even if they lose housing due to eviction, short-term inpatient treatment, although there may be a service hiatus during institutional stays.</td>
</tr>
<tr>
<td>12.</td>
<td>Off-site, Mobile Services. Extent to which social and clinical service providers are not located at participant’s residences and are mobile.</td>
<td>Social and clinical service providers are based on-site 24/7, and have limited or no mobility to deliver services at locations of participants’ choosing.</td>
<td>Social and clinical service providers are based off-site or on-site during the day and have limited mobility to deliver services at locations of participants’ choosing.</td>
<td>Social and clinical service providers are based off-site, but maintain an office on-site, and are capable of providing mobile services to locations of participants’ choosing.</td>
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**SERVICE PHILOSOPHY**

| 13. | Service choice. Extent to which program participants choose the type, sequence, and intensity of services on an ongoing basis. | Services are chosen by the service provider with no input from the participant. | Participants have little say in choosing, modifying, or refusing services. | Participants have some say in choosing, modifying, or refusing services and supports, but program staff determinations usually prevail. | Participants have the right to choose, modify, or refuse services and supports at any time, except three face-to-face visits with staff a month. |
| 14. | No requirements for participation in psychiatric treatment. Extent to which program participants with psychiatric disabilities are not required to take medication or participate in psychiatric treatment. | All participants with psychiatric disabilities are required to take medication and participate in psychiatric treatment. | Participants with psychiatric disabilities are required to participate in mental health treatment such as attending groups or seeing a psychiatrist and are required to take medication but exceptions are made. | Participants with psychiatric disabilities who have not achieved a specified period of symptom stability are required to participate in mental health treatment, such as attending groups or seeing a psychiatrist. | Participants with psychiatric disabilities are not required to take medication or participate in formal treatment activities. |
| 15. | No requirements for participation in substance use treatment. Extent to which participants with substance use disorders are not required to participate in treatment. | All participants with substance use disorders, regardless of current use or abstinence, are required to participate in substance use treatment (e.g., inpatient treatment, attend groups or counseling with a substance use specialist). | Participants who are using substances or who have not achieved a specified period of abstinence must participate in substance use treatment. | Participants with substance use disorders whose use has surpassed a threshold of severity must participate in substance use treatment. | Participants with substance use disorders are not required to participate in substance use treatment. |
| 16. | Harm Reduction | Participants are | Participants are | Participants are not | Participants are not |

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Goss Gilroy Inc. 70
## Approach
Extent to which program utilizes a harm reduction approach to substance use.

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<tr>
<td>17.</td>
<td>Motivational Interviewing. Extent to which program staff use motivational interviewing in all aspects of interaction with program participants.</td>
<td>Program staff are not at all familiar with motivational interviewing.</td>
<td>Program staff are somewhat familiar with principles of motivational interviewing.</td>
<td>Program staff are very familiar with principles of motivational interviewing, but it is not used consistently in daily practice.</td>
<td>Program staff are very familiar with principles of motivational interviewing and it is used consistently in daily practice.</td>
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</table>

## Assertive Engagement.
Program uses an array of techniques to engage difficult-to-treat consumers, including (1) motivational interventions to engage consumers in a more collaborative manner, and (2) therapeutic limit setting interventions where necessary, with a focus on instilling autonomy as quickly as possible. In addition to applying this range of interventions, (3) the program has a thoughtful process for identifying the need for assertive engagement measuring the effectiveness of these techniques, and modifying approach where necessary.

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<td>18.</td>
<td>Assertive Engagement. Program uses an array of techniques to engage difficult-to-treat consumers, including (1) motivational interventions to engage consumers in a more collaborative manner, and (2) therapeutic limit setting interventions where necessary, with a focus on instilling autonomy as quickly as possible. In addition to applying this range of interventions, (3) the program has a thoughtful process for identifying the need for assertive engagement measuring the effectiveness of these techniques, and modifying approach where necessary.</td>
<td>Team only uses #1 or #2.</td>
<td>A more limited array of assertive engagement strategies are used for engagement (partial #1 and #2). Systematic identification is lacking (#3 absent).</td>
<td>Team uses #1 and #2. Team does not systematically identify the need for various types of engagement strategies (#3 absent).</td>
<td>Team systematically uses assertive engagement strategies by applying all 3 principles (see under definition)</td>
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## Absence of Coercion.
Extent to which the program does not engage in coercive activities towards

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<td>19.</td>
<td>Absence of Coercion. Extent to which the program does not engage in coercive activities towards</td>
<td>Program routinely uses coercive activities with participants such as leveraging housing or services to</td>
<td>Program sometimes uses coercive activities with participants and there is no acknowledgment</td>
<td>Program sometimes uses coercive activities with participants, but staff acknowledge that these practices may</td>
<td>Program does not use coercive activities such as leveraging housing or services to promote adherence to clinical</td>
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<td>20.</td>
<td><strong>Person-Centered Planning.</strong> Program conducts person centered planning, including: 1) development of formative treatment plan ideas based on discussions driven by the participant’s goals and preferences, 2) conducting regularly scheduled treatment planning meetings, 3) actual practices reflect strengths and resources identified in the assessment.</td>
<td>Less than 54% of treatment plans and updates satisfy all 3 criteria.</td>
<td>55 - 69% of treatment plans and updates satisfy all 3 criteria.</td>
<td>70 - 84% of treatment plans and updates satisfy all 3 criteria.</td>
<td>At least 85% of treatment plans and updates satisfy all 3 criteria.</td>
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<tr>
<td>21.</td>
<td><strong>Interventions Target a Broad Range of Life Goals.</strong> The program systematically delivers or brokers specific interventions to address a range of life areas (e.g., physical health, employment, education, housing satisfaction, social support, spirituality, recreation and leisure).</td>
<td>Delivered or brokered interventions do not target a range of life areas.</td>
<td>Program is not systematic in delivering or brokering interventions that target a range of life areas.</td>
<td>Program delivers or brokers interventions that target a range of life areas but in a less systematic manner.</td>
<td>Program systematically delivers or brokers interventions that target a range of life areas.</td>
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<td>22.</td>
<td><strong>Participant Self-Determination and Independence.</strong> Program increases participants’ independence and self-determination by giving them choices and honoring day-to-day choices as much as possible (i.e., there is a recognition of the varying needs and functioning levels of participants, but level of oversight and care is commensurate with need, in light of the</td>
<td>Program directs participants decisions and manages day-to-day activities to a great extent that clearly undermines promoting participant self-determination and independence or program does not actively work with participants to enhance self-determination, nor do they provide monitoring or supervision.</td>
<td>Program provides a high level of supervision and participants’ day-to-day choices are not very meaningful.</td>
<td>Program generally promotes participants’ self-determination and independence.</td>
<td>Program is a strong advocate for participants’ self-determination and independence in day-to-day activities.</td>
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<td>goal of enhancing self- determination).</td>
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<td><strong>SERVICE ARRAY</strong></td>
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<td>23.</td>
<td><strong>Housing Support.</strong> Extent to which program offers services to help participants maintain housing, such as offering assistance with neighborhood orientation, landlord relations, budgeting and shopping.</td>
<td>Program does not offer any housing support services.</td>
<td>Program offers some housing support services during move-in, such as neighborhood orientation, shopping, but no follow-up or ongoing services are available.</td>
<td>Program offers some ongoing housing support services including assistance with neighborhood orientation, landlord relations, budgeting, and shopping but does not offer any property management services, assistance with rent payment and cosigning of leases.</td>
<td>Program offers ongoing housing support services including assistance with neighborhood orientation, landlord relations, budgeting, shopping, property management services, assistance with rent payment and co-signing of leases.</td>
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<tr>
<td>24.</td>
<td><strong>Psychiatric Services.</strong> Program successfully links participants who need psychiatric support with a psychiatrist in the community. (documentation evidences participant received services or program routinely attempted engagement within the last 6 months).</td>
<td>Program successfully links less than 54% of participants who need psychiatric support with a psychiatrist.</td>
<td>Program successfully links 55 - 69% of participants who need psychiatric support with a psychiatrist.</td>
<td>Program successfully links 70 - 84% of participants who need psychiatric support with a psychiatrist.</td>
<td>Program successfully links 85% or more of participants who need psychiatric support with a psychiatrist.</td>
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<td>25.</td>
<td><strong>Integrated, Stage-wise Substance Use Treatment.</strong> Program successfully links participants who need substance use treatment with such treatment in the community. (documentation evidences participant received services or program routinely attempted engagement within the last 6 months)</td>
<td>Program successfully links less than 54% of consumers in need of substance abuse treatment with agencies that provide such treatment.</td>
<td>Program successfully links 55 - 69% of consumers in need of substance abuse treatment with agencies that provide such treatment.</td>
<td>Program successfully links 70 - 84% or more of consumers in need of substance abuse treatment with agencies that provide such treatment.</td>
<td>Program successfully links 85% or more of consumers in need of substance abuse treatment with agencies that provide such treatment.</td>
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<tr>
<td>26.</td>
<td><strong>Supported Employment Services.</strong> Supported employment services are provided directly or brokered by the program. Core</td>
<td>Less than 30% of consumers in need of services are receiving them from the team (receiving 1 &amp; 2 or 1 &amp; 3).</td>
<td>30 - 44% of consumers in need of services are receiving them from the team (receiving 1 &amp; 2 or 1 &amp; 3).</td>
<td>45 - 59% of consumers in need of services are receiving them from the team (receiving 1 &amp; 2 or 1 &amp; 3).</td>
<td>60% or more of consumers in need of services received supported employment services (receiving 1 &amp; 2 or 1 &amp; 3).</td>
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### End Homelessness St. John’s Intensive Case Management Program Model – Key Elements

**June 2015**

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<td>services include: (1) engagement and vocational assessment; (2) rapid job search and placement based on participants’ preferences (including going back to school, classes); and (3) job coaching and follow-along supports (including supports in academic settings).</td>
<td>Program successfully links less than 54% of participants who need medical care with a physician or clinic.</td>
<td>Program successfully links 55-69% of participants who need medical care with a physician or clinic.</td>
<td>Program successfully links 70-84% of participants who need medical care with a physician or clinic.</td>
<td>Program successfully links 85% or more of participants who need medical care with a physician or clinic.</td>
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<td><strong>27.</strong> Nursing/Medical care. Program successfully links participants who need medical care with a physician or clinic in the community. (documentation clearly evidences participant received services or programs routinely attempted engagement within the last 6 months)</td>
<td>Less than 54% of consumers in need of services are receiving support for social integration. (At least 1 service)</td>
<td>55 - 69% of consumers in need of services are receiving support for social integration. (At least 1 service)</td>
<td>70 - 84% of consumers in need of services are receiving support for social integration. (At least 1 service)</td>
<td>85% of consumers in need of services are receiving support for social integration. (At least 1 service)</td>
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<td><strong>28.</strong> Social Integration. Extent to which services supporting social integration are provided directly by the program. 1) Facilitating access to and helping participants develop valued social roles and networks within and outside the program, 2) helping participants develop social competencies to successfully negotiate social relationships, 3) enhancing citizenship and participation in social and political venues.</td>
<td>Program has no responsibility for handling crises after hours and offers no linkages to emergency services.</td>
<td>Program does not respond during off hours by phone, but links participants to emergency services for coverage.</td>
<td>Program responds during off-hours by phone, but less than 24 hours a day, and links participants to emergency services as necessary.</td>
<td>Program responds 24- hours a day by phone directly and links participants to emergency services as necessary.</td>
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<td><strong>29.</strong> 24-hour Coverage. Extent to which program responds to psychiatric or other crises 24-hours a day.</td>
<td>Program has no responsibility for handling crises after hours and offers no linkages to emergency services.</td>
<td>Program does not respond during off hours by phone, but links participants to emergency services for coverage.</td>
<td>Program responds during off-hours by phone, but less than 24 hours a day, and links participants to emergency services as necessary.</td>
<td>Program responds 24- hours a day by phone directly and links participants to emergency services as necessary.</td>
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<td>30.</td>
<td>Involved in In-Patient Treatment. Program is involved in in-patient treatment admissions and works with in-patient staff to ensure proper discharge.</td>
<td>Program is involved in less than 55% of in-patient admissions and discharges.</td>
<td>Program is involved in 55 - 69% of in-patient admissions and discharges.</td>
<td>Program is involved in 70 - 84% of in-patient admissions and discharges.</td>
<td>Program is involved in 85% or more of inpatient admissions and discharges.</td>
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<td>30A.</td>
<td>Professional Networking. Program successfully builds professional connections with a range of institutions and providers to facilitate access to treatment and services.</td>
<td>Program has no established relationships with agencies or staff and are not knowledgeable as to what community resources are available to their participants.</td>
<td>Program has few established relationships with agencies and/or referrals are very infrequent.</td>
<td>Program has established relationships with agencies but does not routinely make referrals.</td>
<td>Program has established relationships with agencies that provide a vast array of services and routinely makes referrals.</td>
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**PROGRAM STRUCTURE**

<p>| 31. | Priority Enrollment for Individuals with Obstacles to Housing Stability. Extent to which program prioritizes enrollment for individuals who experience multiple obstacles to housing stability. | Program has many rigid participant exclusion criteria such as substance use, symptomatology, criminal justice involvement and behavioral difficulties, and there are no exceptions made. | Program has many participant exclusion criteria such as substance use, symptomatology, criminal justice involvement and behavioral difficulties, but exceptions are possible. | Program selects participants with multiple disabling conditions, but has some minimal exclusion criteria. | Program selects participants who fulfill criteria of multiple disabling conditions including: 1) homelessness, 2) severe mental illness and 3) substance use. |
| 32. | Low Participant/Staff Ratio. Extent to which program consistently maintains a low participant/staff ratio, excluding the psychiatrist and administrative support. | 50 or more participants per 1 FTE staff. | 36-49 participants per 1 FTE staff. | 21-35 participants per 1 FTE staff. | 20 or fewer participants per 1 FTE staff. |
| 33. | Contact with Participants. Extent to which program has a minimal threshold of non-treatment related contact with participants. | Program meets with less than 60% of participants 3 times a month face-to-face. | Program meets with 60 - 74% of participants 3 times a month face-to-face. | Program meets with 75 - 89% of Participants at least 3 times a month face-to-face. | Program meets with 90% of participants at least 3 times a month face-to-face. |
| 34. | Team Approach. Extent to which program staff function as a multidisciplinary team; clinicians know and work with all program participants. | N/A | N/A | N/A | N/A |
| 35. | Frequent Meetings. | Program meets at least | Program meets at least | Program meets at | Program meets at |</p>
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<td><strong>Extent to which program staff meet frequently to plan and review services for each program participant.</strong></td>
<td>once every two weeks but does not review each participant each time, or meets less than once a week</td>
<td>once every two weeks and reviews each participant each time, and conducts case conferences.</td>
<td>least once a week, but does not review each participant each time, and conducts case conferences monthly.</td>
<td>least once a week and interviews each participant each time, even if only briefly, and conducts case conferences monthly.</td>
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<td>36.</td>
<td><strong>Weekly Meeting (Quality):</strong> The program uses its weekly organizational program meeting to: (1) Conduct a high level overview of each participant, where they are at and next steps (2) a detailed review of participants who are not doing well in meeting their goals (3) review of one success from the past week (4) program updates and (5) discuss health and safety issues and strategies</td>
<td>Meeting fully serves 3 of the functions.</td>
<td>Meeting fully serves 4 of the functions.</td>
<td>Meeting fully serves 5 of the functions.</td>
<td>Weekly team meeting fully serves all 5 functions.</td>
</tr>
<tr>
<td>37.</td>
<td><strong>Peer Specialist on Staff.</strong> The program has at least 1.0 FTE staff member who meets local standards for certification as a peer specialist.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>38.</td>
<td><strong>Participant Representation in Program.</strong> Extent to which participants are represented in program operations and have input into policy.</td>
<td>Program does not offer any opportunities for participant input into the program (0 modalities).</td>
<td>Program offers few opportunities for participant input into the program (1 modality for input).</td>
<td>Program offers some opportunities for participant input into the program (2 modalities for input).</td>
<td>Program offers opportunities for participant input, including on committees, as peer advocates, and on governing bodies (3 modalities).</td>
</tr>
</tbody>
</table>

### 18.3 Data Collection

Under HPS, data collection, sharing and dissemination activities are noted to enhance the understanding of local homelessness issues and help support decision-making, longer-term planning and outcome measurement to prevent and reduce homelessness. It is highlighted that a [coordinated] information management system on homelessness and shelter use will be a critical
tool to support communities in implementing successful HF programs and in reporting and measuring progress.\textsuperscript{38}

The critical nature of data collection to the development and evolution of the St. John's ICM Program cannot be understated. Development of a comprehensive data collection system for the Program will provide a foundation for consistent approaches to data collection, establishing a baseline of service provision, informing strategic planning and enabling evidence-based decision-making. Robust, coordinated and well-designed data collection and reporting processes will allow for:

- a comprehensive description of the scope of program activity
- informing focused and strategic activities
- evidence-based decision making, such as for program design and policy proposal
- promotion of quality practices/improvement, including service coordination
- identification of resource needs
- delineating the extent to which outcomes are achieved
- determining program effectiveness, and
- creative problem solving and collaboration between and among key program stakeholders.

At a minimum it is suggested the following data be captured:

- Number of intakes and exits
- Client demographics
- Number of hospitalizations (including emergency room visits)/incarcerations
- Housing history
- Client needs
- Number of clients in housing
- Number of clients that are rehoused
- Number of housing units identified/available
- Number of occupied units
- Number of rent subsidies paid

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- Number and type of client contacts
- Client goals
- Number and type of service interventions
- Number and type of barriers clients’ experience to, for example, community inclusion, education and/or employment
- Number of direct and indirect hours providing client support and brokerage
- Number of direct and indirect hours providing treatment and intervention
- Number of direct and indirect hours of liaison with landlords
- Number of direct and indirect hours of liaison and collaboration with community service providers, governments, etc.
- Patterns of service use - e.g., reduction in public system utilization (measured by interactions with Emergency Medical Services, emergency rooms, in-patient hospitalization and police)
- Number, type and duration of critical incidents and interventions provided
- Referrals to/from program (to whom, result)
- Clients’ sources of income and related financial stability
- Client outcomes – e.g., in relation to housing stability, education, employment, financial stability
- Housing retention rates
- Lessons learned
- Challenges
- Case notes in relation to for example, health, activity and housing stability
- General comments

Should staff resources be available, a cost benefit analysis could be undertaken as well.

Discussions with the Manager of the HIFIS Software Development Unit with Employment and Social Development Canada reveal that at the time of writing of this report, all of the above data, except for “barriers” can definitely be captured on HIFIS. Examples of “barriers” were presented to the Manager to determine if this can be captured under existing HIFIS modules or if a process for capturing this data can be added to one of the existing modules.
Given the many and different HIFIS “screens” on which data will be entered it is imperative that the St. John’s ICM Program staff have in-depth and ongoing training in HIFIS.

The Newfoundland and Labrador Statistics Agency is providing support to EHSJ and NL Housing to assist with the implementation of the 2014-2019 St. John’s Community Plan based on HF principles. Specifically, the Agency will help with homelessness data collection and coordination by targeting key HIFIS variables, definitions and indicators relating to homelessness and ensuring these data are coordinated to produce quality statistics and analysis.

18.3.1 Confidentiality

Procedures must be developed to protect electronic and physical (hard copy files) from unauthorized access and for example, destruction by fire, power failure and/or other damage. Procedures may include, but are not limited to, the following measures:

- Locked storage for paper files containing personal information
- All computers have up-to-date anti-virus protection
- Secure protocols, including the use of passwords and firewalls which govern the electronic collection and transfer of sensitive data
- Regular backup of all electronic records, which are preferably stored off-site.\(^{39}\)

19.0 Partnerships

HF is a complex intervention and so to be successful, it demands partnerships. Working together across sectors is critical for bridging to the range and diversity of services required for clients to achieve their outcomes. Effective partnerships will result in leveraging needed funds, ensuring complementarity of effort/minimizing duplication, enabling continuity of service provision, planning for sustainability and maximizing outcomes.

The programs reviewed for the jurisdictional scan have a range of partners including other community-based service providers, health and wellness agencies, justice/corrections, municipalities and committees/caucuses of PWLE. Across At Home / Chez-Soi project sites, it was noted, for example, that having a diverse group of partners had been critical to providing a comprehensive continuum of care to participants. Many of the critical partnerships were at the local community level. These local partners were said to have been critical in contributing

expertise and experience to the At Home / Chez Soi project, and increased the project's capacity to integrate into community networks of supports and services.\footnote{Mental Health Commission of Canada National Qualitative Research Team for the At Home/Chez Soi Project. Implementation and Fidelity Evaluation of the Mental Health Commission of Canada’s At Home/Chez Soi Project: Cross-Site Report. 2012. Pg. 18.}

In addition to the organizations that play a primary role (leadership/management and/or funding) with the St. John's ICM Program, it is anticipated there will be a number of partners who play other support and service roles in its implementation and evolution. Given the extent and degree of potential partnerships and the need to ensure complementarity of effort, it will be imperative that the roles and accountabilities of each partner be identified and communicated to ensure effective implementation and evolution. Where necessary, MOUs and/or letters of agreement should be established to guide joint service delivery, joint accountability, decision making and problem solving.

At the time of writing of this report, information was still being sought on potential partners and their contributions to this Program.

### 20.0 Funding and Sustainability

HPS considers projects sustainable when either the project activities or benefits achieved as a result of the project activities continue after the HPS funding has ended. Within HF, sustainability occurs at the client and program levels.

- **Sustainability for HF clients** means ensuring that they have successfully moved to mainstream or other services not funded by HPS or that there are plans in place to transition all existing HPS HF clients to services that will continue after the HPS funding has ended.

- **Sustainability at the HF program level** means working with partners and other funders to ensure that the programs are sustainable in the long term.

The extent to which communities have been able to establish a coordinated and integrated homeless-serving system will support sustainability. Communities implementing the HF approach need to ensure that there will be no gaps in services for HF clients at the end of the HPS funding in March 2019. As such, the communities’ effort to orient their HF clients into
mainstream services is very important to ensure that HF programming effectively brings clients toward self-sufficiency.41

Long term funding is a critical piece of ending homelessness and is crucial for the sustainability of any program or intervention. An important first step in securing longer-term funding is identifying what long-term sustainability is for the people who experience homelessness in the community. Who needs support, at what level, and for how long? Who will be able to achieve independence? It is important to understand what a “graduation rate” from a supportive program might look like for different people.

Some clients are able to live independently of case management supports but need ongoing financial support; some clients might not require social supports, but may never be able to afford market rent. Further, some people might need higher levels of support for longer periods of time. It is important to identify the point in time when it might be systemically cheaper to provide housing to these individuals in a different type of setting than private market units, such as permanent supportive housing. At the same time, agencies and funders need to be wary of creating a co-dependence on the support provided and be mindful of helping people move towards self-sufficiency, so those who might otherwise be independent are not provided with supports they do not really need. The next challenge becomes determining what happens in five years if a client has another crisis. Communities also will need to determine how people will maintain their supports to prevent future experiences of homelessness.42

20.1 The At Home / Chez Soi Project Experience

A current example of the critical nature of sustainability is provided through the At Home / Chez Soi Project: Concerns regarding sustainability arose early in the process and became increasingly of note as the project evolved.43

It was reported that staff and clients were expressing concern about the uncertainty of what the end of the project would bring. Site reports and key informants suggested that the anxiety of staff regarding keeping their jobs was a significant concern, which hindered the sites’ ability to retain and recruit new staff and hindered the housing teams’ efforts to rehouse some participants.

42 Stephen Gaetz, Fiona Scott & Tanya Gulliver (Eds.) (2013): Housing First in Canada: Supporting Communities to End Homelessness.
Despite assurances that people would not be left without housing, the perspective of participants was that they nonetheless still could be losing their homes. While the federal government decided to provide one more year of funding for the rent subsidies at the five sites, some participants did have to move and it was felt that more could lose their current housing when the funding for rent supplements expires after one year. There was also a realization that the project risked losing the hard-won trust of participants, for whom the threat of loss could represent yet another betrayal.

One aspect of the project’s sustainability strategy was contracting with government relations experts to help with knowledge translation efforts and to raise awareness of the project within both political and civil service arenas at each of the sites. At the national level, some "heavy hitters" were called upon to raise awareness of the project and its value with federal decision makers. At the same time, project and MHCC staff at the national and site levels met with a number of decision makers at both federal and provincial levels.

The more general knowledge exchange activities at each site occurred partly by osmosis, as the wider mental health system inevitably learned about the project and was able to see the tangible benefits that it was able to achieve. Knowledge exchange was also happening more intentionally at each site, in conjunction with the release of the project’s Interim Findings report. In some sites, the release was accompanied by media attention, which also raised public awareness about the sustainability concerns surrounding the project.

Another sustainability strategy adopted by some sites (e.g., Moncton) was to attempt to “mainstream” the project and its funding within the regular system from the outset. Other sites, however, were concerned about situating the project too closely within the formal system, given their sense that an organizational culture more conducive to successful implementation, and thus to sustainability, would be found within the non-governmental sector.

Other key informants believed that sustainability would look different in each of the sites and that the basic aspects of the support would be continued, although perhaps in some cases taken on by a different agency. There was a concern that remaining teams might drift from the original model.

### 20.2 Sustaining the St. John’s ICM Program

There are critical lessons to be learned from the At Home / Chez Soi experience to support the St. John’s ICM Program’s sustainability at both the program activity and client outcome levels, including, for example:

- Focus on sustainability from the outset of Program implementation.
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Ensuring key government and community stakeholders have ongoing information on the Program and its outcomes. This can be achieved by ensuring the Advisory Committee referenced in Section 4.3 includes these key stakeholders.

Have an intentional focus on transitioning clients to mainstream or other services not funded by HPS; have a long-term vision for clients’ progress and future.

Ensure service approaches and supports do not unintentionally create dependency.

Develop strategies to ensure clients who have exited will maintain their supports to avoid future homelessness.

Ensure ongoing attention to ensuring HF fidelity within the ICM approach.

21.0 Lessons Learned

21.1 Enabling effective ICM teams

All disciplines are necessary and valued within ICM teams [and more broadly for ICM programs]. Having honest relationships, both among practitioners and between practitioners and clients, enables and supports their practice of ICM. Given solid relationships, people are able to work through the potentially difficult and delicate issues that can arise in case planning and follow through.

The different disciplines involved in an ICM [team and program] have different languages, perspectives and philosophies and may have limited understanding of each other’s roles and responsibilities. Similarly, a lack of understanding of the roles, mandates, legal responsibilities, job functions and resources available to each of the disciplines can be problematic. In some cases the same language is being used but interpretation or use of the words is different. Continual discussion and clarification of perspectives is time consuming but necessary if an ICM team and program are to be effective.

21.2 Housing

Options

Findings from the At Home / Chez Soi project highlighted that a variety of housing options are necessary and engaging landlords is critical. It was found that the vast majority of people who are homeless and have mental illness would prefer to live in an independent unit rather than a

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group living facility. Rent supplements through the At Home / Chez Soi project played a key role in the success of this scattered-site model.

**Choice in housing**

It was noted by the At Home / Chez Soi Toronto site informant that while preference and choice were key factors for finding housing, this was challenging as much time could be invested in determining a client’s preference and then meeting their needs. To enable a more effective process, a cap was put on the number of places viewed. It was stated, however, that when more time was available to help a client in identifying the “perfect” place for them, there was less turnover in housing.

**Support cannot be place-based**

In a scattered-site approach, ICM staff have to be able to “follow” their clients. They cannot be constrained by requirements of supporting clients in specific buildings/locations.

Rental subsidies should not be attached to units as this is not responsive to the needs of clients. For scattered site housing, subsidies should be attached to a person.

**Re-housing**

ICM staff have to be ready to re-house clients multiple times. It may take clients a number of moves before they realize that to maintain their housing, they have to live differently.

**Viewing clients as “tenants”**

If the goal is to promote program participants’ interaction in community settings as full contributing members, it is important that people participating in the program are seen as “tenants” who have a critical role in promoting their own success in community integration. The emphasis on a “tenant role” highlights the potential for individual contributions and expectations of their responsibilities. A sole emphasis on participants’ “client role” would focus on their needs for services, rather than their participation in community settings.45

**Offsetting client isolation**

The research reveals that people who have experienced homelessness are often at risk of extreme social isolation once they have accessed housing; should this occur, the situation can exacerbate other issues and barriers to housing stabilization. More intensive services that focus on linking

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individuals with their communities are needed during the initial stages of adjustment to their new circumstances, to counteract feelings of isolation, loss and loneliness that may arise after they have acquired housing. HF programs must include partnerships with recreation centres, religious institutions, and other community organizations of interest to their clients.  

21.3 Youth

Giving youth choice and voice

Research has revealed the critical importance of choice in young people’s lives. Choice empowers youth and provides the conditions to make them happier and better able to address their other needs. Young people need to be able to choose the neighbourhood they live in so that they can access other services including education, employment and being close to family. Choice also gives youth the opportunity to make mistakes and to learn from them. Giving young people a choice allows them to learn that their ideas have to be self-generated, rather than a response to the presence of a caregiver or enforcer. As a result, young people will be more self-sufficient and able to help themselves.  

Need for intensive case management and long-term support

Many youth experiencing homelessness lack positive relationships. In addition, the earlier they leave home, the fewer opportunities they have to develop the skills necessary for self-sufficiency and the longer they may need to practice these skills. Infinity staff reported that youth under 18 require more intensive advocacy, as well as assistance with education and employment, system and benefit navigation and health and wellness training. When working with youth, there is a need for early assessment and intervention as well as appropriate treatment options and housing with intensive supports. They also require extra financial assistance, including longer and additional rental and living subsidies.

21.4 Planning and working with clients

Having long-term vision

If staff are providing support in the absence of short- and long-term goals, then the focus is on tasks. There is a need to ensure that clients are “going somewhere”. A long-term vision is imperative.

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46 Stephen Gaetz, Fiona Scott, Tanya Gulliver, Housing First in Canada: Supporting Communities to End Homelessness. 2013.  
Change is long-term

Change for clients is a long-term expectation. “Individuals with significant histories of institutionalization did not get there overnight and their recovery/progress will not be overnight.” This understanding must be conveyed to staff on a regular basis to ensure they do not hold unrealistic expectations for their clients’ progress. Individuals with complex needs will need time to gain the skills and confidence necessary to live as self-sufficient adults.

Ongoing review of support

There must be ongoing review of how and what support is provided as clients’ needs are fluid.

21.5 The value of outreach

Diagnosis and other assessments are changed by outreach. The practitioner talks to the client in the client’s own environment and is more likely to meet the client’s family, and there is a lower threshold for neighbours to ask something or say something. In their own environment, clients can show more clearly what they can and cannot manage and what assistance they need. It is easier to see what their talents and hobbies are, where their strengths lie and what support is available in their environment. In turn, this makes it easier to help the client find solutions that tie in with their environment.

Home visits and outreach also contribute to the relationship between client and practitioner. Care practitioners have to ‘blend in’ with the client’s territory. They are no longer in charge (as they are at the hospital); they have entered the other person’s territory, which helps them to accept the other person as they are and which leads to different dialogues.

Outreach also provides information about the client’s strengths. Care practitioners can see how the client is coping – with life in general, housing and the social environment; and what contact they have with neighbours. They can see what the client likes, what their interests are, and perhaps signs of talents that have been neglected, but can be revived.

21.6 Relationship-building

Relationship-building is a foundational element of the programs reviewed and detailed in the literature as critical for supporting clients in moving out of homelessness and street life and on to recovery and stability. Long-term solid relationships must be founded on clients’ choice and self-determination. Supportive, accepting relationships that clients can count on are essential.

As an example, it was stated that developing positive relationships with youth is a particularly integral aspect of Moving Forward, as many of these youth have had difficulty trusting adults. Transporting youth presented the Moving Forward staff with an opportunity to spend time with youth and to build relationships. It was noted that many of the youth find it difficult to engage in social interactions, but that while in transit, conversation can take place without eye contact, which puts some youth at ease.

Flexibility in where staff meet the youth (and clients in general) will be necessary as they do not always respond well to office-based services. Moving Forward staff utilize a variety of communication methods in their work with youth, including texting, face-time, and email.

### 21.7 Awareness of cultural differences

As learned from the Aboriginal clients at the At Home / Chez Soi site in Winnipeg, systemic and cultural barriers prevent them from accessing health, social services and employment. It was noted that racism, stigmatization, discrimination and invisibility are issues faced by this population on an ongoing basis and mainstream services and systems have failed in effectively engaging this population.

To offset these barriers, the approach was to fully involve and engage the Aboriginal population at all levels of the project, including the provision of housing supports, research, service delivery and project coordination. Culturally relevant approaches were adapted in the HF model and the project had strong peer involvement. Such an inclusive approach will be required for the St. John’s ICM Program.

### 22.0 Challenges

#### 22.1 Change management

Informants for the Infinity Project stated that change management is the biggest challenge to ICM program implementation. Historical risk averse approaches to addressing clients’ many issues prior to them accessing housing created barriers that kept them homeless. The change to a client-focused, harm reduction approach was a major shift and required intentionality of approach. There is a need to help staff understand that operating in this way can enable outcomes.

For example, having Infinity youth clients sign contracts related to what they will and will not do in their housing is of no value. Should they break the contract, they cannot be removed from
their housing, as the program has a philosophy of not exiting clients into homelessness. As noted by project informants - returning a client to homelessness is contrary to the end goal.

In the early stages of implementation, ICM may be viewed as a time consuming activity that increases workload and stress. For practitioners who are just beginning to implement ICM, the logistical work associated with arranging case conferences and recording and distributing notes of meetings is, or seems to be, onerous. It is important to establish processes that ensure ICM ultimately will decrease workload and save time.

### 22.2 Housing

Informants for the jurisdictional review and the literature speak to numerous housing-related challenges – all of which have relevance for the St. John’s ICM Program.

**Housing Stock**

A number of the informants in St. John’s and elsewhere highlighted the challenge in securing affordable and appropriate housing for their clients, particularly given that their complexities can create challenging behaviours. It was noted that it is helpful if organizations own housing to which they can direct clients and/or have staff dedicated to securing housing.

**Housing First and safety**

A challenge with HF is to safely enable the balance between a client's right to choose and autonomy with professional and ethical practice responsibilities.

**Restrictive housing policies**

While Calgary’s HomeBase program adopts a harm reduction model of service (e.g., clients are not required to attain sobriety to receive housing), many available units in Calgary have substance use policies. This makes it challenging to secure and maintain housing for clients with substance abuse disorders, due to a higher incidence of behavioural and financial challenges. This population is therefore vulnerable to housing evictions.

### 22.3 Barriers to youth accessing education, training/employment, financial supports and skill development opportunities

The Infinity Project informants highlighted the number of barriers that prevent youth from accessing opportunities that would help them “get off the streets”. They struggle to get/maintain a job often because they have had fewer opportunities to develop relevant skill sets and lack effective communication and conflict resolution skills. There is a need to have a variety of programs which address the vast range of youths’ needs.
Another challenge relates to student financing being dependent on, for example, a minimum of hours of weekly classroom attendance; this constrains youth whose complexities prevent this level of attendance. Too often policy and programming focus on what the youth are not doing, rather than addressing the barriers that prevent them from attending or completing school. Additional advocacy and leniency in funding requirements are required.

Lack of adequate employment options that pay a living wage has been a significant challenge for the Infinity Project. The youth are only qualified for minimum wage employment opportunities due to their lack of experience, age and skill level; this is significantly less than a living wage. This creates challenges in completing educational goals as youth struggle to meet their financial obligations. Higher and longer term subsidies for rent and living expenses are required for this population.

### 22.4 Transportation

The limitations of the public transit system in St. John’s are considered a barrier to community access and engagement. It was also noted that many of the clients lack the skills or confidence necessary to avail of public transportation. A beneficial and effective feature of an ICM program would be provision of some transportation to clients for certain activities (without creating dependence).

### 23.0 Effective Practices and Approaches for ICM Implementation

It is anticipated that the leadership for the St. John’s ICM Program will have identified effective practices for implementing the Program based on their experience and expertise with both ICM and the target population. The following are effective approaches identified through the literature and in discussions with jurisdictional informants which will inform the development of the Program, its implementation and evolution.

#### 23.1 Strategic planning

The importance of a strategic plan cannot be understated. Having clarity of vision, delineated values, a focused mandate and relevant and attainable strategic directions provide an organization a road map for success. Strategic planning is an organization's process of clearly defining its direction over one or more years by focusing on key issues, collectively determining
options and making strategic decisions on allocating its available financial and human resources to the identified direction. It serves a variety of purposes including to:

- establish realistic goals and objectives consistent with an organization’s mission, which are to be achieved in a defined time frame and within the organization’s capacity for implementation;
- communicate those goals and objectives to the organization’s constituents;
- bring together everyone’s best and most reasoned efforts which have important value in building a consensus about where an organization is going;
- develop a sense of ownership of the plan;
- provide a base from which progress can be measured and establish a mechanism for informed change when needed.49

More specifically for the St. John’s ICM Program, a strategic plan will:

- provide a vision
- identify both strengths and challenges which must be considered in moving forward
- provide guidance and direction for all Program activities, which would reflect the needs and expectations of its stakeholders
- inform its resource allocation
- support it to be successful and achieve results
- provide a series of indicators and benchmarks for future evaluations.

A strategic plan for the St. John’s ICM Program will ensure a focus on moving forward on critical goals and objectives to achieve its outcomes.

23.2 Relationship building through individualized assertive engagement50

Assertive engagement is the process wherein staff use a combination of interpersonal skills, flexibility and creative intervention to engage and form a connection with the client. It is both persistent and active with the workers trying new approaches and strategies until they have formed a healthy and effective working relationship that addresses the need of the individual

client. Using this approach, the staff must remain mindful that each client is unique and brings unique challenges and strengths. Their realities, experiences, abilities and capacities vary widely and so the support provided has to be tailored to their individual experiences.

The initial step is to physically meet the client either where they are or in a venue where they are comfortable and feel safe. When forming the relationship, staff should focus on providing practical assistance such as housing, food, transportation and assistance with other basic needs. This creates the basis for a trusting relationship where the client is reassured that the relationship will be of benefit for them.

In this approach, staff adapt to and/or confront coping strategies presented by the client. These may include deliberately missing visits, distractions and/or being intoxicated during visits. In more traditional models, these behaviours might be interpreted as resistance by the client. In assertive engagement, these behaviours are viewed as an indication that the worker needs to adapt their approach to better engage with the client.

The staff strive to understand and accept the client's point of view and remove obstacles that prevent him/her from reaching their goals. An ongoing question should be – “How can I help you achieve your goal?”

### 23.3 The Strengths-Based Model of Case Management\(^{51}\)

A strengths-based approach works to shift perception from "what's wrong" to "what's working".

Research has shown that the Strengths Model approach is very useful in helping clients to learn about their illness, reduce symptoms, develop helpful coping strategies, improve overall performance and promote recovery and healing. Positive outcomes have been cited for reduced hospitalizations, housing, employment, leisure time, social support, enhanced quality of life and/or independent living.

The Strengths Model was developed at the University of Kansas in the early 1980’s as a response to traditional deficit-orientated approaches. It was a response to concerns that traditional approaches to psychiatric treatment and case management overemphasize the limits and impairment associated with psychiatric illness and underestimate the potential assets the client can use to achieve goals.

This Model demonstrates an evidence-based approach to helping people with a psychiatric disability identify and achieve meaningful and important life goals. It is both a philosophy of

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\(^{51}\) Information on the Strengths Model was garnered from a number of sources including those used to inform the jurisdictional review report on Eastern Health's "Strengths Based Model of Case Management".
practice and a specific set of tools and methods, designed to facilitate a recovery-oriented partnership between client and practitioner. This Model focuses on identifying and enriching clients’ strengths, emphasizing that the capacity for recovery and growth is already present within people.

The Strengths Model also emphasizes seeking supports in one’s natural community rather than depending on formal mental health services. This dual focus makes the Strengths Model philosophically compatible with a recovery orientation by helping people with mental illness gain as much control over their lives as possible, while minimizing their reliance on formal mental health services. Case managers use a strengths assessment to help individuals identify important and meaningful goals as well as skills, talents, and environmental strengths that will help in achieving their goals. A personal recovery plan is also used to help people make small, specific, and measurable steps towards achieving their goals.

In summary, the Strengths Model:

- identifies and/or develops community resources where clients can achieve success - resources in employment, education, housing, recreation, health care, social and/or family;
- assists client to secure the resources needed to integrate into the community and improve overall quality of life;
- is based on the belief that all people can succeed when they have access to adequate resources;
- has a focus on possibilities rather than problems, and well-being rather than illness;

This model is being employed by Case Management Services (Eastern Health). See the relevant section in the jurisdictional review for further information on the Strengths Model including the following tools: Strengths Assessment, the Personal Recovery Plan and the Group Supervision process (for the staff team).

### 23.4 Recovery-oriented approach

Services offered under a HF approach should be recovery-oriented, where clients actively participate in identifying goals related to reducing homelessness and increasing social inclusion.

The key elements related to services are:

1. **Choice** – Clients set their own goals and choose when to start working towards each goal. Case managers assist clients to identify appropriate services and facilitate access to the services.
2. Continuous Services/Uninterrupted Services – Program participants are not exited from services even if they lose their housing.

3. Client-centric – Programs and services are adapted to meet the needs of the client, rather than requiring the client to meet eligibility criteria.

4. Comprehensive – Clients have access to a variety of programs to support them to attain their goals.

5. Integrated – Programs and services work together to support clients.

With recovery-oriented approaches, care practitioners

- are attentively present,
- use their professional frame of reference in a restrained and modest way,
- respond personally to feelings and emotions,
- make space for the client’s own narrative, support it and comply with it,
- acknowledge and stimulate the client’s own strengths, both individually and collectively (empowerment),
- acknowledge, utilize and stimulate the client’s experiential expertise,
- acknowledge, utilize and stimulate support given to the client by significant others, and
- focus on alleviating [difficulties/challenges] and enhancing the client’s own autonomy and control of his or her life.\(^5^2\)

Of note, the MHCC has just released the *Guidelines for Recovery-Oriented Practice*\(^5^3\) described as the first comprehensive Canadian reference document for understanding recovery in practice and promoting a consistent application of recovery principles across the country at a policy, program and practice level. The Guidelines were developed after extensive consultation and draw on the many existing pockets of excellence across the country.

While the Guidelines are directed at a wide audience that includes people living with mental health problems and illnesses and their families, they are designed especially for practitioners, managers, administrators and policy- and decision-makers who can help make the practical, organizational and cultural shifts needed to develop a truly recovery-oriented mental health system. They provide guidance on tailoring recovery-oriented approaches to respond to the


\(^5^3\) The information on the Guidelines was garnered from http://www.mentalhealthcommission.ca/English/initiatives/RecoveryGuidelines.
diverse needs of people living with mental health problems or illnesses, whatever their condition, background, circumstance or stage of life.


23.5 Engaging Landlords

A critical piece in the success of [HF] programs is landlord outreach and housing search assistance, where case managers [staff] employ a variety of strategies to educate landlords within the community about the services they provide to individuals and families, while at the same time dispelling the myths that surround homelessness. In addition they provide support to landlords in order to promote successful tenancy. Through the development of trusting working relationships with landlords, the housing options available to households expand, particularly for those who have higher risk factors and barriers to securing rental accommodations in private market rentals (National Alliance to End Homelessness - NAEH, 2008).

It is recognized that organizations and agencies in the City of St. John’s which support their clients to find housing, have developed a level of expertise in relation to landlords. Effective practices identified to date must be continued and as needed additional strategies must be employed.

The following provides for effective practices employed in other jurisdictions to foster and strengthen the landlord-tenant relationship:

→In Vancouver, the successful recruitment of landlords and apartments in a very tight rental market has been accomplished by a small housing team. One of the innovative additions they devised, that was also used in several of the other At Home / Chez Soi sites was to hold landlord appreciation events. These events have been used to strengthen the relationships between the program and the private landlords who have agreed to provide units for participants. They recognize this group as key players in the project and underline for service staff that they are allies rather than outsiders from whom they need to protect the participant. It is also important to reinforce with the landlords that the participants are potential tenants rather than potential problems.

→ Another identified practice was holding regular landlord forums facilitated by housing program staff members who specialize in building community relationships which serve to:

- increase knowledge of all stakeholders regarding roles, rights and responsibilities of tenants, landlords and service providers,
- improve communication and shared problem-solving,
- increase housing stability of program participants,
- retain quality landlords and to expand the availability of safe affordable housing by recruiting new landlords interested in collaborations.

Topics could include addressing barriers to social integration, tenants’ experience of homelessness, reasonable accommodation, promoting stability in housing, recovery and rehabilitation, and discrimination encountered by program tenants.

A noted key component is to ensure landlords have tangible benefits/take-aways – strategies for addressing issues.

→ Staff can make contact with landlords and create an opportunity for discussion of issues and opportunities in the relationship, minimally once every six months.

More generally in working with landlords:

- Use every opportunity to educate landlords on HF.
- Have a clearly identified communication protocol for working with landlords.
- Landlords/superintendents shall be provided with a clear written summary of services - how the staff team supports clients, communication protocols, roles, responsibilities, and emergency contact numbers, before a client moves into one of their units.
- Be aware of landlord expectations.
- Focus on conflict resolution.
- Practice with a client before meeting with the landlord the first time; if needed, work with the client on presentation; coach the client on what the landlord does and does not want to hear (history and struggles with housing).
- Guarantee rent.
- Provide building maintenance support.

https://www.mentalhealthcommission.ca/English/system/files/private/document/Housing_At_Home_Qualitative_Report_Implementation_Fidelity_Cross_Site_ENG.pdf.
• Ensure cooperation of housing and clinical teams with relocations or transfers.
• Have convertible leases.
• During each visit to a client’s home, the HF team member will attempt to make contact with the landlord/building superintendent to advise them of their presence, if there is an on-site property manager.

Some landlords might want to be more active than simply collecting rents and making repairs. Encourage landlords as possible to conceptualize their role in helping tenants, but caution must be taken to ensure this does not drift into the role of a support worker. View them as knowledgeable about the neighbourhood; able to convey that the client is a valued tenant.56

23.6 Housing tools and approaches

Across the programs reviewed for the jurisdictional review, as well as in the broader research undertaken for this project, many and varied housing tools and approaches were identified. A number of these tools are provided in Appendix “E” for information and possible use in the St. John’s ICM Program, including:

• Client self-assessment of current housing
• Permanent Housing Preference Worksheet
• Housing Self-Evaluation (following re-housing)
• Housing Decisional Balance Worksheet (Exploring the Good and Not So Good Things at This Time in my Housing)
• Rights, Roles and Responsibilities of Tenants, Landlords and Service Providers
• Holding of a Key Agreement
• Housing Activity Log

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24.0 Conclusion

The words of those intended to be supported through the St. John’s ICM Program provide the impetus needed for the EHSJ Board to move forward with this Program. The following quotes were garnered during the client survey:

“I feel weird answering some of these questions. No one has ever asked me for my opinion before; they always just looked down on me.”

“Being homeless is the hardest thing to have to deal with. I have had other issues like mental health and when you are homeless, you take all of the problems with you.”

“I am always looking for phone numbers because I keep losing them or keep getting robbed or move a lot. I think it would be a good idea to be able to call one phone number and get the help you need - kind of like 911 but for street people. A free number that we could call from jail, a payphone, hospital, wherever.”

“Thanks for taking the time to help.”
APPENDIX A: Bibliography
Documents:


Case Management Services: Building on Strengths (Article)

Case Management Services – Mental Health and Addictions Program (Eastern Health – pamphlet)

Choices for Youth Moving Forward Program: Final Evaluation Report 2014 http://static1.squarespace.com/static/54873880e4b028ad7a710b0e/t/54f0af0de4b07b4ddf99b41a/1425059597719/Moving+Forward++Evaluation+2014.pdf


Goss Gilroy Inc. Revisioning Choices for Youth’s Supportive Housing Program. October 2011.


Implementation of the Strengths Model (Article)


Moving Forward - Service Delivery Model. An Outreach Model for Providing Intensive Support Within the Community.


The Strengths Model of Case Management – Case Management Services (PPT)


Websites


Choices for Youth. Presentation on the Outcomes Star (PPT)
Choices for Youth website - available at http://www.choicesforyouth.ca/


The Alex’s official website: [http://www.thealex.ca/](http://www.thealex.ca/)


**ASSESSMENT TOOLS**

**Information sources:**

**CSI:**


**EQ-5D:**


**GAIN-SPS:**


**MCAS:**

MINI:


Trotter et al. (2012). “Behavioural Health Assessment in Integrated Primary Care: Conventions, Alternatives, and Mini International Neuropsychiatric Interview.”

Outcomes Star:


QOLI-20:


SPDAT:


VI-SPDAT:

Clarity Human Services. (2014). “Upcoming Implementation of the VI, SPDAT, & VI-SPDAT.”

OrgCode Consulting Inc. (Undated). “Coordinated assessment and the VI-SPDAT.”

http://100khomes.org/sites/default/files/VI-SPDAT%20Final%20PDF%20Version%20-%20December%202013_0.pdf


Various tools:


APPENDIX B: Client survey
ICM model development – client survey

Introduction / Consent to be interviewed

Hi, my name is_____________________. [Name of your organization] is working with a group of other community and government partners to develop a new approach to supporting people who are homeless/who have been homeless to find decent and safe places to live and have the supports they need.

As part of this process we really want to have input from those who have experienced homelessness.

We are wondering if you would take part in a short survey – it should take about 15 to 20 minutes.

Your answers will be kept confidential and your name will not appear on this survey or any report coming out of the survey information.

If there are any questions that you do not want to answer, that is okay.

If you choose to participate you will be provided a [$10 dollar gift card from xxx or $10].

Are you willing to participate? _____Yes _____No
Demographics
(1 and 2 will be the client identifiers)

1. (Do not ask)
   - Male
   - Female
   - Other – please specify____________________

2. Date of birth ____________(Y/M/D)

3. What kind of help do you need in your day to day life? (Prompt: consider your day from the time you get up to the time you go to bed and everything you do – e.g., cooking, appointments, grocery shopping, social activity, riding the bus...)

4. Which of the following best describes your housing needs (CHECK ALL THAT APPLY)
   - I need to be rehoused from my current housing situation
   - I need long-term housing with supports (e.g. on site medical and/or support workers)
   - I need housing with minimal supports (e.g. offsite medical and/or support workers)
   - I need to be housed from a shelter
   - I need to access an emergency shelter
   - I need financial assistance to remain housed
   - I need a referral for services to help me maintain my current housing (e.g. budgeting, employment, treatment, et cetera)
   - Unsure
   - Other - Please specify: ____________________________________________________________
   - None of the above

5. Where do you mainly live now? (Check all that apply.)
   - Outside (rough sleeping, camping, vehicle)
   - Staying with family/friends
   - Hospital/medical facility
   - Transitional Housing
   - Renting- Unsubsidized/Private Housing
End Homelessness St. John's Intensive Case Management Program Model – Key Elements

June 2015

☐ Dwelling unfit for human habitation
☐ Correctional facility
☐ Child intervention services placement
☐ Bed and Breakfast
☐ Long term housing with supports
☐ Own home
☐ Boarding/Lodging home
☐ Emergency shelter
☐ Addiction treatment facility
☐ Hotel/motel
☐ Renting- subsidized

6. Who helps you with the things you have said you need?
   - Prompt for which organizations/agencies? How do they help?
   - Ask if the individual is in specific programs and if so, which ones? Do these programs help them? Why or why not?

7. Would you like to see any changes or improvements in the support/programs and help you get now? If so, what? (Prompt for changes in the specific programs/help they mentioned in #5.)

8. What other help do you need during your day/in your life? (Prompt for what they said they needed in #3 and for which they have not mentioned any support services/systems.)
a. **Who do you think could provide this help to you?**

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

9. **What do you think are the most important things that can be done to prevent people from becoming homeless?** *(Prompt for what services and supports they need.)*

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

10. **Do you have anything else you wish to say?**

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Please thank the individual for his/her participation and provide them their $10 gift card/$10.
APPENDIX C: Sample Terms of Reference - People with Lived Experience Caucus
TRANSITIONS TO HOME
Consumer Advisory Group Terms of Reference

The term consumer refers to the fact that as a recipient or user of the services Transitions to Home provides, you are in a unique position to provide the program with insight, opinions and ideas on how to provide these services.

As an Advisory Group member your role will be:

- To the best of your ability represent all people who participate in Transitions to Home
- Talk to other participants at group and recreation events to find out their thoughts and opinions about the program
- Share your experiences and knowledge to help problem-solve and maintain the relevance of Transitions to Home to the people who use the services
- Provide advice, input and feedback to the Director and other staff regarding the planning and delivery of the program
- Directly and indirectly demonstrate respect for the full range of other member’s opinions, values, expertise and life circumstances
- Contribute to open discussions by expressing your views, respectfully listening to and considering the views of others and expressing differences of opinion so that they can be explored further
- Assist the Director in evaluating the effectiveness of the program
- Attend, chair and lead meetings as required
- Represent Transitions to Home and help it to continue
APPENDIX D: Sample policies
CONFIDENTIALITY

Employees are required to read and sign the confidentiality policy. This policy applies to all staff, community support and outreach staff. It is understood that the term “client” as used in this policy, refers to participants of the Community Support Program.

(a) Every staff member will, when beginning employment, sign a form promising to treat information on all clients as strictly confidential and only to be shared outside the agency as outlined in (b) below.

(b) No information shall be provided to outside persons or agencies without the consent of the client and the client being fully aware of the information being released. The client may be required to sign a “release of information” form which will be kept in his/her file.

(c) The only exception to (b) would be where it is required by law to release personal information (i.e., child welfare matters or suicidal/homicidal concerns). Clients should also be aware that the courts could subpoena any information contained in his/her files.

(d) Clients shall be made aware of the fact that all pertinent information is shared among members of the community support team.

This will confirm that I have read and received a copy of the Confidentiality Policy. I fully understand the importance of confidentiality and agree to adhere to the principles outlined in this policy.

_______________________________  ________________________________
Staff                                          Witness

_______________________________
Date                                          Date
CODES OF ETHICS AND CONDUCT

Respectful workplace and harassment

Community Support will not tolerate any form of disrespect or any form of harassment of, or by, employees, participants, students, contractors, suppliers or other individuals associated with the Stella’s Circle Organization while engaged in activities pertaining to the workplace. Where harassment has been determined to have occurred, disciplinary action, up to and including dismissal will be taken. Please see the Progressive Discipline Policy for further information.

Every employee has a responsibility to create a respectful workplace that is free from abuse of authority, disrespectful behavior or any form of harassment. The best way to ensure that this happens is to engage in respectful behavior toward others. The following guidelines describe the responsibilities of the employer, supervisors and managers, employees, students, volunteers, and participants which are necessary to achieve a respectful workplace.

If staff have a concern, they should contact the CSP Manager immediately.

Conduct with Colleagues

The Community Support Program strives to maintain a positive work environment that is characterized by respect, is harassment free and supportive of the dignity, self-esteem and productivity of every staff member. All staff must treat each other in a fair and equitable manner and must conduct themselves professionally and ethically.

Specifically, all staff are expected to:

- Fulfill their duties to the best of their ability.
- Perform all duties with good intentions and above all, do no harm.
- Refrain from engaging in conversations or actions with another staff member that seeks to directly or indirectly undermine or demean another staff in their workplace.
- Resolve conflicts that they may have with other staff members directly, constructively and in a timely fashion. If staff are unable to resolve a conflict between them, it is the role of the Community Support Manager to assist in finding a resolution.
- Accept no gifts from participants, their families or friends or from any other source associated with the performance of their duties that has any potential to influence or to create a perception of influence.
- Honor and respect all racial, sexual, ethnic, cultural and religious differences and refrain from any act of harassment or slurs related to race, sexual orientation, religion, ethnicity, cultural diversity or position within the organization by treating others with courtesy and respect.

- Recognize their position of public trust and represent their services and capabilities fairly and accurately.

**Sharing personal information/home numbers/e-mail**

CSP staff are not permitted to provide home telephone numbers, personal home addresses or email addresses to program participants. Clients who need to contact workers can do so through speaking to office staff. Workers need to recognize the limits of personal information sharing with clients and be able to share only that information that is not harmful to the clients.

Staff should not engage in planned social contact with clients outside of their working hours. That includes in-person, by telephone or utilizing computer internet forums such as Facebook, where dialogues occur with “friends”, or through email.

Any information of a sensitive nature or relating to a personal problem should be discussed with a CSP coordinator before being shared. It is a critical role of CSP workers to model appropriate boundaries.

**Lending money/cigarettes**

Lending money or cigarettes to clients is not permitted. Clients who are seeking financial support or looking for cigarettes are asked to speak to a CSP coordinator or case manager.

**Sharing visual and print material with clients**

Staff who wish to bring in visual or print materials, such as movies or magazines, to share with clients need to be aware of the content of the material they are sharing. Materials containing graphic sexual and/or violent material is not appropriate. If the content is questionable, it should be discussed with a case manager before offering it to the client. If the client wishes to view or share such material with a worker, the worker must refuse.

**Gift giving**

Gift giving from staff to clients is **not** permitted. Generally, gifts for program participants will be provided on special occasions through purchases paid for by the program and given on behalf of all workers.
**Client/staff relationship**

The client will be introduced to a new worker by a staff person in the CSP who is known to them.

The client has the right to ask the worker to leave his/her home at any point during the shift. He/she is asked to contact the CSP Manager to discuss any problems that may have arisen during that shift.

The client has the right to request a change in workers, if there is a problem with their current support worker. However, every effort will be made to work through the problem. If this is not successful a new worker will be selected.
UNIVERSAL PRECAUTIONS

Universal precautions are infection control guidelines designed to protect Community Mental Health Workers from diseases spread by blood and certain body fluids. Staff are advised to assume that all such blood and body fluids are infectious for blood borne diseases and any spill must be reported to Case Management staff.

As part of the orientation to the Community Support Program, new staff are advised about universal precautions. Annual presentations about universal precautions are given to all program staff during a monthly staff meeting. Proper hand washing techniques are also taught.

In working with individuals who have complex mental health issues, there is an expectation that program participants will clean up their own blood and body fluid spills whenever possible. Guidance and direction is provided in that clean up by the Community Mental Health Workers. However, when a participant is unable to clean up, Community Mental Health Workers are responsible and must ensure use of protective barriers i.e. gloves which are provided by the program. They are also responsible for the proper disposal of materials used in the cleanup. Disinfectants are also supplied.

Universal precautions should be followed when workers are exposed to blood and certain other bodily fluids, including:

- semen
- vaginal secretions
- synovial fluid
- cerebrospinal fluid
- pleural fluid
- peritoneal fluid
- pericardial fluid
- amniotic fluid

Universal precautions should be applied to all bodily fluids when it is difficult to identify the specific body fluid or when body fluids are visibly contaminated with blood.
Medication and Dispensing

Guiding Principles

- Staff do not directly administer medications. Staff supervises the self administration of medication.

- All youth who require medication must turn in their prescription medication prior to admittance to the program. The team lead will then contact the pharmacy.

- Medications are to be dealt with in a confidential manner and must be kept in a locked, safe location.

Procedure - Medication and times need to be written in the medication log and medication needs to be placed in the locked medication cabinet immediately or a locked area such as safe. All medication must be stored in a locked area, in the container in which it was dispensed by the Pharmacist.

Narcotics (Concerta, Dexidrine, Oxycontin, Tylenol 3) will be stored in a locked cabinet/area. If staff is unsure whether a medication is a narcotic, they can confirm with a pharmacist.

NOTE: Dispense medication only as prescribed. For example, if a youth misses a dose – Do not double up. Always consult pharmacy/doctor first if you have any questions. Then inform team lead.

Staff and youth are jointly responsible for knowing medication schedules. This includes: When to dispense (i.e. before/after meals, time between dosages) and when not to dispense (before/after meals, time between dosages, interaction with other medication, etc)

Remember the 3R’s: Right Person, Right Dose, Right Time

For safety reasons, youth will not be allowed to have any medication on them. Moving Forward will have all medications in locked area.
The supervision of self-administered medication (prescription/nonprescription) will be recorded in the medication logs. Staff will sign that medication has been dispensed in blue or black ink (not pencil).

In the event of missing signatures, the staff responsible will be contacted to confirm that the medication was given and asked to sign the medication log as soon as possible. Under no circumstances can staff sign for each other.

☞ NOTE: Prescription medication is to be recorded on medication log. Over the counter drugs (including vitamins and cough syrup, Advil) are to be recorded on the medication administration records sheet (MARS) medication logs.

☞ Important: medication is not to be given to a youth who is intoxicated or under the influence of illegal drugs.

Refusal to Take Medication - Under no circumstance will a youth be forced/pressured/coerced to take medication against his or her wishes.

Medication handling for new staff - All new staff must double up with the full time staff person on shift for the first three times they supervise the self administration of medication. Once medication is checked and the medication self administered to the youth, both the new staff person and the full time staff person on shift will sign off on the medication sheet. Once a new staff member has supervised the self administration of medication with the assistance of a full time staff member on three occasions, they are then permitted to dispense medication unassisted unless otherwise directed.

Remaining medication will be returned to the case worker, and in the absence of a case worker, medication will be returned to the youth when they exit the Moving Forward program. The date, time and medication that was returned to the youth will be documented in their exit forms.

IMPORTANT: should a youth leave the program voluntarily or involuntarily in an agitated state (suicidal, threatening, escalated) staff will not turn over all of their medication. The amount needed to get through one day will be issued.

Illegal medication or medication not specifically prescribed to a youth are to be returned to the Shea Heights pharmacy.

Under no circumstance will medication not strictly prescribed to a specific youth be returned to their possession.
Staff will not supervise the self administration of any medication that is not in a proper container.

911 must be called for all medical emergencies. In each case when 911 are called an incident report and follow-up must be completed.

**Medication Error or Loss Procedure**

*Definition(s)*

Medication Error – when a youth is dispensed the wrong medication.

Medication Loss – when a youth’s medication is found to be lost or stolen.

In every case of a medication error or loss these procedures need to be followed.

- Identify the error, i.e. incorrect medication has been given or medication has been missed, an incident report is completed by the staff person who initially finds that an error or loss has occurred.
- The coordinator(s) is to be notified.
- The coordinator will notify staff and request written reports from all staff(s) involved.

**IMPORTANT:** Should a youth ingest a medication that is dispensed in error; staff shall immediately call Poison Control and follow their instructions.

Oversight: The Team Lead (s) will audit the medication logs on a weekly basis.
SAFETY

WORKING ALONE POLICY (DRAFT)

The Community Support Program requires employees to meet with program participants off site. Precautions have been set in place to meet the requirements of Working Alone Safely Legislation.

Prior to arranging a meeting with participants, the worker must be familiar with the participant’s file, background, and any other issues that may pose a risk to the staff member. This may require requesting specific information from the client and/or referral source regarding family violence, history of charges relating to violence, mental health issues and/or substance abuse.

The purpose of this policy is to provide employees with strategies and interventions to minimize risks when working alone either in an area of Stella’s Circle, or on outings, meetings, et cetera outside of Stella’s Circle. All Staff, who have direct client contact, must have current first aid certificates, Non-Violent Crisis Intervention training and be qualified in the activities they lead.

In all situations, employees will do a prior review of plans and procedures to minimize potentially dangerous situations in Stella’s Circle, traveling in vehicles, home visits, or on outings with clients or meeting with families.

All staff will access and assess reports on road and weather conditions prior to departing from the city. This includes home visits, recreational trips, travel for business, et cetera.

Employees will assess environmental safety conditions and respond in a manner that limits potential risk to self and others. Employees will follow the identified safety procedures. Situations may include, but not to be limited to:

- Potential road/weather hazards
- Unsafe locations (i.e. unsafe areas, isolation, unsafe buildings, poorly lit areas)
- Presence of threatening or potentially threatening persons.

All persons will wear or have access to appropriate clothing/footwear for the activity and/or season.

If there are concerns regarding unsafe road/weather conditions, these must be discussed with a supervisor to decide if the trip is to be cancelled.
Every time a community contact is planned, staff will:

Inform CSP Manager or On Call of the planned visit, including location, client name and any additional information that will enable the manager to evaluate the need for intrusion if the staff member is not back at the time planned and contact has not been initiated by that staff person.

If there is no cell phone available, the meeting must be rescheduled.

If the meeting runs past the expected time, staff must call the check in person to give an update time of return. The check in person will inform the manager.

Staff will call again at the conclusion of the meeting, or to update information plans change, such as a decision to take a client to the Food Bank for example.

When staff is traveling out of town they must also provide a route plan detailing which route they will be taking to reach their destination.

**Communication:**

Employees who are making or receiving telephone calls on their cell phones while in transit MUST only do so when the vehicle is STOPPED in an area that is safe for oneself and other motorists.

Employees who are leaving their vehicles for purpose of meeting in a client’s home WILL carry an activated phone on their person at all times.

Employees will ensure their cell phones are in good working order prior to leaving.

**Home Visits:**

Staff will adhere to and follow all safe work procedures when meeting in participant homes.

Staff will have current training in Non-Violent response to threatening situations.

Staff will assess the following safety factors and make an evaluation of risk to self PRIOR to attending home visits:

- Staff will assess the participant’s attitude, behaviour and potential risk to staff or self.
- Staff will use their professional discretion. Staff may choose to bring a second staff member when meeting with unpredictable participants.
- Staff may disengage and reschedule any meeting if there is perceived potential risk to others.
- Staff may, when prudent to do so, contact emergency services for back up and support.

Staff may assess and implement safety procedures that may include, but not be limited to:

- Always arranging the seating plan of the room (i.e. in office or home to provide you and the client an easily accessible exit route.)
- Developing (with CSP manager) a Safe Visit Plan for the potentially high risk situations:
  - Arranging for a second staff to be part of the visit
  - Arranging to meet the participant at Stella’s Circle site or another safe location
  - Cancelling all meetings with the participant until all safety concerns are addressed and met
  - Contacting emergency support services if risk escalates (i.e. RNC)

**Overdue Employees**

If the employee has not returned within 15 minutes of the expected time, the contact staff will call the cell number to check on the staff member. If there is no answer, contact staff will inform the SCP manager and the course of action will be determined. If the CSP manager is not available, another program manager or the CEO will be informed.

**Recreational Outings/Out of Town Travel**

- Ensure that the cell phone is activated and is in the “ON” position.
- Follow all vehicle safety guidelines.
- Ensure supervision is distributed throughout the vehicle.
- Briefing with participant prior to the outing, outlining behaviour expectations and how infractions will be handled.
- Ensure trip plans that include check in times, appropriate policies et cetera are completed and in possession of the identified staff contact person. Check in times should also be noted in the communication log.
- Ensure that there is NO deviation from the trip plan, route or check in time without notifying the contact person. Emergency follow up will occur when arranged contact is 15 minutes late.
- If safety needs cannot be accurately assessed or provided for, the trip is to be cancelled.
• When the staff are traveling out of town for meetings or conferences, they shall provide to their manager detailing the following:
  o Travel route
  o Departure time and method of travel
  o Estimated destination arrival time
  o Name, location and phone number of accommodations and/or meeting place
  o Identify who will be the Community Support contact.

VISITORS
Program participants should not entertain visitors while CSP staff are present. If a client wishes to have a visitor, the worker should offer the option to leave the shift. A worker should always keep in mind the element of risk when visitors arrive at a participant’s home. Clients who wish to socialize are encouraged to do so but do not need a support worker to assist in this. Any exceptions need to be discussed with a coordinator.

Generally, workers do not accompany clients to visit friends or other clients of the CSP during a shift. Any exceptions to this need to be discussed with a coordinator.
SAFETY AND CRITICAL INCIDENTS

Calgary Homeless Foundation - Critical Incident Review Process

Calgary Homeless Foundation (CHF) recognizes that agencies will experience serious situations that may require prompt response, documentation and notification. These situations are referred to as Critical Incidents. Critical Incidents are often health and safety related and may include, but are not limited to:

- Medical Emergencies
- Dangerous situations
- Incidents of abuse or allegations of abuse
- Legal offenses
- Arson
- Suicide attempts and/or severe self-harm behaviour
- Significant housing issues (structural, infestation, etc.)
- Threatening behaviour
- Death or serious injury
- Incidents where the media is involved

Agency Critical Incidents

It is expected that all CHF funded agencies have written policy and procedures that require appropriate reporting, documentation and review of critical incidents. Agency policy and procedures should include, but not be limited to:

1. Documentation:
   a) A history of the events or circumstances leading up to the incident;
   b) Behaviour of the client that required case management intervention, if applicable;
   c) Description (duration, intensity, approach) of case management intervention used;
   d) Follow-up actions, policy and procedural changes and recommendations.
2. Debriefing the incident:
   a) When appropriate, debriefing with client and others who may have been affected, and
   b) Was the client informed of their rights (i.e. grievance process, legal representation, etc.)

Timelines for reporting to the appropriate authorities (CHF, police, etc.). It is expected that all Critical Incidents are reported to CHF within 24 hours.
SERIOUS INCIDENT REPORTING FORM (CHF)

Agency: program name:

Person completing this report:

Contact information (email & phone number):

Agency executive director/lead name & contact information:

Date & time where incident occurred:

TYPE OF INCIDENT (check which applies):

- Death
- Attempted Self-harm/Suicide
- Personal Information (as defined by FOIP) has been disclosed in breach of the terms of FOIP or your funding agreement
- Risk to Public Safety (including criminal charges related to violent/dangerous offences, i.e.; armed robbery, assault, assault with a weapon, arson, Form 10/mental health warrant)
- Allegations of Abuse (***not including child abuse - these incidents must be reported to the proper authorities)
- FOIP Breech
- Abuse or serious harm to another program client/staff by a program client

DESCRIPTION OF INCIDENT:

(NOTE: unless person/s involved have signed consent to share identifying information with the Calgary Homeless Foundation, please do not use the individual’s names or identifying information)

Describe response/action taken by program (include persons notified – who did you contact?):

Describe any additional action to be taken by program:
SAFETY AND CRITICAL INCIDENTS – Community Support Program

Safety is an important concern both for the participants of the Community Support Program as well as the community support workers. A worker may leave the home of a client at any time should they feel their safety is at risk. Whenever possible, the worker should let the client know that they have to leave and reassure the client that every effort will be made to resolve the problem. They are then asked to contact the Community Support Manager and explain the situation, or if this occurs after hours, to contact Emmanuel House staff immediately.

When applicable, an incident form should be completed and given to the Coordinator for follow up. Incident forms should always be completed when a worker has been threatened with violence or where an act of violence has occurred. The CSP has a zero tolerance policy for violence and staff will be supported should they wish to pursue a charge when an act of violence has occurred.

In the event of threat of harm or actual harm to a worker after office hours, On Call should be contacted immediately.

The issue of safety is also addressed in the Stella’s Circle Orientation and Policy manual, Workplace Violence and Critical Incident Protocol.
Stella’s Circle
Critical Incident Report

Date of incident: __________________________________________

Time of incident: __________________________________________

Location (include address where applicable):
_______________________________________________________________

Name of person completing form:
_______________________________________________________________

Position of person completing form: ______________________________

Contact no: ________________________________

Employees/Volunteers/others involved in incident:

1. Name ________________________________________________
2. Name: ________________________________________________
3. Name: ________________________________________________
4. Name: ________________________________________________
Clients involved in incident:

1. Name________________________________________________________
2. Name:_________________________________________________________
3. Name:_________________________________________________________
4. Name:_________________________________________________________
5. Name:_________________________________________________________

Description of incident and background (relevant information leading up to the incident, circumstances, whether the incident was witnessed and other relevant issues):

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Who was informed of the incident (Manager, Police, Fire Brigade) and when?

1. ______________________________________________________________
2. ______________________________________________________________
3. ______________________________________________________________
4. ______________________________________________________________
5. ______________________________________________________________
Actions taken to date: (including date and time of contact that Manager and other agencies were informed, as well details of support provided):

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Follow up action required:

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

_________________________________________________________

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

_____________________________________________ Date: ____________

(Signature of Employee)

_________________________________________________________

(Signature of Manager)
APPENDIX E: Housing-related tools

The following housing tools were taken from the University of Kansas School of Social Welfare. Supported Housing Resource Kit. Office of Mental Health Research and Training, Lawrence, Kansas. January 2011. Available from:

Client self-assessment of current housing

Having a decent living situation is a very important support to recovery. An overwhelming number of people who are in recovery identified that having decent and safe housing was the factor that allowed them to make their turnaround toward recovery. This tool is meant to help people assess their current housing situation.

Where are You in Regard to Having Decent Housing and a Sense of Home?

☐ Check all that apply:

☐ I feel at home where I live.

☐ My living situation feels safe.

☐ My housing is affordable (I pay less than 30% of my income for housing).

☐ My living situation is personalized to reflect my interests and tastes.

☐ I’m living in an area where I want to live.

☐ I have enough privacy where I live.

☐ I keep my living situation up well enough based on my preferences.

☐ I have my living situation organized to support my health and well-being.

☐ I want to stay where I am.

☐ The make-up of my household (e.g. living alone or with others) is what I want.
**Permanent Housing Preference Worksheet**

Directions: To be completed by consumer alone, or with MHC staff, when need for new housing arises.

<table>
<thead>
<tr>
<th>Type of Housing</th>
<th>Housing Availability</th>
<th>Housing Choice #1 Address</th>
<th>Housing Choice #2 Address</th>
<th>Housing Choice #3 Address</th>
<th>Final Choice Address:</th>
<th>MATCH?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Bedroom Apt in apt. complex</td>
<td>In Community</td>
<td>Where such housing does not exist, indicate with N/A</td>
<td>Indicate (with an “x”) the characteristics of this choice</td>
<td>Indicate (with an “x”) the characteristics of this choice</td>
<td>Indicate (with an “x”) the characteristics of this choice</td>
<td>Indicate (with an “x”) where there is a match between consumer preference and final choice</td>
</tr>
<tr>
<td>Studio Apt in Apt. Complex</td>
<td>Rate top 3 preferences, only, using a scale of 1-3, with 1 being most desirable</td>
<td></td>
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<tr>
<td>2-Bedroom Apt. in Apt. Complex</td>
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<tr>
<td>1 Bed Apartment in House, with own kitchen and bath</td>
<td></td>
<td></td>
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<tr>
<td>1 Bed Apartment in House, sharing kitchen and bath</td>
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<tr>
<td>Duplex</td>
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<tr>
<td>House – Rent</td>
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<td>House – Own</td>
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<tr>
<td>Mobile Home</td>
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<td>Other:</td>
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<td>Other:</td>
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</tr>
<tr>
<td>Location</td>
<td>Housing Availability In Community</td>
<td>Housing Choice #1 Address</td>
<td>Housing Choice #2 Address</td>
<td>Housing Choice #3 Address</td>
<td>Final Choice Address:</td>
<td>MATCH?</td>
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<tr>
<td>Place a check for desired location</td>
<td>Rate top 3 preferences, only, using a scale of 1-3, with 1 being most desirable</td>
<td>Where such housing does not exist, indicate with N/A</td>
<td>Indicate (with an “x”) the characteristics of this choice</td>
<td>Indicate (with an “x”) the characteristics of this choice</td>
<td>Indicate (with an “x”) the characteristics of this choice</td>
<td>Indicate (with an “x”) where there is a match between consumer preference and final choice</td>
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<tr>
<td>Near work</td>
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<tr>
<td>Near family</td>
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<tr>
<td>Near friend(s)</td>
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<tr>
<td>Near park or other recreation center</td>
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<tr>
<td>Near movie theatre, or other entertainment venue</td>
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<tr>
<td>Near child’s school</td>
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<tr>
<td>Near grocery store</td>
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<tr>
<td>Near bus line</td>
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<tr>
<td>Near doctor’s office</td>
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<tr>
<td>Near Mental Health Center</td>
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<td>Other:____________</td>
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</tr>
<tr>
<td>Place a check for desired living arrangements</td>
<td>Housing Choice #1</td>
<td>Housing Choice #2</td>
<td>Housing Choice #3</td>
<td>Housing Choice #4</td>
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<tr>
<td>Living Arrangements</td>
<td>Choose one (or more)</td>
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<td></td>
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<tr>
<td>Live alone</td>
<td>Check off how well this choice matches consumer preference</td>
<td></td>
<td></td>
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<tr>
<td>Live with roommate (have someone in mind)</td>
<td>Check off how well this choice matches consumer preference</td>
<td></td>
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<tr>
<td>Live with roommate (do not have anyone in mind)</td>
<td>Check off how well this choice matches consumer preference</td>
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<tr>
<td>Live with partner</td>
<td>Check off how well this choice matches consumer preference</td>
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<tr>
<td>Live with a family member (specify:</td>
<td>Check off how well this choice matches consumer preference</td>
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<tr>
<td>Group Home</td>
<td>Check off how well this choice matches consumer preference</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place a check for desired living arrangements</th>
<th>Amenities</th>
<th>Rank Order These</th>
<th>Check off how well this choice matches consumer preference</th>
<th>Check off how well this choice matches consumer preference</th>
<th>Check off how well this choice matches consumer preference</th>
<th>Check off how well this choice matches consumer preference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allows pets</td>
<td></td>
<td></td>
<td>Check off how well this choice matches consumer preference</td>
<td>Check off how well this choice matches consumer preference</td>
<td>Check off how well this choice matches consumer preference</td>
<td>Check off how well this choice matches consumer preference</td>
</tr>
<tr>
<td>Accessibility – for physical limitations (big bathroom)</td>
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<tr>
<td>Has storage room</td>
<td></td>
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<tr>
<td>Has carport or garage (circle one)</td>
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<tr>
<td>Enough sunny windows</td>
<td></td>
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<tr>
<td>Balcony</td>
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<tr>
<td>Area for gardening, or other green space</td>
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<tr>
<td>1st floor</td>
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<tr>
<td>2nd floor or above</td>
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<tr>
<td>Elevator</td>
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<tr>
<td>Dishwasher in kitchen</td>
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<tr>
<td>Onsite laundry facility</td>
<td></td>
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</tr>
<tr>
<td>Pool</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Wi-Fi Availability</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Utilities included</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cable included</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scenic view (trees, landscaped front yard, etc)</td>
<td></td>
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</tr>
</tbody>
</table>

Signature (Consumer) : ____________________________ Date: ________________
Housing Self-Evaluation (following re-housing)

Name:________________________________________

Date:________________________________________

Now that you have been living here for at least three months, it is time to check in and review how things are related to your housing situation. Answering the following questions honestly will start a conversation between you and your case manager about your current situation, and she or he will have a record of your feelings and thoughts about where you are currently living, in order to determine your future housing goals.

I’ve lived in my current housing setting since:
____________________________________________
(approximate date)

☐ Yes or ☐ No: Overall, I am satisfied with my current housing setting.

What, if anything, would you like to change to make improvements to your current housing situation?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

☐ Yes or ☐ No: I am satisfied with the location of my housing.

What, if anything, would need to change in your housing location to be more satisfied?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
☐ Yes or ☐ No: I need help around the house (for example, help with cleaning, making meals, taking trash out, etc.)

If you do need help around the house with some activities, please list what that might be and how often you would need help with those tasks.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

☐ Yes or ☐ No: I feel safe in my current housing setting.

If you do not feel safe, please specify what, if anything, would help the situation, including moving to another location.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

☐ Yes or ☐ No: I feel as if I have just the right amount of opportunities for socializing.

Depending on one’s housing setting, people may feel isolated, or feel as if there are too many people around too much of the time. If you feel as if you need more or less opportunities for socializing, please note that here.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
☐ Yes or ☐ No: The actual layout and arrangement of my housing setting is comfortable for me (for example, you live on the 2\textsuperscript{nd} floor, but would prefer to live on the 1\textsuperscript{st}, etc.)

If you have some preferences that are not currently met by your current housing situation, please note it here, so that we know what to look for in the future.
**HOUSING DECISIONAL BALANCE WORKSHEET**

Exploring the Good and Not So Good Things at This Time in my Housing

Describe your housing situation and any concerns you have about it:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Concerns

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

| Step 1: List the good and not so good things about your current housing situation |
| --- | --- | --- | --- |
| List the good things about your current housing | Your Rating | List the Not so good things about your current housing | Your Rating |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
Step 2: On the list above, rate each item on your list of terms of how important they are to you. Use the numbers below.

1 = Not so important to me
2 = Somewhat important to me
3 = Very important to me

Step 3: Discuss your work with someone you trust. Then on the line below, circle which way you are leaning in your decisions to stay or leave.

I am considering leaving
I am unsure
I am considering staying
### Table 1 – Rights, Roles and Responsibilities of Tenants, Landlords and Service Providers
(adapted from TAC, 1994)

<table>
<thead>
<tr>
<th>ROLES</th>
<th>RESPONSIBILITIES</th>
<th>RIGHTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenant</td>
<td>• Renter • Consumer of services • Concerned citizen</td>
<td>• Access to housing</td>
</tr>
<tr>
<td></td>
<td>• Pay rent and bills on time • Maintain property in good condition</td>
<td>• Non-discrimination related to disability</td>
</tr>
<tr>
<td></td>
<td>• Respect rights of other tenants • Utilize services as needed</td>
<td>• Privacy and confidentiality of medical information</td>
</tr>
<tr>
<td>Landlord</td>
<td>• Provider of housing • Concerned citizen • Natural support • Consultant to housing program</td>
<td>• Receive fair market rent</td>
</tr>
<tr>
<td></td>
<td>• Maintain property in good condition • Arrange with tenant regular payment of his/her portion of rent</td>
<td>• Fulfillment of lease agreements (e.g. prompt payment)</td>
</tr>
<tr>
<td></td>
<td>• Address problems with both tenant and housing program</td>
<td>• Respect condition of property</td>
</tr>
<tr>
<td>Service Provider (e.g. clinician, case manager)</td>
<td>• Care provider • Advocate for client • Consultant to housing program • Consult with landlords (with tenant consent)</td>
<td>• Access to housing program resources for their clients</td>
</tr>
<tr>
<td></td>
<td>• Maintain contact with tenant as long as enrolled with service • Identify and address problems that may affect tenancy • Notify housing program of any change in service</td>
<td></td>
</tr>
<tr>
<td>Housing Program</td>
<td>• Administrator/Director • Technical assistant • Problem mediator • Trainer • Convener of stakeholders</td>
<td>• Responses to requests for information related to housing program eligibility and lease agreements</td>
</tr>
<tr>
<td></td>
<td>• Screen referrals and apartments • Establish lease agreement and procedure for payment • Resolve problems with lease or tenancy • Develop programming to support successful housing</td>
<td></td>
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</tbody>
</table>
"Holding of a Key" Agreement

I (print name)  

Give a copy of my key(s) to my residence to:  

a representative of (identify mental health agency):  

on this date of:  

The reason for giving my key or a copy of my key is as follows:  

S/he may only enter my residence with the key under the following circumstance: (check at least one or both)  

- [ ] During my absence  
- [ ] While I am present  

Another representative from the agency (check either):  

- [ ] May come in the place of the person identified above  
- [ ] May not come in the place of the person identified above  

Before entering my apartment, the representative (check either):  

- [ ] Needs to inform me in the following manner (circle as many as is appropriate):  
  - Phone  
  - e-mail  
  - text  
  - in-person  
  - other:___________  
  - At least _____ days/ hours prior to entering  
- [ ] Does not need to inform me
If the representative is unable to inform me in the ways identified above (check one):

☐ s/he may still enter
☐ s/he may NOT enter

This agreement expiration is as follows (check one):

☐ Expires on this date: ______________________________
☐ Expires when I am discharged from the agency
☐ Expires if the representative identified above would leave the agency, or was no longer working with me.
☐ Is renewed every time the treatment plan is renewed (about every 90 days).
☐ Other

Client (signature) __________________________  Case Manager/Housing Specialist __________________________  Date ______________

Witness

This form is available from the following document:

**Housing Activity Log**  
(Can be used as a summary documentation tool for housing)

Client: __________________________________________

<table>
<thead>
<tr>
<th>Housing Location</th>
<th>Move in Date / Move out</th>
<th>Reason for Leaving</th>
<th>Actions taken to Resolve Reason for Leaving</th>
<th>Resources used to Move</th>
<th>Services &amp; Supports Needed (see progress notes to see what was received)</th>
<th>Financial Assistance</th>
</tr>
</thead>
<tbody>
<tr>
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