HOMELINESS PREVENTION & RAPID REHOUSING PROGRAM MODEL
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## List of Acronyms

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACT</td>
<td>Assertive Community Treatment</td>
</tr>
<tr>
<td>CA</td>
<td>Coordinated Access</td>
</tr>
<tr>
<td>CA Worker</td>
<td>Coordinated Access Worker</td>
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<tr>
<td>CAB</td>
<td>Community Advisory Board</td>
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<tr>
<td>CE</td>
<td>Community Entity</td>
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<tr>
<td>COH</td>
<td>Canadian Observatory on Homelessness</td>
</tr>
<tr>
<td>CYFS</td>
<td>Child, Youth and Family Services</td>
</tr>
<tr>
<td>EHSJ</td>
<td>End Homelessness St. John’s</td>
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<tr>
<td>HIFIS</td>
<td>Homeless Individuals and Families Information System</td>
</tr>
<tr>
<td>HMIS</td>
<td>Homeless Management Information System</td>
</tr>
<tr>
<td>HPRR Program Model</td>
<td>Homeless Prevention and Rapid Rehousing Program Model</td>
</tr>
<tr>
<td>HPS</td>
<td>Homelessness Partnering Strategy</td>
</tr>
<tr>
<td>HFSCI</td>
<td>Housing First System Coordination Initiative</td>
</tr>
<tr>
<td>HFSCI Advisory Team</td>
<td>Housing First System Coordination Initiative Advisory Team</td>
</tr>
<tr>
<td>ICM</td>
<td>Intensive Case Management</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>NLHHN</td>
<td>Newfoundland and Labrador Housing and Homelessness Network</td>
</tr>
<tr>
<td>NL Housing</td>
<td>Newfoundland and Labrador Housing</td>
</tr>
<tr>
<td>NLSA</td>
<td>Newfoundland and Labrador Housing Statistics Agency</td>
</tr>
<tr>
<td>PIT</td>
<td>Point-in-Time: Homeless Point-in-Time Count</td>
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Introduction

The 2014-2019 St. John’s Community Plan to End Homelessness calls for the development of Rapid Re-Housing and Prevention program interventions targeting approximately 300 individuals or 200 households at risk or experiencing transitional homelessness.  

**Rapid Rehousing** provides targeted, time-limited financial assistance and support services for those experiencing homelessness in order to help them quickly exit emergency shelters and then retain housing. The program targets clients with lower acuity levels using case management and financial supports to assist with the cost of housing. The length of stay is usually less than one year in the program as it targets those who can live independently after receiving subsidies and support services.

**Prevention** programs provide assistance to individuals and families at risk of becoming homeless. Prevention programs couple financial support (rent and utility arrears, damage deposit etc.) with case management to achieve housing stabilization. These programs stabilize those at imminent risk for homelessness using supports and connecting program participants to financial assistance; programs divert clients at the shelter door and connect clients to financial assistance.

Prevention and Rapid Rehousing programs tend to target lower acuity clients with less frequent homelessness lengths of stay and episodes (transitionally/episodically homeless). The elements of these program types can be combined to ensure a continuum of supports is in place for those at imminent risk and/or transitonally homeless. The aim is to shorten the time homeless as much as possible, where preventing a homelessness episode is not possible.

In some communities, these types of programs are delivered separately and may be specifically focused further on sub-populations (families, youth, singles being discharged from public systems, etc.). For these programs to be effective, they will need to be tailored to meet the priority needs of the St. John’s community and leverage its strengths effectively.

End Homelessness St. John’s (EHSJ) retained the services Dr. Alina Turner (Turner Research & Strategy) to facilitate the development of the Homelessness Prevention/Rapid Rehousing (HPRR) program model and related funding proposals for approval by the EHSJ Board on May 31, 2016. With the approval of the Board, service delivery is set to commence September 1, 2016 by selected community-based partners.

This report provides an overview of the key elements of the proposed St. John’s HPRR initiative and outlines the respective program models of the two implementing organizations: Stella’s Circle and Choices for Youth.

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The Context for the HPRR Model

Plan to End Homelessness in St. John’s (2014-2019)

St. John’s has a long-standing commitment to collaborative, locally-driven solutions to homelessness. The multi-stakeholder St. John’s Community Advisory Committee on Homelessness was established in 2000 to develop and implement previous Homelessness Partnering Strategy (HPS) plans to address homelessness.

The St. John’s CACH laid a solid foundation for our future success, investing $18.3 million in HPS funds (levering significant funding from other partners) to address community priorities through a range of initiatives, including the creation of 65 emergency shelter beds, 37 transitional housing beds (22 units), and 237 supportive housing beds (163 units). Other supported projects have included renovations and accessibility improvements to shelters, transitional and supportive housing, non-residential service facilities and new social enterprises, plus a range of initiatives to engage partners, raise awareness, mobilize knowledge, and build capacity. None of this would have been possible without strong partnerships across all sectors.

In 2014, the Community Advisory Committee was renamed and restructured as End Homelessness St. John’s (EHSJ) with a new Board of Directors, and committed to developing and leading the implementation of Ending Homelessness in St. John’s: Our 5-Year Plan (2014–2019) (the Plan). The Plan includes the Homelessness Partnering Strategy (HPS) Community Plan to guide federal investments locally based on Housing First principles.²

The Government of Canada’s Homelessness Partnering Strategy (HPS) supports communities to develop local solutions to homelessness. HPS funds local priorities identified by communities through a comprehensive community planning process involving officials from all levels of government, community stakeholders, and the private and voluntary sectors. St. John’s is the only HPS-designated community in Newfoundland & Labrador (one of 61 participating communities across Canada). HPS was allocated stable funding over five years (2014-2019) with the goal of supporting communities in developing longer-term solutions to homelessness, in particular moving to a Housing First approach. In the 2016 Federal Budget, HPS received an additional $111 million over two years to be invest in communities.

The City of St. John’s acts as the HPS Community Entity (CE) that administers federal homelessness funds for End Homelessness St. John’s (through the Non-Profit Housing Division of its Community Services Department) and provides the community development and brokering necessary to move the community forward as a collective.

The Plan outlines the following four priority areas:

1. **System Coordination**: A coordinated approach to housing and supports following the Housing First philosophy.
   - Organize the homeless-serving system.
   - Implement coordinated access and assessment.
   - Develop discharge/transition planning measures.

2. **Integrated Information System & Research**: Integrated information system and research to support ending homelessness efforts.
   - Implement an integrated information system.
   - Build partnerships with the research community.

3. **Housing & Supports**: Developing a range of housing and supports choices to meet diverse participant needs.
   - Support measures to increase housing affordability and reduce homelessness risk.
   - Introduce and ramp up a range of Housing First programs.
   - Tailor supports to meet the needs of diverse groups.
   - Support the enhancement of service quality and impact.

4. **Leadership & Resources**: Securing the necessary leadership and resources to support the Plan to End Homelessness.
   - Develop the infrastructure necessary to implement the Plan.
   - Coordinate funding to maximize impact.
   - Champion an end to homelessness.

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/episodically homeless</td>
<td>300 (approx. 200 households)</td>
</tr>
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</table>

The 2014-2019 St. John’s Community Plan to End Homelessness calls for the development of Rapid Re-Housing and Prevention program interventions targeting approximately 300 individuals or 200 households at risk or experiencing transitional homelessness. EHSJ’s Plan estimates that approximately $1.2M will be needed to realize these targets starting in Year 3 of the Plan (2016/17). Of these, $592,811.25 have been earmarked in the Plan using Homelessness Partnering Strategy (HPS) funds from 2016/17 to 2018/19. The contract for the implementation of the Prevention/Rapid Rehousing is for about a year and a half (from September 2016 until March 2018) with the possibility of extension to March 2019 in accordance with the duration of the 5 year EHSJ Community Plan.

<table>
<thead>
<tr>
<th>Prevention/ Rehousing Projections</th>
<th>Rapid Budget</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPS</td>
<td>$174,356.25</td>
<td>$209,227.50</td>
<td>$209,227.50</td>
<td>$592,811.25</td>
<td></td>
</tr>
<tr>
<td>Matching Contribution Needed</td>
<td>$174,356.25</td>
<td>$209,227.50</td>
<td>$209,227.50</td>
<td>$592,811.25</td>
<td></td>
</tr>
<tr>
<td>Combined</td>
<td>$348,712.50</td>
<td>$418,455.00</td>
<td>$418,455.00</td>
<td>$1,185,622.50</td>
<td></td>
</tr>
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</table>

The aim is to secure matching resources, either matching funding or in-kind contributions from community and system partners, to deliver on the targets outlined in the Plan to assist approximately 200 households (300 individuals) over the course of the investment. EHSJ will work with selected proponents to secure additional matching resources; the final outcome of these efforts will influence the final service agreements. If these funding sources are not secured, adjustments to funded positions, targets, and other aspects of the service agreement will be adjusted.
Housing First

Our guiding philosophy – Housing First – is about those we serve: it calls for the recognition of housing as a basic human right. As a recovery-oriented approach, Housing First is focused on quickly moving people from homelessness into housing and then providing supports necessary to maintain it. Rather than requiring homeless people to first resolve the challenges that contributed to their housing instability, including addictions or mental health issues, Housing First approaches propose that recovery should begin with stable housing.

There is an important distinction between Housing First as a philosophy that emphasizes the right to a place of one’s own to live, and as a specific program model of housing and wrap-around supports based on participant choice. We will use the philosophy as guiding principle for our Plan – but also implement specific new housing and supports to support our vision. Our approach is to build the Housing First philosophy into our system coordination work across program types.

HPS has defined the six Housing First principles:

1. **Rapid housing placement with supports**: This involves helping participants locate and secure accommodation as rapidly as possible and assisting them with moving-in.
2. **Offering participants a reasonable choice**: Participants must be given a reasonable choice in terms of housing options as well as the services they wish to access.
3. **Separating housing provision from treatment services**: Acceptance of treatment, following treatment, or compliance with services is not a requirement for housing tenure, but participants are willing to have monthly visits.
4. **Providing tenancy rights and responsibilities**: Participants are required to contribute a portion of their income towards rent.
5. **Integrating housing into the community**: This encourages participant recovery.
6. **Recovery-based and promoting self-sufficiency**: The focus is on capabilities of the person, based on self-determined goals, which may include employment, education and participation in the community.

While Housing First, as a philosophy and specific type of program intervention, is a critical part of efforts to address homelessness, it is its strategic application across the homeless-serving system that is essential to making a sustained impact on homelessness.

System Coordination

System coordination, also referred to as system planning, using Housing First as a guiding philosophy is a method of organizing and delivering services, housing, and programs that systematizes diverse resources to ensure efforts align with ending homelessness goals. Rather than relying on an organization-by-organization, or program-by-program approach, system coordination aims to develop a
framework for the delivery of initiatives in a purposeful and strategic manner for a collective group of stakeholders.

At its most basic definitional level, a system is the integrated whole comprised of defined components working towards a common end. System coordination requires a way of thinking that recognizes the basic components of a particular system and understands how these relate to one another, as well as their basic function as part of the whole. Processes that ensure alignment across the system are integral to ensure components work together for maximum impact.

Applying this concept to homelessness, a homeless-serving system comprises a diversity of local or regional service delivery components serving those who are homeless or at imminent risk of homelessness.

Reviews\(^3\) of best practices in systems approaches have identified several elements that should be considered in operationalizing such approaches to homelessness grounded in Housing First. These practical elements of homeless-serving system planning and coordination should be considered at various organizational levels within a service network, particularly for stakeholders involved in managing coordination functions. In some sites, these roles are located within municipalities, non-profit funders, agency collaborations, or government departments.

**Essential Elements**

<p>| | |</p>
<table>
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<tr>
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<tbody>
<tr>
<td>1.</td>
<td><strong>Planning &amp; Strategy Development</strong> process follows a systems approach grounded in the Housing First philosophy.</td>
</tr>
<tr>
<td>2.</td>
<td><strong>Organizational Infrastructure</strong> is in place to implement homelessness plan/strategy and coordinate the homeless-serving system to meet common goals.</td>
</tr>
<tr>
<td>3.</td>
<td><strong>System Mapping</strong> to make sense of existing services and create order moving forward.</td>
</tr>
<tr>
<td>4.</td>
<td><strong>Coordinated Service Delivery</strong> to facilitate access and flow-through for best participant and system-level outcomes.</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Integrated Information Management</strong> aligns data collection, reporting, intake, assessment, referrals to enable coordinated service delivery.</td>
</tr>
<tr>
<td>6.</td>
<td><strong>Performance Management &amp; Quality Assurance</strong> at the program and system levels are aligned and monitored along common standards to achieve best outcomes.</td>
</tr>
<tr>
<td>7.</td>
<td><strong>Systems Integration</strong> mechanisms between the homeless-serving system and other key public systems and services, including justice, child, youth and family services, health, immigration/settlement, domestic violence and poverty reduction.</td>
</tr>
</tbody>
</table>

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\(^3\) Beyond Housing First: Essential Elements of a System-Planning Approach to Ending Homelessness  
Performance Management Guide for Community Entities Working in a Housing First Context -  
System Coordination Framework

While diverse services may exist in the homeless-serving system, it is essential to develop processes to effectively match participant needs to the right service, at the right time so having a coordinated access and assessment process in place that uses common acuity measures and prioritization processes to determine program match and eligibility is a key ingredient to a well-functioning system.

The development of common processes to ensure alignment across the homeless-serving system is integral to ensure program components work together for maximum impact. This also ensures participants move through the system effectively and have access to the right resources at the right time.

Common system coordination processes include:

1. **Coordinated access** processes with clear eligibility and prioritization criteria;
2. **Coordinated assessment** to determine the appropriate level, intensity and frequency of supports;
3. **Performance management** and quality assurance processes integrated with Homeless Management Information Systems.

The St. John’s Plan to End Homelessness prioritizes the development of a systems approach grounded in Housing First where diverse services are organized and delivered in a coordinated manner to advance common community priorities. The purposeful, design and management of St. John’s homeless-serving system is critical to meeting the community’s objective of ending homelessness.

These elements are articulated in the St. John’s Homeless-Serving System Coordination Framework. The HPRR model is aligned with the proposed Framework’s key recommendations regarding coordinated access, assessment and performance management.

Community Engagement Process

Background Research

Dr. Turner, the EHSJ Community Development Worker and Local Coordinator engaged community stakeholders to inform the proposed approach through an online survey, key stakeholder meetings, focus groups with those with lived experience and two separate community forum events.

develop the HPRR, the project team undertook the following activities:

- Review promising and best practices, with particular focus on tailoring program design.
- Leverage the System Coordination Survey to gauge current system capacity and gaps to serve the HPRR target populations.
• The main tenets of successful program elements and practices were presented during the March Provincial Housing First Forum; additional resources and a summary of the program models were provided as pre-reading to participants. These are further summarized in this report as context for the proposed program model.

• Conduct an onsite meeting specifically dedicated to the HPRR model during the March Housing First Forum to discuss proposed approach with key stakeholders with an interest in being primary or secondary providers.

• Engage those with lived experience, service providers and funders in strategic conversations regarding model scope, target population, service delivery model, budgets, performance measures, and capacity building needs.

• Develop and facilitate an Expressions of Interest process to select primary providers for the HPRR project.

• Work with selected proponents to develop the full program model, budget, and necessary service agreements, MOUs, etc. to advance service delivery.

• Present a proposed course of action for discussion during the May Review Session to gauge feedback from key community stakeholders.

• Engage key stakeholders to secure resources for the program during the course of the project.

• Present a final HPRR model to the EHSJ Board on May 31, 2016 for approval and make any necessary adjustments.

Provincial Housing First Forum

EHSJ collaborated with the Newfoundland and Labrador Housing and Homelessness Network (NLHHN) to identify potential areas of leveraging funding. EHSJ had secured for a Housing First Forum to ensure maximum impact from a province-wide and regional perspective. EHSJ and NLHHN were encouraged by provincial partners to develop a Provincial Housing First Forum that would engage key stakeholders in shaping a coordinated homeless-serving system, prevention and rapid re-housing interventions, and foster an enhanced understanding of trauma-informed systems and services.

The Provincial Housing First Forum took place March 1-3, 2016 at St. John’s City Hall, and aimed to:

1. Provide participants with comprehensive information regarding promising practices in system coordination, including Coordinated Access, prioritization, and performance management as well as an overview of program implementation options to deliver prevention and rapid rehousing services.

4 Funders included HPS, NL’s Department of Seniors, Wellness & Social Development, NL Housing, NL’s Office of Public Engagement, and the City of St. John’s.
2. Deliver hands-on training to leaders in the sector specific to trauma-informed practices to advance Housing First adoption across Newfoundland and Labrador.

3. Engage in an in-depth discussion regarding key areas of strategic importance to explore potential priority directions moving forward at the local and regional levels.

The Forum responded to needs identified by the community as well as the priorities identified in the Community Plan. Over the three days, 80 individuals from all regions of the province participated in sessions. These individuals came from a wide variety of government and community bodies.

Coming out of this Forum a What We Heard document was produced, drawing together discussion notes taken at each table during the Forum. The document will be shared across the province to ensure that the conversation on ending homelessness continues well beyond the Forum itself. The document was a key source of input into the design of the HPRR program, as this was the focus of Day 2 of the Forum.

Based on this early engagement phase, Dr. Turner facilitated a one-day session on March 2, 2016 during the Provincial Housing First Forum with interested community and system partners. On February 25, 2016, prior to the March 2nd session, EHSJ invited frontline agencies and system partners to inform us of their potential interests to serve in a primary or secondary role on in EHSJ's Prevention & Rapid Rehousing service model.

**Primary roles** refer to agencies engaged in the actual service delivery for the project. These agencies would hold a service delivery agreement with the City of St. John’s as the CE. Those with **secondary roles** can include agencies who may be a source of referral into the program or who provide access to their existing services to clients in the program. It can include public system partners (health, addiction treatment, corrections) who partner with the program in some fashion, or it can include a funder.

During the March 2nd session, findings from the research and consultations were shared and key elements of the Prevention & Rapid Rehousing program model for St. John’s were presented. Attendees also engaged in a discussion on next steps for implementing the model locally and some self-identified as potentially playing a primary or secondary role in implementation.

On March 8, 2016, an Expression of Interest (EOI) form was distributed by the City of St. John's to organizations that self-identified to play either a potential primary or secondary role. The EOI form was completed by four interested potential primary providers and submitted to Judy Tobin, Housing Manager, Community Services Department, City of St. John's by March 18, 2016. See Appendix U below for the Expression of Interest form.

A Sub-Committee made up of non-conflicted members of the EHSJ Board and public system partners was struck to review the four Expressions of Interests received and make a recommendation for funding. The consultant then worked with the recommended proponents - Choices for Youth and Stella's Circle - to flesh out the proposed direction.
Review Session

A one-day review session was held on May 4, 2016 with the purpose of engaging stakeholders in discussions to provide input on key system coordination components as well as the new HPRR program model co-presented by Dr. Turner and the two selected HPRR providers.

Additional community input from the Review Session was incorporated in the program development. Once finalized, the program model and necessary documents, including service agreements, was approved by the EHSJ Board on May 31, 2016.

Lived Experience Focus Groups

As a part of the community consultations for the Housing First Systems Coordination Initiative, three lived experience focus groups were held in February 2016 at Iris Kirby House, Choices for Youth, and The Gathering Place. These locations were selected to ensure representation from known sub-populations including: women fleeing domestic violence, youth, adults and seniors. There were 30 total participants in the three sessions: 6 from Iris Kirby House, 12 from Choices for Youth, and 12 from The Gathering Place.

A wide range of ages were represented among the 30 participants. This includes 10 youth (16-24), 16 adults (25-54), and 4 older adults (55+).

With respect to gender, 50% self-identified as male compared to 37% females. Thirteen per cent did not indicate a gender. Participants’ experiences of homelessness are represented in the figure below.

Two Social Work Students from Memorial University were note takers during the sessions, drafting reports for each session and conducting a thematic analysis to capture key themes. The focus group guide included questions regarding: services available, supports needed for rapid rehousing, gaps and
barriers encountered, coordinated access to housing and supports, homelessness prevention, homeless count considerations, and processes for the ongoing engagement of persons with lived experience. A full report was prepared based on this input, which was drawn from to develop the HPRR program model.

**HPRR Program Model**

**Overview**

Building upon the existing EHSJ’s investment in Intensive Case Management (Front Step), Choices for Youth (CFY) and Stella’s Circle (SC) will partner in delivering the HPRR functions in community via their respective funding agreements. The primary delivery mechanisms for each agency will be the Brian Martin Housing Resource Centre (BMHRC) at SC and the Outreach and Youth Engagement Program (OYEP) at CFY.

The HPRR initiative will provide prevention and rapid rehousing supports on a continuum across the two agencies, recognizing the fluid nature of housing instability in the target population. Staff will provide short-term assistance (less than 12 months) to individuals and families at risk of becoming homeless, or who are considered transitionally or episodically homeless.

Financial supports (first-months’ rent, damage deposits, rental/utility arrears) will be provided on a case-by-case basis, alongside landlord-tenant relations and housing location services.

A service agreement and MOU is being 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.

**Enhancing Existing Services**

The underlying rationale behind the two agencies delivering HPRR is to harmonize existing programming and leverage services already in place to build on a continuum of supports that already exists. Both SC and CFY have well documented histories of serving a high volume of clients who fit the target population for rapid rehousing and prevention.

As a result, both the BMHRC and OYEP already oversee a continuum of services ranging from emergency shelter, prevention and rapid rehousing, permanent supportive and transitional housing, and intensive case management.
The two agencies currently operate the following services.

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Choices for Youth</th>
<th>Stella’s Circle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Shelters - Youth</td>
<td>Shelter for Young Men (9 beds)</td>
<td>Naomi Centre for Young Women</td>
</tr>
<tr>
<td>Permanent Supportive Housing</td>
<td>RallyHaven (17 beds)</td>
<td>76 units</td>
</tr>
<tr>
<td>Transitional Housing</td>
<td>The Lilly (14 beds)</td>
<td>Jess’ Place (women in recovery)</td>
</tr>
<tr>
<td>Rent Supports</td>
<td>N/A</td>
<td>80 rent supplements (25% in SC units)</td>
</tr>
<tr>
<td>Intensive Case Management</td>
<td>Front Step Moving Forward Program</td>
<td>Front Step Community Support Program</td>
</tr>
<tr>
<td>Prevention/ Rehousing</td>
<td>Outreach and Youth Engagement Program (Momma Moments for female-led households)</td>
<td>Brian Martin Housing Resource Centre</td>
</tr>
</tbody>
</table>

The HPS funds will be used to enhance current programming at OYPEP and BMHRC. This will not only add additional capacity to serve the target population, but also stimulate re-alignment of current programming at the two sites towards alignment with the System Coordination Framework, adding significant value to the HPS investment.

The two HPRR components will be outlined separately for clarity in the next sections, with specific articulations among CFY and SC highlighted throughout.

**Community Partnerships**

**The Gathering Place**

The Gathering Place, which regularly sees in excess of 200+ clients per day, has indicated that their organization would be willing to play a role in the delivery of HPRR. The full scope of what that would entail will be developed, but notionally would involve a regularly scheduled presence by the HPRR team at their site and coordination with their staff/volunteer team.

**Thrive**

Thrive currently employs a Case Manager to work directly with individuals who are homeless, or at risk of becoming homeless, and have also indicated that their organization would be willing to play a role in the delivery of rapid rehousing and prevention. Thrive’s work involves providing supports and interventions to help individuals avoid eviction and/or find appropriate housing.

The Case Manager supports individuals to conduct housing searches, accompanies individuals to look at housing options, problem solves issues in collaboration with clients and landlords to prevent evictions, and provides intensive supports to help clients connect with necessary supports to help increase housing stability.

Thrive’s Street Reach program has 2 Outreach Workers who also work with clients who are homeless and/or at imminent risk of being homeless and provides supports and outreach services to assist these clients increase housing stability. As a result of Thrive’s participation in the consultations held by EHSJ’s,
there is an opportunity to collaborate on a new Prevention and Rapid Rehousing Program, and they look forward to contributing existing resources, where appropriate, to strengthen the model.

Downtown Health Care Collaborative

CFY, SC, Eastern Health, and EHSJ and the Gathering Place are all signatories to the newly formed Downtown Health Care Collaborative. This involves the establishment of a hub and satellite model of primary healthcare services for vulnerable populations in the downtown core. As an initial step, effective March 2016, CFY has provided the first (1 Public Health Nurse, 1 part-time Nurse Practitioner, 2 part-time Physicians) of what will be a series of satellite clinics for this new initiative.

The partners involved will bring this new service to the table in providing much needed medical and treatment supports to HPRR clients. Recognizing the impact access to physical and mental health services plays in housing stability, this resources can be leveraged further to facilitate access to essential health services for HPPR clients.

MOUs are being explored between HPRR and the aforementioned partners.
HPRR Service Delivery Component 1:
Stella’s Circle Brian Martin Housing Resource Centre

As aforementioned, HPS funds will be used to enhance current programming at OYEP and BMHRC. The two HPRR service delivery components will be outlined separately for clarity in the next sections, with specific articulations among CFY and SC highlighted throughout. The program operations common to both service providers are dealt thereafter.

Stella’s Circle

Stella’s Circle’s vision is “A home, a job, a community,” and a mission of “Transforming lives through real homes, real work and real help”.

The role of the corporation is to create opportunities and to facilitate change through the provision of support and resources.

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 current housing and supports model under Stella’s Circle is outlined in the chart below.

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 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.

The Naomi Centre offers temporary shelter and support for young women within a harm reduction model. In 2014-15, there were 115 admissions and departures, a 91% occupancy rate and 322 turnaways.

In 2014-15, 400 individuals accessed the services of the BMHRC. This represents 4,529 requests for service, with 1,765 rapid rehousing related requests that included: emergency placements, housing retention services, and prevention/diversion services. In that same fiscal year, 56 individuals were assisted to find housing, of which 44 scored a moderate acuity on the SPDAT.

The Brian Martin Housing Resource Centre

The BMHRC is funded by the Newfoundland and Labrador Housing Corporation (NLHC) for $533,525 per year to provide counselling, advocacy and other support services to help people find and retain housing. A further $176,037 comes from Eastern Health for 2 staff positions (1 Program Director and 1 Tenant Relations Specialist). Services include landlord recruitment/support, drop in services, computer/fax/phone, and bus passes. The BMHRC also currently supports:

- Clients in 76 units of permanent supportive housing in SC buildings
- Clients receiving 80 units of rent supplements. Approximately 25% of these supplements are used for tenants in SC buildings with the balance in private market units leveraging relationships with 39 private landlords.

BMHRC staff include:

- 1 Program Director (program management, supervision, leadership role in community)
- 1 Administrative Assistant (general administration support to BMHRC staff)
- 1 Social Worker (intake, assessment, support to tenants and case management)
- 2 Housing and Tenant Relations Specialists (system navigation, landlord recruitment, support to SC housing units)
- 2 Housing Support Workers (front-line, hands on support to individuals that require housing stability supports)
- 1 Seconded Occupational Therapist (OT work for the entire organization)

The current BHMRC organizational chart is outlined below. The proposed changes with the HPS enhancement are illustrated after.
Current BHMRC Organizational Chart

- 1 FTE Program Director
  - 1 FTE Social Worker
  - 2 FTEs Tenant Relations Specialists
  - 2 FTEs Housing Support Workers
  - 1 FTE Admin Assistant
  - 1 FTE Occupational Therapist (for Stella’s Circle)

Proposed BHMRC Organizational Chart (with HPRR Enhancements in red; blue indicates positions already in place)

- 1 FTE Program Director
  - .05 FTE HPRR funded
    - 1 FTE HPRR Program Coordinator
    - .05 FTE HPRR funded
      - 1 FTE HPRR Case Manager
  - 1 FTE Admin Assistant
  - 1 FTE Occupational Therapist (for Stella’s Circle)
  - 2 FTEs Tenant Relations Specialists
  - 2 FTEs Housing Support Workers
BMHRC Prevention/Rapid Rehousing Enhancement

Through the HPS investment, an additional Case Manager would be added to the BMHRC leveraging existing resources. The Case Manager would focus on rapid rehousing and prevention and work with existing 2 Tenant Relations and 2 Housing Support staff in meeting the HPRR targets. The overall work of the team will entail: landlord recruitment and retention, system navigation and providing outreach support to clients, conducting intake assessments and developing individualized plans based on client acuity.

The addition of funds to the existing Social Worker position will enhance her role into that of a Program Coordinator for the BHMRC, ensuring consistency across the services to function as an effective HPRR program aligned with the tenets of the System Planning Framework around coordinated access and assessment, performance management and HMIS integration.

The rework of the BMHRC will require significant leadership from the Director in implementing the model. There is the direct supervision involved in prevention and rapid rehousing, but in addition the community/system-level leadership needed to begin implementing elements of the System Coordination Framework both the BMHRC and broader homeless-serving system, particularly coordinated access and assessment, system-level performance management, service standards and information management.

These community-level initiatives would impact the operations of BMHRC beyond the direct HPS investment in staffing delivering support, and will require significant change management and leadership at the Director level. To this end, a portion of the salary of the Director is included in the program budget accordingly.

Notably, housing location and landlord liaison work would be supported by the Front Step BMHRC Housing Support Workers to ensure no duplication of efforts and leveraging of resources already in place. In addition, the Family Support Worker HPRR enhancement at Choices for Youth would also work closely with the team to coordinate services for youth participants. This will allow for an enhanced approach and ensure the HPRR is making the most impact. This relationship will be described in the MOU with Choices for Youth.

Position Descriptions

The following position descriptions have been reworked to reflect the shifts in programming needed across operations at the BMHRC.

**HPRR Program Coordinator (Stella’s Circle)**

The Program Coordinator will provide day-to-day leadership, mentoring and support to program staff, ensuring that the team works effectively together and delivers high-quality services to clients. The Coordinator will supervise Case Manager, Tenant Relations, and Housing Support Workers within the Brian Martin Housing Resources Centre. They will also maintain a small caseload (10:1).
Duties:

- Working in collaboration with the Program Director and staff to further the goals and objectives of the program and ensure the EHSJ’s performance targets are being met.
- Map and establish policies and protocols for the BMHRC, ensuring alignment with System Planning Framework.
- Liaise with Eastern Health to establish a referral protocol, housing and support plan for individuals moving from hospital into the community.
- Liaise with Eastern Health to coordinate the support plan and transition of patients from Waterford hospital into the community.
- Ensuring fidelity to the HF program intervention.
- Working with the Program Director 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 Case Managers and Housing Support Workers in collaboration with the Program Managers.
- Providing ongoing leadership, mentorship and support to the Case Managers and Housing Support Workers in collaboration with the Program Managers.
- Receiving client referrals and conducting assessments for individuals who fit the Program criteria; assigning staff 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 program staff 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 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, 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.
- 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 Director. Note that only .05 FTE of this position is funded by HPRR.

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

HPRR Program Director (Stella’s Circle)

Position description is forthcoming from Gail Thornhill, Program Director, Stella’s Circle.

Reports to the Executive Director. Note that only .05 FTE of this position is funded by HPRR.

Salary range: $80,000 – $85,000 + benefits: ~ $90,500 - $96,250 based on a 37.5 hour work week.

HPRR Case Manager (Stella’s Circle)

Using a strengths-based approach, the HPRR Case Manager will provide individualized support services to persons who have been referred to and accepted under the criteria for the HPRR Program in order to prevent homelessness and provide rapid rehousing. 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 with the following skills:

- Understands the needs and concerns of landlords
- Able to help participants identify their housing needs
- Knowledgeable about landlord-tenant law
- Provides case management at intake, during and/or after housing placement
- Links clients to mainstream and community resource
- Helps client identify and avoid behaviors that contribute to housing instability
- Helps client identify short- and intermediate-term goals
- Specializes in one or more areas relating to income and benefits
- Assists client in accessing mainstream income and benefits resources at shelter entry
- Has excellent knowledge of mainstream community resources
- Is culturally competent
- Able to handle crisis situations
- Experience working with clients with multiple needs

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.

**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.
- 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. - attention to detail in follow-up and case notes;
- Strong interpersonal skills.
- Effective problem-solving and negotiation skills;
- Ability to see both sides in a dispute and help parties develop compromise situations,
• Ability to remain calm and focused in situations where clients or landlords may be angry or anxious;
• Ability to interact respectfully with people of diverse ages, gender, cultural background and household composition.
• Experience with household budgeting.
• Knowledge of income assistance benefit programs and landlord-tenant laws.
• 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.

Duties
• Interview individuals who are homeless/at risk of homelessness;
• Review past housing history and identify possible barriers to obtaining and retaining housing;
• Negotiate with landlords to “sell” program and convince landlords to accept tenants they would normally screen out;
• Assess and verify tenancy problems such as late payments, damage or lease violations, income, and financial assistance needs;
• Consult with legal services staff regarding actions to prevent evictions;
• Map and establish policies and protocols for the BMHRC, ensuring alignment with System Planning Framework.
• Liaise with Eastern Health to coordinate the support plan and transition of patients from Waterford hospital into the community.
• Negotiate with landlords regarding late payments, damage or lease violations; consult with legal services staff regarding actions to prevent evictions;
• Negotiate with host-guest households and families/partners experiencing conflict to find compromise solutions to domestic problems;
• With client permission, request mediation services for more serious conflict;
• Help family connect with employment services and/or obtain financial assistance from government or private sources;
• Recommend for supervisory approval the financial assistance and services needed to resolve current tenancy problems;
• With household, develop a Housing Plan with goals for successful case closing;
• Implement Housing Plan;
• Provide information to individuals regarding additional community resources they may need and want and make referrals as the family chooses;
• Build a working relationship with each client, getting to know them as a unique individual and clarifying the role of the Case Manager.
• Conduct risk assessments and establish safety plans with clients.
• In concert with the Housing Support Workers, 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.
• Schedule support services for clients and accompany clients to meetings, as appropriate.
• 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.
• 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.
• Participate in program and policy development/improvement by continuously re-evaluating forms and processes of everyday tasks and conveying any concerns to the Program Coordinator.
• Participate in bi-weekly staff meetings, as well as other scheduled team meetings.

**Reporting Relationship:**

Reports to the Program Coordinator.

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

**Budget & Targets**

See Excel Sheet.
HPRR Service Delivery Component 2:
Choices for Youth Outreach & Youth Engagement Program

Choices for Youth Programs

CFY has provided a continuum of services which focus on housing, education and employment since 1990. CYS works 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 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 Stella’s Circle 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 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. 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.

RallyHaven has 1 Coordinator and 3 Housing Support Workers that support 11 units with 6 more under construction. The Shelter for Young Men has 9 beds and remains at capacity 92-94% percent of the time, with 150 admissions last year and 204 turn-aways. Of particular note, the number of admissions has declined due to the fact that clients are unable to secure stable, safe, affordable housing, thus the need for greatly enhanced rapid rehousing supports. As a result of our organizational policy to respond even when our shelter is full, the 204 individual turn-aways also reflect a significant need for rapid rehousing.
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.

**Outreach and Youth Engagement Program (OYEP)**

OYEP works with young people aged 16-29 to provide a range of supports including daily drop-in and extensive housing supports that include assistance securing housing, landlord engagement, life skills support, budgeting, and advocacy work. Funding from diverse sources totals $1,057,800 for this program.

<table>
<thead>
<tr>
<th>OYEP Revenue Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Youth &amp; Family Services (Youth with Transitions)</td>
<td>344,085</td>
</tr>
<tr>
<td>Advanced Education and Skills (CEYS)</td>
<td>236,460</td>
</tr>
<tr>
<td>Child Youth &amp; Family Services (Core Funding)</td>
<td>177,057</td>
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<tr>
<td>Health and Community Services (Budget Funds)</td>
<td>220,000</td>
</tr>
<tr>
<td>Eastern Health (Funded Position)</td>
<td>65,460</td>
</tr>
<tr>
<td>Social Enterprise Revenue</td>
<td>14,738</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,057,800</strong></td>
</tr>
</tbody>
</table>

The OYEP Momma Moments program provides these and other supports to 45 young mothers (and 56 children) who are at high risk of family breakdown and homelessness. Many young people facing personal crises often feel helpless and are unaware of their options. OYEP focuses on connecting with these young people and building a caring relationship of mutual trust.

Often a first point of contact, OYEP supports and advocates for at-risk youth and helps them identify and move towards their goals. Working with government and community partners, this program addresses major life concerns, including housing, employment, education, life skills, lifestyle choices, and mental health and addictions supports.

Every day, OYEP staff meet individuals seeking anything from personal care items to access to a phone, from medical care to legal assistance, from a hot meal to a meaningful conversation - in all of this, OYEP is consistently working longer term, helping youth work toward safe and supportive housing, improved wellness, and increased support systems. In addition to general supports, OYEP hosts drop-in meals, the Youth in Transitions initiative, the Momma Moments initiative and the Jumpstart initiative.

The drop-in component of the OYEP program is critical to building trust and relationships with at-risk youth, and opens the door to providing individualized supports (e.g. counselling sessions, accessing other CFY programming, help with gaining access to income supports, managing addictions, etc.).

Notably, the organization has developed considerable experience delivering programming aligned with Housing First principles through its previous operation of the Supportive Housing Program (defunded by CFYS) and ongoing delivery of Moving Forward for complex youth facing housing instability. As a result,
organizational experience can be leveraged in the delivery of prevention, rapid rehousing and intensive case management components outlined in the System Coordination Framework.

In 2014-15, the OYEP had approximately 15,000 requests for a broad range of services, with 624 individual requests for support in finding housing. OYEP served approximately 900 (1,000+ across the entire organization) individual young people in 2014-15. The site also houses the RallyHaven supportive housing program, as well as an Emergency Shelter for Young Men.

The OYEP employs 1 Coordinator, 2 Team Leads, and 4 Youth Support Workers. This program uses a dispersed model for the delivery of rapid rehousing and prevention as it is a shared responsibility throughout the team.

**OYEP Prevention/Rapid Rehousing Enhancement**

The HPS investment in HPRR will be used by Choices to enhance the OYEP with 3 additional positions reporting to the Coordinator of Outreach:

- 1 Case Manager
- 1 Housing Support Worker
- 1 Family Reconnect Worker

The Case Manager would focus on rapid rehousing and prevention and work with existing staff in meeting the HPRR targets. The Housing Support Worker (HSW) will fill a similar role to that of the HSW in the Front Step Program. The overall work of the team will entail: landlord recruitment and retention, system navigation and providing outreach support to clients, conducting intake assessments and developing individualized plans based on client acuity.

Given the evidence regarding best practices in homelessness prevention with youth (as identified by the Canadian Observatory on Homelessness) the partnership will also establish the first ever Family Reconnect Program in the Province of NL. This will be a dedicated position which is linked across both the Front Step (ICM) and RRH Programs. It will also be connected to both youth emergency shelters in the city (SC and CFY) and Thrive Community Youth Network. The intent of a Family Reconnect Program is to explore immediate (upon contact) opportunities with youth where families can be engaged to establish or re-establish supportive relationships and ultimately prevent homelessness or rapidly rehouse a population of at risk youth outside of the homelessness serving system.

The availability of flexible funds for damage deposits, rent supports and emergency funds added to BMHRC and OYEP will further enhance current services to those who need it and work with more individuals quicker than current capacity.

Notably, housing location and landlord liaison work would be supported for the OYEP staff by the Front Step and Brian Martin Housing Resources Centre Housing Support Workers to ensure no duplication of efforts and leveraging of resources already in place. This relationship will be described in the MOU with Stella’s Circle.
In addition, the HPRR enhancement of the OYEP would also work closely with the Outreach Workers to coordinate services, particularly once rehousing and stabilization have been achieved with youth. This will allow for an enhanced approach and ensure the HPRR component can be focused on housing for most impact. The details of how service delivery will be managed with clients between the OYEP Outreach Workers and the HPRR components will need to be further fleshed out as the program rolls out.

*Current OYEP Organizational Chart*

*Proposed OYEP Organizational Chart* (with HPRR Enhancements in red, blue boxes show existing positions)
Position Descriptions

Family Reconnect Worker (Choices for Youth)

The HPRR Family Reconnect Worker provides advocacy, system navigation and relationship-based case management to support youth and families. The Family Reconnect Worker aims to prevent, divert youth from, and address homelessness by connecting clients with the necessary resources in an effort to strengthen relationships. Additional information on family reconnection is provided in the next section of this report.

Using a strengths-based approach, the Family Reconnect Worker will provide individualized support services to persons who have been referred to and accepted under the criteria for the HPRR Program in order to prevent homelessness and provide rapid rehousing. The role provides solutions to barriers that perpetuate homelessness such as long processes and wait times, lack of transportation, intimidating program facilities, complex systems of support, interventions that precede assessment, and lack of support and connection prior to receiving community services.

Qualifications:

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 with the following skills:

- Degree in Social Work preferred; equivalencies of education and experience may be considered. Minimum of five years’ experience in providing family assessment and counseling services to youth and their families.
- Communicates clearly, listens actively, is open to feedback, resolves conflict appropriately, and displays sensitivity to others.
- Collaborates well with others, promotes cooperation and teamwork.
- Advanced knowledge and understanding of issues pertaining to homeless, street involved and at risk youth.
- Demonstrated experience counselling youth and families with mental health and addiction issues.
- Demonstrated oral and written communication skills; facilitation and mediation skills considered an asset.
- Ability to work independently while supporting and achieving the overall goals of the program.
- Proficiency in the use of computers and software applications such as word processing, spreadsheets and databases
- Able to help participants identify their housing needs
- Has excellent knowledge of mainstream community resources
- Is culturally competent
- Experience working with clients with multiple needs
- Able to handle crisis situations
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**

- Work with clients to establish shared goals and a plan for the services that will be provided
- Provide child development, parenting and relationship education and support
- Provide system navigation to connect clients with resources, referrals, and assistance for identified needs
- Assist clients with problem solving and crisis response, and the development of enhanced problem solving skills
- Provide families with tools to improve relationships and mutual support
- Provide consultation to HPRR staff at Choices for Youth and Stella’s Circle in their direct work with youth.
- Support enhanced overall well-being of the client and family
- Work within the cultural context of the family
- Provide case management at intake, during and/or after housing placement
- Link clients to mainstream and community resource
- Helps client identify and avoid behaviors that contribute to housing instability
- Helps client identify short- and intermediate-term goals
- Provide individual and family counseling, mediation, mental health and addiction counseling
- Completion of individual and family assessments and the provision of goal orientated interventions to youth and families.
- Advocacy and referral to community agencies.
- Outreach work with youth and families in the community and in family homes.
- Providing and maintaining of clinical records, statistics, and financial expenses.
- All other duties and responsibilities as may be assigned from time to time by direct supervisor.
- Initiate contact with street youth and identify at risk and high-risk youth.
- Assist clients to adapt to and maintain a life off the streets by providing guidance and emotional support.
- Monitor their wellbeing and provides feedback and support to families of clients.
- Recognizes and analyses potential emergency situations and develops strategies to deal with them.
- Assists clients to obtain temporary or permanent housing either directly or in coordination with other community services.
- Provides information that helps clients to make better-informed choices.
- Advocates for youth and assists them in self-advocacy.
- Reviews clients’ progress and makes reports regarding their daily activities and progress.
- Liaise with other agencies, professionals, ministry staff and the community.
- Performs other related duties as required.

**Reporting Relationship:**

Reports to the OYEP Coordinator

*Salary range: $60,000 – $65,000 + benefits: ~ $68,000 - $75,000 based on a 37.5 hour work week*
HPRR Case Manager (Choices for Youth)

Using a strengths-based approach, the HPRR Case Manager will provide individualized support services to persons who have been referred to and accepted under the criteria for the HPRR Program in order to prevent homelessness and provide rapid rehousing. 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 with the following skills:

- Understands the needs and concerns of landlords
- Able to help participants identify their housing needs
- Knowledgeable about landlord-tenant law
- Provides case management at intake, during and/or after housing placement
- Links clients to mainstream and community resource
- Helps client identify and avoid behaviors that contribute to housing instability
- Helps client identify short- and intermediate-term goals
- Specializes in one or more areas relating to income and benefits
- Assists client in accessing mainstream income and benefits resources at shelter entry
- Has excellent knowledge of mainstream community resources
- Is culturally competent
- Able to handle crisis situations
- Experience working with clients with multiple needs

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.

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.
- 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. - attention to detail in follow-up and case notes;
• Strong interpersonal skills.
• Effective problem-solving and negotiation skills;
• Ability to see both sides in a dispute and help parties develop compromise situations,
• Ability to remain calm and focused in situations where clients or landlords may be angry or anxious;
• Ability to interact respectfully with people of diverse ages, cultural backgrounds, gender and household composition.
• Experience with household budgeting.
• Knowledge of income assistance benefit programs and landlord-tenant laws.
• 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

Duties
• Interview individuals who are homeless/at risk of homelessness;
• Review past housing history and identify possible barriers to obtaining and retaining housing;
• Negotiation with landlords to “sell” program and convince landlords to accept tenants they would normally screen out;
• Assess and verify tenancy problems such as late payments, damage or lease violations, income, and financial assistance needs;
• Consult with legal services staff regarding actions to prevent evictions;
• Negotiate with landlords regarding late payments, damage or lease violations; consult with legal services staff regarding actions to prevent evictions;
• Negotiate with host-guest households and families/partners experiencing conflict to find compromise solutions to domestic problems;
• With client permission, request mediation services for more serious conflict;
• Help family connect with employment services and/or obtain financial assistance from government or private sources;
• Recommend for supervisory approval the financial assistance and services needed to resolve current tenancy problems;
• With household, develop a Housing Plan with goals for successful case closing;
• Implement Housing Plan;
• Provide information to individuals regarding additional community resources they may need and want and make referrals as the family chooses;
• Build a working relationship with each client, getting to know them as a unique individual and clarifying the role of the Case Manager.
• Conduct risk assessments and establish safety plans with clients.
• In concert with the Housing Support Workers, 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.
• Schedule support services for clients and accompany clients to meetings, as appropriate.
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.

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.

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

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

**Reporting Relationship:**

Reports to the OYEP Coordinator.

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

**HPRR Housing Support Worker (Choices for Youth)**

The HPRR Housing Worker will provide outreach services to all program clients using a strength-based approach. They will collaborate with clients and HPRR Case Managers to assist in the development and implementation of a client’s individualized Housing 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 requires a dynamic individual with skills in the areas of advocacy, crisis intervention and conflict resolution with the following skills:

- Understands the needs and concerns of landlords
- Able to help participants identify their housing needs
- Knowledgeable about landlord-tenant law
- Helps client identify and avoid behaviors that contribute to housing instability
- Helps client identify short- and intermediate-term goals
- Has excellent knowledge of mainstream community resources
- Is culturally competent
- Able to handle crisis situations
- Experience working with clients with multiple needs

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:

- Support the HPRR Case Managers in provision of outreach services to clients through 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 Housing Support Worker.
- Work with and support the HPRR Case Managers to ensure individualized Housing Plans are implemented.
- Support clients to maintain housing/achieve housing stability.
- Provide information to the HPRR 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.
- 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 participants 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.
- Provide direct support to tenants regarding housing retention, mediation and conflict resolution.

Qualifications:

- 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 of community resources, in particular the housing market.
- 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.
- 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.
• Excellent communication skills.
• Strong interpersonal skills.
• Effective problem-solving and negotiation skills;
• Ability to see both sides in a dispute and help parties develop compromise situations,
• Ability to remain calm and focused in situations where clients or landlords may be angry or anxious;
• Ability to interact respectfully with people of diverse ages, cultural backgrounds, gender and household composition.
• Experience with household budgeting.
• Knowledge of income assistance benefit programs and landlord-tenant laws.
• 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 HPRR Case Manager.

Salary range: $45,000 – $50,000 + benefits: ~ $51,000 – $57,5000 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 Program Coordinator be implemented regardless of the level of funding ultimately available to support the Program.

Budget & Targets
See Excel Sheet.

Program Operations

This section was developed using best practice toolkits and guidelines developed by the National Alliance to End Homelessness based on best practices in delivering rapid rehousing and prevention. In addition, the model incorporates learnings from the following jurisdictional review of practices in Canada:

1. CUPS Keys Case Management (formerly Rapid Exit), Calgary
2. Boys and Girls Clubs of Calgary Elements Program, Calgary

3. Eva’s Initiatives, Family Reconnect Program, Toronto
4. Medicine Hat Community Housing Society Rapid Rehousing Program, Medicine Hat
5. Bredin Centre for Learning PATH Prevention Program, Red Deer
6. Brian Martin Housing Resource Centre, St. John’s
7. Choices for Youth Outreach and Youth Engagement Program
8. Hennepin County Rapid Rehousing Rapid Exit Program, Hennepin County

Of note, the consultant, Dr. Alina Turner, oversaw the program development and performance of over 40 programs in the Calgary Homeless-Serving System which included programs for singles, youth, and families. This expertise was drawn upon for the program model development as well.

Principles of Homelessness Prevention and Rapid Rehousing

Prevention and Rapid Re-Housing programs (HPRR) are proven strategies for ending homelessness. The intent is to minimize the length of time an individual or family remains in the limbo of homelessness and to help households quickly re-establish stability. In the safety and predictability of permanent housing, they are encouraged to choose how, when and where they will address other life problems or goals using mainstream resources. HPRR programs resolves the crisis of homelessness; the rest is up to the individual or family—and their community support systems.

Key principles are outlined below:

1. **Crisis Resolution.**
   
   Every situation that could result in homelessness is a crisis for the person experiencing it. Crisis resolution responses must include: rapid assessment and triaging, based upon urgency; an instant focus on personal safety as the first priority; de-escalation of the person’s emotional reaction; definite action steps the individual can successfully achieve; assistance with actions the individual is temporarily unable or unwilling to attempt; and returning the person to control over their own problem-solving.

   People in crisis may feel paralyzed by the urgency and the potentially devastating consequences of their situation. HPRR services must help people in crisis regain a sense of control and feeling of empowerment to actively overcome obstacles. A constant emphasis on the client’s goals, choices, and preferences, an unwavering respect for their strengths, and reinforcement of progress are essential for empowerment. This does not mean clients are protected from the natural consequences of their actions. Households are empowered to make their own choices and to respond to the consequences of those decisions. HPRR does not guarantee risk-free housing and some households will fail. But services are voluntary. Choices are “participant” driven.

2. **The Right Assistance, at the Right Time**
   
   HPRR provides the minimal amount of assistance—amount and length—needed to obtain and retain housing for the shortest time possible. Respect includes “letting go” as soon as the person has the resources, knowledge and tools to continue their lives--however they choose to live them. Providing “just enough” to prevent and end homelessness enables a program to help far more people in crisis. Often this means ensuring resources are used to help persons at-risk of
losing housing of any kind—persons who would otherwise end up on the street or in an emergency shelter—before using resources to provide assistance for other needs. Providing non-essential assistance to a program client will cost someone else in the community their housing.

The earlier a program intervenes in a housing crisis, the lower the cost. The outcomes may look impressive, but research shows that most people who receive prevention assistance would not have become homeless even without assistance. The later the intervention, the costlier and the lower the success rate. But at the latest stages of an individual’s housing crisis, it is virtually certain she or he would have become homeless without assistance. Good programs strive to target people who have the highest risk of becoming homeless but who also have a good chance of remaining housed if they receive assistance.

3. **Leveraging Community and Mainstream Resources**

Mainstream resources are a critical part of stability for everyone living in a community and are intended to be the backbone of every community. HPRR helps households connect to the supportive, community-based resources they will use long after services are ended. Creating duplicate services for a sub-population such as people at risk of homelessness allows mainstream agencies to continue to bypass or ineffectively serve people who have a right to better quality and access. Duplication also wastes valuable, limited resources that could be spent to keep more households from becoming homeless.

4. **Housing-Focused**

People move directly from homelessness to housing. There are no intermediate programs that delay their move to housing. The key to successful re-housing is understanding the individual’s barriers to getting and keeping housing—then finding ways to eliminate or compensate for those barriers.

Household problems that are not directly related to housing are addressed only if and when the client chooses. This does not mean that programs offering short or medium-term rental assistance have no expectations of the household. Effort or progress towards obtaining a long-term subsidy or increasing income enough to remain housed without the rental assistance is a reasonable program requirement. But the focus, again, is directly related to housing.

5. **Landlords** are a HPRR’s most valued resource. If the program cannot meet the reasonable expectations of landlords, many clients will not be re-housed and stabilized. Programs that adopt an adversarial attitude towards landlords are much less likely to succeed.

In some cases, particularly for youth, the most appropriate housing situation may involve family reconnection or moving in with **natural supports** who can provide financial or other support.
Target Population

In order for HPRR to be successful, appropriate targeting measures must be taken to serve individuals who have the ability to remain independent after short-term interventions. Thus, low-mid acuity at risk, transitionally and episodically homeless clients should be the primary focus.

HPRR should be directed toward those who:
- are experiencing homelessness or are at imminent risk
- have difficulty exiting homelessness on their own
- do not have major barriers (e.g. serious mental or physical disabilities, chronic addictions), and;
- have capacity to live independently and retain housing after short-term, limited financial assistance and supportive services.

Since housing instability may continue after a client is rehoused, particularly resulting from persistent poverty and high housing costs, system navigation and low intensity case management can assist in stabilization and linking with appropriate mainstream services thereby reducing homelessness to a minimum.

Prioritizing these groups for rehousing and supports, including limited financial supports will ensure that those at the highest risk for homelessness have the income assistance in place to be stably housed. Further, for those who experience homelessness, the service should be offered to clients who demonstrate an ability to remain housed after the passage of a short-term crisis as the length of stay in the program should be under 12 months.

The two programs will target clients who are at risk of or experiencing homelessness in St. John’s. While chronically homeless clients may be served, the primary homelessness histories of participants will likely be episodically, transitionally homeless or at imminent risk using HPS definitions. Chronically homeless clients likely have higher levels of needs and may be better served by other services (ie. ACT, NAVNET, ICM).

To meet program eligibility criteria, the clients must meet the following criteria:

1. Must be 16 years of older
2. Able to maintain housing stability after less than 12 months of program intervention
3. Willing to participate in case management with HPRR staff
4. Must be at imminent risk of homelessness, transitionally or episodically homeless (as defined below)

a) Populations at **imminent risk of homelessness** are defined as individuals or families whose current housing situation end in the near future (i.e. **within 2 months**) and for whom no subsequent residence has been identified. These individuals are unable to secure permanent housing because they do not
have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or a public or private place not meant for human habitation. To be considered at imminent risk of homelessness, the following conditions must be met:

a. the client receives an eviction, foreclosure, or utility termination; or
b. the client cannot make essential household payments due to a sudden reduction in income and as a result, the assistance is necessary to avoid an eviction or termination of utility services.

b) **Transitionally homeless** persons may be homeless for the first time (usually for less than three months) or has had less than 3 episodes in the past three years. Most people experience homelessness for a short time and infrequently in their lifetime. Usually, this is a result of lack on income or housing affordability challenges.

c) **Episodically homeless** people experience recurring episodes of homelessness throughout their lifetime. This group is likelier to face more complex challenges involving health, addictions, mental health, violence. According to HPS, an *episodic* homeless person is currently homeless and has experienced 3 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 inhabitable location (HPS). For the Plan’s purposes, once we address the needs of 90% of the estimated episodic group using the HPS definition, we would then move to a broader group which is defined using the Alberta government’s episodic homeless definitions of someone who is homeless for less than a year and has fewer than 4 episodes of homelessness in the past 3 years.

d) **Chronically homeless** refers to individuals, often with disabling conditions (e.g. chronic physical or mental illness, substance abuse problems) who experience long-term and ongoing homelessness as result of complex barriers, particularly related to mental health and addictions. According to HPS, they are currently homeless and 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) (HPS). For the Plan’s purposes, once we address the needs of 90% of the estimated episodic group using the HPS definition, we would then move to a broader group which is defined using the Alberta government’s chronic homeless definitions of someone who is homeless who has either been continuously homeless for a year or more, or have had at least 4 episodes of homelessness in the past 3 years.

NOTE that clients who are chronically homeless should be considered for referrals to higher intensity programs to ensure appropriate levels of supports are in place, as per System Coordination Framework.

5. **Must have a score of 15-35 on the Vulnerability Assessment Tool (VAT).** (Refer to the St. John’s Homeless System Coordination Framework for a full overview of the VAT). The programs will focus on the clients experiencing the low to mid-acuity levels using the VAT. Higher scores may indicate the client may be better suited for higher intensity supports (i.e. ICM, ACT, etc.).

a) **High Acuity:** most vulnerable people in the homeless population, presenting with co, or tri-morbidity. They tend to have high rates of health problems, including severe mental illness and substance abuse disorders, conditions that may be exacerbated by physical illness, injury or trauma. Consequently, they may be frequent users of emergency services, crisis response, and public safety systems

b) **Mid Acuity:** having difficulty exiting homelessness on their own, largely due to financial barriers and may have major barriers (e.g. serious mental or physical disabilities, chronic addictions) but not co-

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6 HPS definitions are available online at http://www.esdc.gc.ca/eng/communities/homelessness/funding/directives.shtml#fn3
7 HPS definitions are available online at http://www.esdc.gc.ca/eng/communities/homelessness/funding/directives.shtml#fn3
occurring and which may be resolved, and; have lived independently in the past with demonstrated ability to live independently again after a short term intervention.

c) Low Acuity: have difficulty exiting homelessness on their own, largely due to financial barriers and do not have major barriers (e.g. serious mental or physical disabilities, chronic addictions), and; have lived independently in the past with demonstrated ability to live independently again after a short term intervention.

The services offered would start at age 16 with no age limit and will target those experiencing homelessness so that they can quickly exit emergency shelters and obtain housing. The BMHRC will provide coordination HPRR services for adults, and the OYEP will focus HPRR supports for youth. The addition of a new Family Reconnect Worker position for youth through OYEP will focus on supporting youth from the two youth emergency shelters and the Thrive Community Youth Network.

Referral Process

Referrals may come from any organization or public system serving individuals who are homeless and/at risk in adherence to the System Coordination Framework. 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. All referrals will come to the Program Coordinator who will be responsible for intake and assessment.

All CA agencies are expected to provide preventative and diversionary supports where possible. If the participant requires additional supports, particularly if they are at imminent risk as defined by HPS or already homeless, the CA Worker would administer the VAT assessment to determine appropriate referrals. If an appropriate match is made to HPRR programs, a referral for a client at risk of homelessness can be made without a full VAT once screening for prevention is completed. At this point, HPRR staff receiving the referral would be responsible for administering the VAT to ensure the client fits within its criteria. This approach is aimed at reducing the number of VATs being completed for clients who are at risk of homelessness but may not need HPRR intervention, or qualify for it.

Screening and Assessment

The term “screening” usually refers to a first-level decision about whether the potential client is eligible for a program and/or would have a priority for those services. “Assessment” is a somewhat deeper level of inquiry into the actual problem and the client’s strengths and needs related to solving the problem.

Screening

Screening determines who receives assistance; assessment information determines the expected type, intensity and duration of assistance. Screening may be extremely simple: does the person meet eligibility requirements? Verification of eligibility information is typically included in screening. Does the person have pay stubs or a social assistance benefits notification letter? Does the property owner confirm the amount of overdue rent?
Where many people are eligible for help and resources are limited, the program also determines how to prioritize those who are at highest risk and must be helped first. Priorities are suggested by research but may also rely on case-by-case determinations.

In a practical sense, every person in crisis who walks through the program’s front door is a client, at least until the critical question has been asked and answered: **Do you have a safe place to stay tonight?** If the answer is no, the program must know how and where to find immediate help and make the appropriate referral – including to an emergency shelter program.

Where the household is at risk for losing housing, these questions can help the program prioritize among many requests for assistance:

- How urgent is this household’s situation?
- Without help, would housing be lost today? Next week?

At some point, when the program’s entire prevention budget is not enough to assist all the high priority households seeking help, screening criteria that were originally used to prioritize may become threshold eligibility criteria. At that point, only those with a priority need may receive help. A program with limited resources should consider the question of priority vs. eligibility early in implementation. But such decisions can also evolve over time, through experience.

**Assessment**

Assessment should focus on information that is timely and relevant to the current housing situation. For example, providers may request detailed information about household income and expenses. This is timely and relevant in determining whether the household could, with better budgeting, keep their housing with only one-time assistance. Sometimes it is immediately apparent that a household must move; housing has been condemned or foreclosed and the deadline has arrived. In this case, detailed information about past evictions, criminal history, debts, and employment history is timely and relevant for relocation assistance because potential landlords will see and judge the same information in making a decision.

While both agencies will use the VAT as a first component of assessment and to determine program fit, additional information will be needed to develop a service approach. There are three critical barriers to obtaining and maintain housing: financial, tenant screening, and housing retention barriers.

1. **Financial barriers** can be overcome by assuring that funds are available to pay housing startup costs that are beyond the reach of the homeless household. Sources of assistance can include mainstream public benefits. To assure the unit is not lost, funds must be immediately available when a household’s tenant application is accepted.

2. **Tenant Screening Barriers** are more complex but rarely impossible to overcome. Ideally, a household would work on repairing their credit history, establish a new history of timely payments, and avoid any criminal behavior. But these are steps that take considerable time – steps that can be better achieved from a stable living situation.

   The household needs to convince a landlord to rent to them. This is the role of the HPRR provider. Landlords screen to minimize the risks of unpaid rent, property damage, police calls and conflict with other tenants. HPRR providers make the landlord an even better offer: they
promise to identify rental problems and resolve them, and to respond to landlord concerns (such as late rent or apparent lease violations). Thus, there is less risk renting to HPRR households than renting to other applicants who may look better on paper but later have many tenancy problems – and no program to help resolve those problems for the landlord.

3. **Housing Retention Barriers** concern households’ housing histories. HPRR staff can identify recurring issues that have resulted in housing loss in the past. These situations may present a risk to maintaining housing in the future.

   Barriers often include:

   - A lack of any **emergency reserves** to meet unexpected financial demands is common and often results in non-payment of rent. Lack of sufficient income, excess debt, a poorly-managed budget: all are frequent barriers to maintaining housing.
   - Lack of information about **tenant responsibilities** and expectations. This includes lack of understanding regarding legal requirements in the lease, and failure to meet basic expectations for noise, care of the unit, and other behavioral norms.
   - Common problems include the **behavior of guests** (who may cause noise or damage), including friends or relatives who move in without the landlord’s permission or "borrow" the rent money. Other personal problems that result in failure to pay the rent, care for the unit and interact positively with other tenants or the landlord.
   - A person with a developmental **disability** or traumatic brain injury, for example, may have special difficulty organizing and scheduling bill-paying or setting limits on guests' behaviors.
   - A person experiencing domestic violence may have particular **safety issues** that must be addressed in her housing plan.
   - Someone who uses **alcohol or drugs** may then have difficulty paying the rent or may be evicted if the landlord learns of illegal behavior or problems with conflict or unit damage due to chemical use.

**Sample Questions**

Selecting or constructing screening and assessment applications or interview guides requires careful consideration of the least information needed to determine the best response at the time the individual or family asks for help. Asking for too much information can be intrusive and may confuse both staff and client about the purpose and plan for assistance.

1. How urgent is the housing crisis? Without intervention, how soon will housing be lost? Higher priority is assigned for more urgent situations.
2. What is the crisis and the goal? Can housing be preserved or is relocation necessary? Nonpayment, lease violations, conflict within household may be resolvable. Condemnation, foreclosure, abuse or violence would trigger immediate or planned relocation, depending upon safety in current housing.
3. Does the person or family meet the eligibility requirements for assistance? Income verified? Situation verified? Does the household have any assets, friends, relatives or connections to organizations that could assist?
4. What is the immediate/initial response needed to preserve housing or relocate the household? One-time payment? Negotiation with the landlord or family/co-habitants? Use of a shelter or motel for crisis housing? Legal services? Before approving short- or medium-term rental assistance, is additional information needed?

5. Other information that may be needed to assign priority or to approve supportive services and/or rental assistance. What are the costs and risks if housing is lost? Does the household have community supports (friends, relatives, children’s school) that would be disrupted by housing loss? Is current housing subsidized or more affordable than alternatives would be? If relocated, would housing start-up costs be especially high? Does the person or household have tenant screening barriers that would make it difficult to find alternate housing? Is there a history of homelessness?

The VAT assessment should be used in tandem with these questions to help assess the client’s level of acuity. Once the VAT is adjusted by the Canadian Observatory on Homelessness for youth and families, it should be used as appropriate at program intake, follow up and exit to assess changes across acuity domains.

Acuity Assessment and Services Planning

Based on this initial screening and assessment, the household at risk of homelessness can be classified according to the level of need. The program should have a mix of levels 1 to 4 being served at any one time, being mindful of program resources and staff caseloads. The caseloads will likely range from 20-30 per program staff, but will depend on the levels of needs among clients. For instance, a lower caseload (20) would be more appropriate if the staff is dealing with all Level 4 clients with high VAT scores.

Determination of caseloads varied widely across the jurisdictional programs reviewed as well as the literature. However, a standard did appear to be between 1:20 and 1:30. 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 1:20.

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 Case Managers working with youth given the findings of the Infinity Project and the experience identified through Choices Moving Forward Program.

<table>
<thead>
<tr>
<th>Level 1 – Household/Individual Needs (~3 months of support)</th>
<th>Tenant Screening Barriers (Barriers to Obtaining Housing)</th>
<th>Retention Barriers (Barriers to Sustaining Housing)</th>
<th>VAT Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>The household will need minimal assistance to obtain and retain housing. Program offers the following for most Level 1 households: Financial assistance for housing start-up (e.g. first month’s rent, security deposit, utility deposit) Initial consultation related to</td>
<td>Household has no criminal history Rental history: an established local rental history.</td>
<td>No significant barriers except financial: very low income, insufficient emergency reserves</td>
<td>Low-Mid Range with high scores in Basic Needs Organization/Orientation Communication Social Behaviours Homelessness</td>
</tr>
</tbody>
</table>
housing search (e.g. where to find rental information, how to complete housing applications, documentation needed)
- Time-limited rental assistance, per client Housing Plan
- Home visit/check-in after move-in
- Offer of services (at tenant request) for up to 3 months.
- Home visits as needed after move-in.

Landlord assistance will likely include only program contact information for tenancy concerns.

<table>
<thead>
<tr>
<th>Level 2 – Household/Individual Needs (≈6 months of support)</th>
<th>Tenant Screening Barriers</th>
<th>Retention Barriers</th>
<th>VAT Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program offers the following for most Level 2 households:</td>
<td>Household has no serious criminal history, but may have a few minor offenses such as moving violations, a DUI, or a misdemeanor</td>
<td>Financial barriers include very low income, may have inconsistent employment, poor budgeting skills</td>
<td>Low-Mid Range with high scores in</td>
</tr>
<tr>
<td>• Financial assistance for housing start-up</td>
<td>Rental history is limited or out-of-province.</td>
<td>No serious mental illness or chemical dependency that affects housing retention.</td>
<td>• Basic Needs</td>
</tr>
<tr>
<td>• Time-limited rental assistance, per client Housing Plan</td>
<td>May have 1-2 explainable evictions for nonpayment. Prior landlords may report a problem with timely rent.</td>
<td>May have some level of depression or anxiety or problems responding to conflict</td>
<td>• Organization/Orientation</td>
</tr>
<tr>
<td>• Initial consultation and ongoing assistance with housing search, including bus tokens as needed</td>
<td>Credit history shows pattern of late or missed payments</td>
<td>May lack awareness of landlord-tenant rights/responsibilities.</td>
<td>• Communication</td>
</tr>
<tr>
<td>• Development of Housing Plan to work on any identified retention barriers</td>
<td></td>
<td>May have minor problems meeting basic household care/cleaning.</td>
<td>• Social Behaviours</td>
</tr>
<tr>
<td>• Weekly home visits for first two months; then reduce to bi-weekly or monthly as most Housing Plan goals are met.</td>
<td></td>
<td>May have been homeless once before.</td>
<td>• Homelessness</td>
</tr>
<tr>
<td>• Services available for up to 6 months, depending on housing problems and progress toward Housing Plan goals.</td>
<td></td>
<td></td>
<td>• Mental Health</td>
</tr>
<tr>
<td>• Home visits as needed after move-in.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Landlord assistance:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 6-month availability: landlord can call with tenancy issues and program will respond.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Program will check in with landlord periodically for updates.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Program will relocate household if landlord is considering eviction.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 3 - Household/Individual Needs (≈9 months of support)</th>
<th>Tenant Screening Barriers</th>
<th>Retention Barriers</th>
<th>VAT Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>The household will need more intensive and/or longer assistance to obtain and retain housing.</td>
<td>Household may have some criminal history,</td>
<td>Household is very low income, has periods of unemployment, no</td>
<td>Mid-High Range with higher scores in</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Basic Needs</td>
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<tr>
<td></td>
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</tbody>
</table>
The program offers the following for most Level 3 households:

- Financial assistance for housing start-up
- Time-limited rental assistance, per client Housing Plan
- Initial consultation and ongoing assistance with housing search, including bus tokens as needed. Staff may accompany client to the landlord interview.
- Development of Housing Plan to work on any identified retention barriers
- Weekly home visits for first two months; then reduce to bi-weekly or monthly as most Housing Plan goals are met.
- Services available for up to 9 months, depending on housing problems and progress toward Housing Plan goals.

**Landlord assistance:**

- 9-month availability; landlord can call with tenancy issues and program will respond even after services end.
- Program will check in with landlord periodically for updates.
- Program will relocate if an eviction is being considered. If household will not leave, program may pay court costs.
- Program may pay or repair damages.

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**Level 4 - Household/Individual Needs**  
(~12 months of support)

<table>
<thead>
<tr>
<th>Tenant Screening Barriers</th>
<th>Retention Barriers</th>
<th>VAT Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal history, violations may include drug offense or crime against persons or property</td>
<td>Extremely low income, no emergency reserves, bank accounts closed, lacks budgeting skills</td>
<td>Mid-High Range with high scores in</td>
</tr>
<tr>
<td>Rental history includes up to five evictions for non-payment and/or lease violations.</td>
<td>May be using drugs/alcohol and/or has mental health problems.</td>
<td>Survival Skills</td>
</tr>
<tr>
<td>Landlord</td>
<td>May have conflict with child/ren or partner.</td>
<td>Basic Needs</td>
</tr>
<tr>
<td></td>
<td>May lack ability to care</td>
<td>Indicated Mortality Risks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical Risks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Organization/Orientation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Substance Use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Behaviours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Homelessness</td>
</tr>
</tbody>
</table>

- Problems with mental health or alcohol/substance use that somewhat impacts tenancy
- Partial damage deposit returned.
- Some complaints by other tenants for noise
- Credit history includes late payments and possible court judgments for debt, closed accounts
- Criminal history, violations may include drug offense or crime against persons or property
- Rental history includes up to five evictions for non-payment and/or lease violations.
- Landlord
- Emergency reserves, lacks budgeting skills
- Problems with mental health or alcohol/substance use that somewhat impacts tenancy
- Partial damage deposit returned.
- Some complaints by other tenants for noise
- Credit history includes late payments and possible court judgments for debt, closed accounts
- Criminal history, violations may include drug offense or crime against persons or property
- Rental history includes up to five evictions for non-payment and/or lease violations.
- Landlord
- Emergency reserves, lacks budgeting skills
- Problems with mental health or alcohol/substance use that somewhat impacts tenancy
- Partial damage deposit returned.
- Some complaints by other tenants for noise
- Credit history includes late payments and possible court judgments for debt, closed accounts
- Weekly home visits for first two months; then reduce to bi-weekly or monthly as most Housing Plan goals are met. Include unannounced drop-in visits.
- Services available for up to 12 months, depending on housing problems and progress toward Housing Plan goals.
- Home visits as needed after move-in.

**Landlord assistance:**
- 12-month availability; landlord can call with tenancy issues and program will respond; ongoing option to call even after services are ended can be offered or negotiated on a case-by-case basis.
- Program will check in with landlord monthly (or more often if landlord prefers) for updates/issues.
- May pay an additional damage deposit and/or last month’s rent in addition to normal start-up costs.
- Program will relocate household if an eviction is being considered. If household will not leave, program may pay court costs of eviction.
- Program may pay or repair damages.

<table>
<thead>
<tr>
<th>Level 5 - Household/Individual Needs</th>
<th>Tenant Screening Barriers</th>
<th>Retention Barriers</th>
<th>VAT Scores</th>
</tr>
</thead>
</table>
| Household needs longer or more intensive services; may need staff with more professional training. HPRR program refers household to appropriate program, such as intensive case management, permanent supportive housing or other local resources. | Extensive criminal background
Extremely poor rental history, multiple evictions, serious damage to apartment, complaints
Credit history includes multiple judgments, unpaid debts to landlords, closed accounts | Extensive criminal background
Extremely poor rental history, multiple evictions, serious damage to apartment, complaints
Credit history includes multiple judgments, unpaid debts to landlords, closed accounts | High range across all dimensions
- Survival Skills
- Basic Needs
- Indicated Mortality Risks
- Medical Risks
- Organization/Orientation
- Mental Health
- Substance Use
- Communication
- Social Behaviours
- Homelessness |
All Rapid Re-Housing programs must also be Homelessness Prevention programs, which include a focus on housing stabilization. Financial crises will occur even in households who may have been rehoused and relocations will be required. If there is a history of household conflict, disputes may arise again. The program must be able to help the family quickly obtain mainstream or specialized resources when and if they are needed. The System Coordination Framework should be referred to with respect to broader triage and coordinated access issues the community is working on.

To further refine the intensity and duration of supports provided, the program can consider:

- **What promises were made to the landlord?** The primary reason programs are able to obtain housing for households with Tenant Screening Barriers is because they promise landlords that program staff will be available to resolve tenancy problems for a specific period of time. If a program promises staff will make home visits and respond to landlord concerns for six months, housing stabilization must be provided for six months. The frequency of home visits and landlord “check-ins” can vary, based upon the household’s overall housing history, but some level of stabilization support must be offered as promised.

- **What assistance does the household want?** Sometimes, an individual or family wants and needs very little help after they find housing. However, the program-required monitoring and stabilization home visits offer an opportunity for staff to develop a strong relationship with the household. This allows staff to better help the household mediate and resolve issues with their landlord when necessary. Frequently, this level of trust also enables a client to request help with other life concerns. For example, after the staff has proven s/he can find daycare for the parent, that parent might broach the subject of her child’s behavior problems and ask for help finding a good pediatrician.

- **Caseload Size, Frequency and Duration of Contact.** Some households may need only infrequent home visits; others may require regular contact to help them acquire the skills needed to meet their obligations as tenants. Practitioners who work with a mixed caseload of families with moderate to moderately high barriers may carry up to 20 cases at any point in time. If the duration of services is about six months, this means staff would close—and open—about 1-2 cases per month.

  A program that provides longer-term services could carry a similar caseload but with somewhat fewer openings and closings per month. Note: longer-term services do not necessarily translate into more intensive services. A household that recently experienced a job loss may need months of rental assistance while the wage-earner(s) attempts to secure employment, but if they have a history of housing stability, the frequency of contact for housing related supports could be quite low.

**Housing Plan**

Whether the program offers only short-term financial assistance or provides longer-term assistance and services, good HPRR programs utilize individualized plans as tools for both the client and staff. The
Housing Plan focuses on the end goal and works backwards, through the steps the client and the program will take to accomplish that goal.

The end goal is relatively simple: retaining housing or, where necessary, relocating to new and sustainable housing. The task is defining the steps needed to reach that goal. Barriers to keeping housing or relocating into new housing have already been identified during the assessment process. Steps in the plan will relate to overcoming those barriers.

The Housing Plan should be developed collaboratively with the client and focuses on what has to happen to assure barriers to securing and maintaining new housing are addressed and overcome. The degree to which those barriers are likely to impede obtaining housing or undermine housing stability will determine the action steps and frequency of contact in the Plan.

Goals identified in the plan should be concrete, achievable and, where appropriate, tied to a specific timeframe. The family and program staff should each have specific assignments (action steps). To the maximum extent possible, the Plan should identify and utilize community resources to address financial and personal housing problems.

The Plan should also include the length of time the agency has promised to be available to the household and the landlord for problem-solving. The Plan can be a simple list of steps that will be taken before the next client-staff meeting. Or it can be written as a longer-term plan covering all of the goals and steps to be taken to obtain housing and improve housing stability during the projected time the household will participate in the program. In either the case, the Plan should be frequently revisited and updated as it serves as the agreed upon ‘road map’ to housing stability.

The Plan must include actions to overcome or minimize these two critical barriers to obtaining housing. Financial barriers can be overcome by assuring that funds are available to pay housing startup costs that are beyond the reach of the homeless household. Sources of assistance can include mainstream public benefits, or any other source of public or private funding. To assure the unit is not lost, funds must be immediately available when a household's tenant application is accepted.

Note that tailoring the approach to youth will likely involve their natural supports, particularly in light of the Family Support Worker’s role in HPFR. In this manner, the program may begin with serving a youth in crisis and then realize they are in fact serving a larger family unit with rehousing. This will impact caseloads and the housing plan itself further.

**Plan to Get Housing**

1. **Assessment of Tenant Screening Barriers**
   a. Housing History
   b. Criminal History
   c. Credit History
   d. Employment/Income
2. **Plan: Housing Search**
   a. Goal
   b. Action Steps
3. **Plan: Application, Landlord Interview, and Leasing**
   a. Goal
   b. Action Steps
Plan to Keep Housing

1. Housing Retention Barriers
   a. Financial
   b. Tenancy Information
   c. Relationships
   d. Other Issues

2. Financial
   a. Goal
   b. Action Steps

3. Tenancy Information
   a. Goal
   b. Action Steps

4. Relationships
   a. Goal
   b. Action Steps

5. Other Issues
   a. Goal
   b. Action Steps

I agree:

- To allow (name of HPRR worker) to visit my apartment every week the first month, then every two weeks for six months.
- I understand that the landlord is likely to approve my rental application because (HPRR worker) promised to help me and the landlord get along.
- To work on these goals and to discuss my progress when (HPRR worker) visits.
- To call HPRR Worker whenever I’m having trouble with my apartment, landlord or other tenants.

Client Name                  Client Signature                  Date

Financial Assistance

A financial means assessment should be used to determine the appropriate amount of subsidy. This will include an assessment of assets and debts as well as a calculation to determine the percentage of income to be paid towards rent. This involves asking for as many pay stubs as possible for the last three months and determining an average income.

Rent Supports

Rental supports should be as short and as shallow as possible, so the program can assist as many households as possible. The priority is for the program staff to assist clients in accessing available
mainstream subsides, before using program resources to this end. This adheres to the HPS Directives around rent supports, in order to ensure provincial accountabilities for rent supports and income assistance are tapped first.

To calculate the rent supplement, the program will ensure that amounts are capped at 30% of client income relative to average rental costs according to the most recent CMHC Rental Market Report, less any other rent supports the client may be receiving from other sources (NLHC, AES, etc.).

For households who do not have sufficient income to pay for rent and utilities in even the most modest housing, the program should develop clear criteria for deciding which households will qualify and which will receive priority. It should further define the expectations that will accompany subsidy, including frequency of re-assessing need/eligibility, as well as the criteria and process for terminating a subsidy, including appeal rights and procedures.

In the case of youth, particularly those under 18, the types of financial supports available are limited as is their ability to hold leases. In such cases, the program may need to reserve HPS funds to fill such gaps and can consider taking on master leases to the agency, and in turn sub-let to youth.

Utility Assistance

A household may be able to maintain housing with only a utility subsidy. Or they may benefit from a shallow rent subsidy combined with utility assistance. When utility assistance and rental assistance are provided simultaneously, the overall impact on a household can be significant and the combined assistance may result in a larger “cliff effect” once assistance ends. This refers to the difference between the income of the client while in the program being potentially higher than when they are exited, creating a large drop in income.

A good approach to avoid this is to calculate the total assistance provided and the household’s ability to increase income or decrease expenses enough to transition off subsidy. In all cases, households should be encouraged and assisted, as needed, to apply for utility assistance offered through any utility assistance programs for which they may be eligible first.

Housing Start-Up Costs

It is recommended that the program develop a method of assuring immediate access to financial assistance for housing start-up costs when a household locates housing.

To do so, the program should:

- Identify financial assistance resources and related eligibility criteria for housing start-up costs that are currently available in the community.
- Develop a method to rapidly assess clients for eligibility to obtain publicly or privately funded assistance for damage/security deposit, first month’s rent, etc.
- Train staff on available community resources for housing start-up, including eligibility criteria and referral/linkage procedures.
- Establish formal or informal partnerships to ensure efficient and effective access to assistance.
Hours of Operation

The Brian Martin Housing Centre is open from 9am to 4:30pm, during which time clients could access supports onsite. Many of the programs reviewed provided service outside of regular business hours. Hours of delivery must be flexible and able to be extended or modified based on the needs of the clients.

HPRR staff coverage would be from Monday to Friday, 8:30am to 4:30pm, with evening and weekend available in a flexible manner from Housing Support workers and Case Managers as needed. This is already an occurring practice in the agency, recognizing that processes put in place to ensure responsiveness to the needs of the clients. Being available to provide outreach support to clients in their homes and outside regular business hours, the program will likely find better success meeting clients where they are at. This weekend and evening support should be closely monitored to identify the ongoing need and should abide by safety protocols and working alone policies outlined in the program manual.

Clients must also 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 should be written into the clients’ service plans.

Family Reconnection

Homeless youth are facing many complex challenges such as family breakdown, addiction, mental health, poverty, trauma, violence, immigration, isolation, and illness. These young people face significant barriers to stability and well-being, feelings of defeat, confusion, self-doubt and hopelessness.

Youth homelessness is defined by inherent instability, profound limitations and poverty. At a time when these young people are experiencing loss and potentially trauma, they are simultaneously charged with managing a diverse and complex set of tasks, including obtaining shelter, income and food, making good decisions and developing healthy relationships. Youth who remain homeless for extended periods of time are also exposed to early sexual activity, exploitation, addictions and safety issues.

Research on youth homelessness is fairly consistent in identifying difficult family situations and conflict as the key underlying factors in youth homelessness. Strains within the family may also stem from the challenges young people themselves face. Personal substance use, mental health problems, learning disabilities, disengagement with the education system and dropping out, criminal behaviour and involvement in the justice system are key factors.

Family breakdown is one of the leading causes of youth homelessness. The factors that lead to this breakdown vary, but family challenges and conflict is most often the precursor to youth homelessness. Prevention including family mediation has been identified as a key strategy by the Canadian Observatory on Homelessness in efforts to end youth homelessness. Yet, one of the persistent features of responses
to youth homelessness is the noticeable absence of family work. Reconnecting with, or repairing relationships with family, are largely ignored as strategies addressing youth homelessness.

Promising Practice: Eva’s Initiative Family Reconnect Program

The award-winning Family reconnect Program at Eva’s Initiatives provides another example of promising practice in this area. This section comes from the Family Matters: Homeless Youth & Eva’s Initiatives Family reconnect Program Report prepared by Winland and Gaetz (2011)¹, who provide an overview of the approach:

- The Family Reconnect staff use a client-centered case management model, and facilitate access to appropriate and effective services and supports for young people and their families. In addition to facilitating access to supports, staff may accompany young people to services in those cases where they are having difficulty accessing their appointments.
- Counseling is at the centre of the work of the Family Reconnect team. Based on family systems theory, counselors provide short term and ongoing counseling and support.
- Counseling may also involve family members, with the idea of nurturing and promoting positive change and understanding. In some cases, young people and family members participate together in family counseling; in other cases, family members themselves receive counseling and support.
- Mental health supports are central to this work. Many young people, and in some cases family members, have mental health problems and/or addictions that underlie family conflict. Mental health support is provided by counselors, and access to other mental health professionals is facilitated through the work of the program.
- Many young people receive crucial psychiatric diagnoses that help identify mental health challenges, learning and other disabilities. This often paves the way towards more effective solutions and supports (2011, p. 9).

Key outcomes of the Eva’s Family Reconnect Program include:

- Many young people renew contact with family members as a result of program involvement. This may happen quickly, or may be the result of longer term work.
- The work of the Family Reconnect program demonstrably improves relations between many young people who participate in the program, and family members. Even where relations have not been completely reconciled, there is often an increased understanding of the nature of family conflict that helps young people and families move forward with their lives.
- The housing and material circumstances of young people improve as a result of program involvement. With appropriate supports, many move off the streets, either back home or into independent living.
- Mental health issues become more clearly identified, greater understanding of these issues is gained by all family members, and better supports are put in place.
- Family Reconnect shifts the work of street youth services, by focusing on prevention and in supporting young people in reconnecting with families and communities (2011, p. 11).
Promising Practice: Eva’s Initiative Family Reconnect Program

How the Program Works

Client Intake

Young people (16-24 yrs of age) and families come into contact with Family Reconnect through a number of channels. For most clients, the first point of contact is through staff working at Eva’s Place shelter. In fact, the Family Reconnect staff rely heavily on referrals by front line shelter staff, who will inform the FRP team of cases in which a youth might be interested in and/or can potentially benefit from youth and/or family counseling.

In these cases, youth are not obliged to consult with the Family Reconnect Program staff but are made aware of the resource. In some cases, parents and/or other family members may directly contact the FRP before a young person becomes homeless. They may request the involvement or intervention of the FRP staff, however, counseling may only proceed with a youth’s explicit consent. This kind of preventive work often involves young people under the age of 16.

Other sources of client intake include referrals through external agencies, such as child services, community agencies (including those serving street youth), hospitals or health facilities and in some cases agencies outside of Toronto. Family Reconnect Program staff occasionally liaise with Toronto Police Services, specifically 33 Division located near Eva’s Place shelter. Officers who engage in family disputes may refer young people and parents to the Family Reconnect program (2011, p. 28).

Casework and Counseling

The client-centered casework model of the Family Reconnect program involves a range of interconnected activities designed to help clients deal with problems, improve relationships and lead to positive outcomes for young people and their families. A three-pronged approach to counseling involves individual counseling with youth clients, family counseling involving youth and family member(s), and counseling with family members separately. It is important to understand then that in many, if not most cases, casework involves more than the clients by themselves, and can include a range of other significant persons in the young person’s life, including parents, siblings, and other relatives such as aunts/uncles, cousins and grandparents.

Each case is managed by a member of the Family Reconnect team. The Family Reconnect counselor is responsible for providing the client and family with counseling, support in accessing services, referrals to appropriate community, social and health services and, where appropriate, diagnostic assessment (for mental illness, addictions and / or learning disabilities). The key work of the Family Reconnect program is counseling based on a systems theory perspective. According to this theory, individuals and social groups as enmeshed in dynamic systems that provide a context for understanding the situations that impact on individuals, and how they make decisions in such contexts.

Counseling may involve instrumental and/or therapeutic counseling, as well as family counseling. Instrumental counseling provides someone with information and resources to undertake tasks, such as obtaining a health card, learning how a system works, writing a resume, etc. In the case of Family Reconnect, it may also involve helping someone initiate contact with family members, or facilitating the process of moving home. Therapeutic counseling, on the other hand, involves helping a client come to a better understanding of their challenges, strengths and relationships. The focus is often on the thoughts, feelings and behaviors of the client, with the understanding that greater knowledge in these areas will help clients make positive changes.

For young people who participate in the FRP, the content or focus of counseling – what actually gets dealt with – is quite broad and varied. Because family conflict is at the root of most youth homelessness, this is often the original focus of the work. In some cases, clients are interested in renewing contact with family members, and the work begins with an attempt to learn about the causes and potential pathways to resolution and/or reconciliation. This may involve eventual reconciliation with family members or recognition of the need to break ties either temporarily or permanently. The staff is committed to ensuring that whatever decisions are reached, these occur in a safe, secure space where family and youth clients can work towards moving forward with a healthier perspective on relationships and coping strategies.
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Counseling may also involve family members. That is, family counseling sessions may be arranged where the goal of the work is mediation and the development of a more empathetic understanding of the issues that underlie family conflict. The key approach here is Family Therapy. Based on Family Systems Theory, the idea is to work with individuals (in this case youth), in conjunction with their families and caregivers in order to nurture and promote change. This approach suggests that individual problems are often best addressed by drawing in family members and involving them in solutions. Strategies include helping family members understand relationship patterns, often by revisiting specific conflicts, and helping them consider other ways of addressing the conflict, as well as, come up with new ways of thinking about relationships, and engaging with each other.

While young people and families may enter therapy in crisis, the work actually involves going beyond the immediate issue to look at the big picture, and dig deeper to identify and work on underlying problems. Counseling may also occur with family members alone, as in many cases the key work that has to be done is not so much with the client, but with the family member who has issues and challenges to address. In some cases, this work is to help family members understand their child better, especially in cases where conflict stems from undiagnosed or untreated mental health and/or addictions issues, LGBTQ issues including homophobia in communities, schools and families, or in some cases learning disabilities (2011, p. 28-29).

**Mental Health Problems, Addictions and Disability**

There are a large number of youth (and families) for whom mental health issues may be at the centre of (or outcome of) family conflict. It is well understood that young people who are homeless are more likely to experience mental health problems, ranging from depression to more serious mental health disorders including schizophrenia and bipolar disorder (for more details, refer to Chapter 2 of this report). Many also struggle with addictions and in some cases these occur alongside mental health problems. Still others suffer from disabilities, including ADD and ADHD.

The staff at Family Reconnect echo concerns raised by others in the street youth sector, that the number of young people who are presenting with serious mental health problems and addictions has been increasing in recent years. All psychological assessment recommendations that include a suspected mental health diagnosis, must be confirmed by a psychiatrist. Only a psychologist and/or a psychiatrist can make an official mental health, developmental or learning disability diagnosis.

The FRP staff access these professional services at a number of facilities including the Centre for Addiction and Mental Health, Surrey Place, Central Toronto Youth Services’ New Outlook Program as well as the psychiatrist on staff at Eva’s Satellite. The FRP now has a psychiatrist on staff that visits Eva’s Place on a weekly basis. Psychological testing is paid for by a parent’s insurance plan (when possible) or through the Family Reconnect Program’s budget (2011, p. 29-30).
A key component of the HPRR model is the incorporation of a Family Reconnect Worker in the Choices for Youth model. The Boys and Girls Clubs of Calgary (BGCC) Elements Program serves youth with Family Reconnect Workers. Their role is to provide advocacy, system navigation and relationship-based case management to support families in connecting with the necessary resources in an effort to strengthen relationships and ultimately divert youth from ever experiencing homelessness. Support includes the following:

- Work with clients to establish shared goals and a plan for the services that will be provided
- Provide child development, parenting and relationship education and support
- Provide system navigation to connect clients with resources, referrals, and assistance for identified needs
- Assist clients with problem solving and crisis response, and the development of enhanced problem solving skills
- Provide families with tools to improve relationships and mutual support
- Support enhanced overall well-being of the client and family
- Work within the cultural context of the family

The CFY Family Reconnect Worker aims to prevent, divert youth from, and address homelessness. More specifically, the role provides solutions to barriers that perpetuate homelessness such as long processes and wait times, lack of transportation, intimidating program facilities, complex systems of support, interventions that precede assessment, and lack of support and connection prior to receiving community services.

As a result, the following significant impact can result:

- Youth are not alone
- Youth are less likely to fall through the cracks
- Youth are supported while they are on wait-lists
- Youth are not required to try and navigate complicated and complex systems on their own.
- Youth are matched with the least intrusive, most appropriate support(s).
- Youth are able to get connected to multiple supports through one phone number.
- Youth are respected, empowered and supported.
- Youth are prevented from becoming homeless, diverted from homelessness services, or assisted in exiting homelessness.

By working to support youth and their natural supports, the CFY Family Reconnect Worker adds an innovative resource to the HPRR model complementing the focus on housing loss and retention with family and youth work.

Landlord Recruitment

Landlords are the primary partners of every HPRR program. Without landlords who are willing to accept tenants with poor rental, income, credit and/or criminal histories, households who are homeless or
experiencing housing instability remain homeless. At best, they would likely obtain very substandard housing.

Landlords screen to reduce their risks of late rent, damage, criminal behaviors and dealing with complaints from other tenants. All landlords know that while screening is helpful, it does not eliminate risk. Every landlord has been “burned” by a tenant who looked good on paper but turned out to be a catastrophe once accepted.

HPRR programs are able to offer landlords a better deal than the applicants they are already accepting into housing, because clients enrolled come with back-up—a highly credible intermediary who can be called and will step in if/when trouble occurs.

Here are examples of how staff can help resolve landlord problems:

- For a defined period of time, they can be called for any tenancy problem.
- If the rent is late, the landlord can call the program rather than, or in addition to notifying the tenant.
- If the landlord receives complaints from other tenants about parties, noise or out of control children, if damage occurs to the unit or other lease violations occur they can call the program.
- If problems continue or cannot be worked out, landlords can turn to the program to work with the household and figure out a solution to avoid filing an eviction.
- As a last resort, landlords can call the program and staff will help the tenant find alternative housing.

Landlords gain several benefits from participating in our program. Consider the following advantages in your messaging to potential landlord partners

**Benefits to Landlords**

- *Eliminate advertising costs.* Working with our program gives you access to a pool of ready-to-rent tenants. Just call us up when you have a vacant unit, and we’ll immediately match you with a client that is looking for housing.
- “*Smart*” renters. Our clients have attended training on such topics as personal budgeting, understanding rental agreements, housekeeping and general apartment maintenance, being a good neighbor, etc.
- *Damage/security deposits.* Our organization aims to help individuals get back up on their feet. We have found that many low-income clients can afford the monthly rent, but have difficulty saving enough money for their security deposit. As a result, we help clients put together this one-time payment.
- *Clients have access to time-limited subsidies.* Again, our organization aims to help individuals get back up on their feet. As a result, eligible clients receive a subsidy to help them cover the first three months of their rent. This allows clients some time to stabilize and build an emergency fund for the future.
- *Guaranteed rent payments.* Our clients are pre-screened and have a stable source of income. However, should one of our clients run into a problem, we have a pool of funds set aside to help get clients through those rough spots. We will also co-sign leases in some situations to help eliminate risk to landlords.
• *Clients are attached to needed services.* Some of our clients have special needs, but we work with our clients on an ongoing basis to make sure they have the support they need to succeed. We work with clients to correct past mistakes and prevent future problems, and through our network of partners, clients have access to an array of supportive services.

• *Problem prevention through regular home visits.* Our case managers conduct regular home visits to ensure that clients are stabilized in their new environments, that their jobs are going well, and that they are getting the support they need. Regular follow up with clients allows us to identify and address problems early before they become irreparable.

• *Neutral party to mediate problems.* Despite best efforts, problems are sometimes inevitable. However, when problems arise, it can be reassuring to know that there is someone to call. We care as much about our relationship with our landlords as we do our clients. We need everyone to make our program work. The job of a case manager is to be a neutral party, ensuring that everyone is treated fairly and that problems are resolved quickly and impartially.

• *Satisfaction from helping others.* Everyone deserves a safe and affordable place to live. Some people make mistakes, but everyone deserves a second chance. By helping house our clients, you are playing an integral role not only in helping individuals take charge of their lives, but also in making your community a better place to live.

**Communicating with Landlords and Clients**

Some landlords will become interested in the household’s problems and progress. The program should not share information about the personal problems or services received by clients. It is helpful to develop a generic statement to respond to inappropriate (although usually well-meaning) questions from landlords. For example: “Mary is working with our program to be sure she can be a good tenant. That is our goal and we need you to let us know if there are problems so she can address them.”

A program should have a Release of Information form signed by the client, allowing the program to talk about tenancy problems with the landlord. Likewise, the program should let the landlord know what information should be communicated to the program. Staff do not want the landlord to wait until the rent has not been paid for three months. Problems addressed early are less expensive to resolve.

Communication when a problem occurs is better than no communication, followed by a simmering disagreement, and eventually a big blow-up. Below is a sample tool developed by Hennepin County, Minnesota for defining communication expectations.

**Landlord-Tenant-Case Manager Agreement**

This communication agreement should be filled out and signed by the tenant and then provided to the landlord to promote open communication between the landlord, tenant, and case manager. The form can easily be modified, but includes those issues most frequently cited by landlords as “red flags.” The important thing is to identify and address problems before they lead to lease non-compliance and possible eviction. Note that before this agreement is used, you may want to have your client sign an information release authorization form.

Dear [NAME OF LANDLORD]: My goal is to pay my rent on time, follow the provisions of my lease, keep my apartment in good condition, and get along with my neighbors. I am working with a program that
will help me do this, but I need your help. I am asking you to inform both my case manager and me if any of the following occur.

You can fill out the form and send it to the addresses below or contact us by telephone. We appreciate your cooperation.

_____ Landlord has not received full rent by the 3rd day of the month.
_____ Landlord has received a complaint that there is too much noise from the tenant’s apartment.
_____ Landlord has significant concerns about the condition of the tenant’s unit. (Examples: Landlord has seen damage or received complaints about bad smells that could be related to garbage.)
_____ Landlord thinks someone is living in the tenant’s unit who is not named on the lease.
_____ Landlord thinks someone in the tenant’s unit may be doing something illegal.
_____ The behavior of someone living in or visiting the tenant’s unit is causing other tenants to complain.
_____ Landlord has seen something that is a violation of the lease. Describe:
_____ Other

Please contact me in writing at the following address: or call me at this number:

Please also contact my case manager (name): at (agency/address) or call at this number (phone/cell/pager):

Finally, be sure to recognize landlords who house program clients. An Appreciation Breakfast, Certificates of Appreciation, Thank You cards from program staff or clients—these are meaningful ways to show gratitude to landlords who took a chance on the credibility of the program and the commitment of your clients to improve their stability.

Housing Location

There are several options that the program can explore in terms of housing location for the client. Private market housing may not always be the best approach. In some instance, family reunification may be more beneficial, particularly in the case of youth.

Rejoining Family/Partners or Other Co-Housing Arrangements

Many people enter homelessness as the result of conflict in their household: parent-youth conflict, spouse-spouse or partner-partner, and host-guest. Disagreements may end with one member (or a parent with her children) being expelled or abandoning the housing unit. Likewise, many people leaving homelessness want to reunite with their relatives, partners or friends.

Sharing housing is probably the least costly option for people with extremely low incomes. If the joined household has two wage-earners, the combined income may be the best possible safety net against future homelessness. It is good practice to help a homeless household negotiate the details of home-
sharing, especially if the prior arrangement resulted in homelessness. A neutral facilitator can help the household develop “house rules” for behaviors that have caused conflict in the past and may reoccur.

When abuse or neglect to a child or domestic violence are issues, a trained practitioner should guide the process of deciding whether to live together again, and under what circumstances and assess service needs. Written approval of the landlord is also required to add the new tenant to the lease.

Young people with little experience living independently who want a roommate for financial reasons or companionship should develop a written agreement listing expectations. Youth are unlikely to anticipate potential disagreements. Once the situation has escalated, one may move out; the roommate left behind is frequently unable to pay the rent or find a suitable roommate in time to prevent housing loss.

A roommate agreement should include the items that most often lead to arguments and, ultimately, housing loss:

- How is the rent paid? What is each roommate’s share and who takes the full amount to the landlord? Landlords rarely evict only the person whose share is missing, so one roommate’s failure to pay risks everyone’s housing.
- What happens if someone loses a job? Will roommates provide each other with short-term loans or should each roommate have a relative or friend who can act as back-up in an emergency?
- Who gets which bedroom? All bedrooms are not alike; some are larger or better situated than others. Do roommates pick rooms by lottery? Or does the person with the best room pay a higher rent?
- Is food handled jointly or individually? Will each renter buy his or her own food? Will “staples” be shared? How and where will each store his or her food? Or if groceries and household supplies are purchased jointly, how and when are the costs divided?
- Who does what chores? How often? Are chores the same every month or will they be rotated so no one has to clean the bathroom for the next year? It is usually assumed that each person cleans (or fails to clean) their own bedroom. Does each tenant wash his or her own dishes and utensils? Or will the kitchen be one person’s daily job? Chores are a major source of disagreement within households, particularly when housemates have different standards of cleanliness!
- How will everyone share the bathroom, entertainment center, kitchen, etc.? Will they use a sign-up sheet? Schedule who gets the bathroom first based on job hours? If no one wants rules, how will they handle one roommate’s excessive use/misuse?
- How will co-tenants handle overnight guests or frequent visitors? Often one roommate ends up with a “guest” who practically lives in the apartment, using the household TV and eating the household food. What limits are fair? What if a roommate objects to a particular guest’s behavior?
- What if one co-tenant causes damage? If the landlord takes the group’s security deposit, what does the offending roommate do to reimburse the other roommate(s)? What if there is no agreement about who caused the damage?
- What if one co-tenant violates the agreement or simply cannot get along with the other(s)? How will the group decide who leaves? How much notice will be given? What will the remaining tenants do to fill the “vacancy”?
• What if one roommate wants to leave and the others cannot afford the rent? How much notice does the roommate have to give? Is the roommate responsible for finding a replacement? How will the tenant(s) decide if they want the new roommate? What happens if none of the possible roommates are acceptable? Does the entire group give notice to the landlord to move out?

• How will utilities be shared? How will the cost of utilities be split? How will temperature for heat and air conditioning be set? Young adults may not be particularly fond of rules! Likewise, persons who share living arrangements may not feel the need to establish an agreement given the informal nature of the arrangement. However, unless some agreements are worked out in advance, roommate conflict can lead directly to homelessness.

Private Market Housing

Most households will have to select unsubsidized housing in the private market. Their choices will be limited by the income they can spend on rent. Nearly all extremely low-income households will be severely rent-burdened, often paying more than half their income on rent and utilities. For such households, searching for a unit that requires only 30% of their income (i.e. affordable housing) is rarely realistic. Selection is much more likely to focus on:

• Safety: Is the housing safe? Is the neighborhood safe? In fact, people who are extremely low income usually have few choices—and those choices may be far from ideal. By having connections with good landlords, the program can maximize the quality of the choices available.

• Children: If the household has minor children, can they continue to attend the school where they were enrolled prior to homelessness? Children who change schools may find they have missed important lessons or must repeat work already mastered. Positive relationships with their teacher or peers are lost. But if the children must change schools, can they select housing where the new school is as good—or better? Programs can mitigate the effects of homelessness and moving to a new school by collaborating with the local school system(s), which is required under federal law to provide assistance for children who are homeless.

• Support: Can the household be re-housed in an area where they already have positive supports—relatives, friends, a church, familiar surroundings? If not, the program can help the household establish new “roots” by helping orient to their new neighborhood, know where the bus line is, and figure out ways to stay connected to family and friends who provide positive support. If a household can achieve this, the move is much more likely to be successful. The household’s choice of location will affect the program’s work with landlords. If many households choose one or two neighborhoods (because of affordability and/or prior connections), the program can recruit landlords primarily in that area. Then, when a household is ready for re-housing, the program may be able to quickly locate a vacancy with a partner landlord. But if the household wants a different area, the program should be prepared to help the individual or family search for housing in that area and approach landlords accordingly.

Affordable Housing

Deep, long-term, rent subsidies and social housing are difficult to obtain. In some communities, the waiting lists are rarely open for new applications. The wait for the waiting list to open, combined with the actual waiting list, can add up to multiple years. But households who meet program eligibility
requirements should apply. Subsidized buildings are worth serious consideration, even if the housing does not meet all the household’s preferred amenities or location criteria. Most communities have listings of subsidized rental housing, as well as coop housing.

Very low-income persons with disabilities who are unable to achieve sufficient income through employment should consider public housing as a longer-term strategy to avoid homelessness. Permanent supportive housing programs subsidize rent and offer services that can assist an individual or family to develop skills and resolve tenancy problems. Supportive housing can be extremely helpful for people who need ongoing support to remain stably housed, but it is important to ensure that clients need and want such intensive supports before making a referral.

To assist in the housing locations process, a “Housing Protocol” can be developed. The following is an example from Homeward Trust Edmonton’s Housing First Service Manual.8

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.
- 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

Services That Contribute to Housing Stability

Understanding Expectations for Tenant Behavior Being a successful tenant includes a certain level of conformity with the explicit expectations found in a lease, but also the unwritten, implicit expectations of the building’s landlord/manager and tenants. Some individuals, due to their youth, inexperience, recent immigration, and/or poor role models have very little understanding of the social norms of renting. These tenants are at high risk of future problems, such as lease violations and even eviction. Unfortunately, the most effective way to discover social norms is to violate them and learn from the consequences. And that is exactly what programs prefer to prevent.

Good HPRR programs do not assume that tenants understand either their leases or the “unwritten rules” in new housing. Clients should be routinely given a short quiz near the time of intake to assess their familiarity with landlord-tenant rights/responsibilities and also expected tenant behavioral standards. If the client fails the quiz, formal or informal training is included as a part of housing stabilization. The most common “behavioral” problem areas:

• **Noise.** A common source of complaints is music, television, or conversation that is too loud and/or too late at night. Domestic arguments can result in 911 calls to the police if the noise is too loud or long. Leases often prohibit disturbing the “peaceful enjoyment” of the other tenants.
• **“Unauthorized tenant.”** Tenants often feel that paying the rent means they have total control over what happens inside their unit. They often do not realize that a long-term guest is usually a violation of their lease.
• “Excessive traffic.” Landlords often use this term to indicate suspected drug-selling or buying. Whether drugs are involved or simply a lot of parties, leases may have a prohibition against “excessive traffic.”

• Unsupervised children. Children at play in the hallways are likely to be loud, and other tenants are likely to object.

Understanding lease requirements and landlord-tenant rights/responsibilities is equally important. It is often helpful for a household to sit down with a staff who has legal training or extensive experience with leases and talk through the entire lease, jotting down, in plain language, the things the household can and cannot do. Reading the lease is the most important place to start. To guard their rights and fulfill their responsibilities, the tenant requires knowledge.

Orientating Clients. Many households will be very willing and able to independently learn the resources in their new neighborhood, but more youthful or stressed households benefit from assistance locating bus routes, 24-hour pharmacies, daycare and grocery stores. They will appreciate help enrolling their child in a new school. This can be part of a routine orientation just before or soon after moving. The goal is to help the household get a good fresh start.

Orientation “welcome” activities can include:

• A drive-around, to get some idea of the location and distances to key amenities, such as groceries, etc. This can be combined with a grocery-shopping trip to obtain household grocery staples.
• A map of the area, with locations of community resources (school, parks, etc.) marked.
• An attractive wall-hung calendar the household can use to keep track of appointments while they are getting accustomed to new routines.
• Bus routes and schedules
• A notebook or storage bin for important papers, including the lease. A big, colorful plastic notebook is less likely to be lost in a pile of papers or put into a drawer and forgotten. Include a welcome letter, checklist of the condition of the apartment (helpful to later obtain the security deposit), contact information for the program, etc.
• Visiting a second-hand and/or inexpensive store to buy things the household lacks, whether furniture, towels, bedding or groceries. Some non-profits offer free furniture to extremely low-income households.
• A visit soon after move-in to help the household properly hang and display personal pictures, art or other objects. The household could spend time in advance verifying landlord/lease rules regarding attaching objects to walls, ceilings and/or woodwork. This demonstrates the importance of the lease and assures the tenant will not be charged for damage. Feelings of “ownership” can promote care of the unit and may reduce mobility; it should be a goal of the early stages of re-housing.
• A small gift the tenant might enjoy--such as a plant, baked goods, treats for the children or gift card. These gifts strengthen the client’s engagement with the program and make drop-in visits (announced and unannounced) something to look forward to rather than something to dread. Otherwise, some tenants may assume every home visit will focus exclusively on criticism.
• Connect new tenants with peers in the same building or nearby.

Budgeting and Credit Repair. All Housing Plans should include a budget review, so households can (1) reduce expenses as much as possible, (2) increase or supplement their incomes with free in-kind
commodities and services, and, if at all possible, (3) set aside a small amount of money every month for an emergency reserve to manage unexpected expenses that could prevent the household from paying the rent.

Other Goals and Community Resources. Many families and individuals require some time to settle into a new routine, and that routine will be their primary concern for at least a few weeks. Eventually, the apartment is organized, the refrigerator filled, and everyone in the household has re-established their everyday habits.

At some point, once a certain level of normalcy has been achieved, the parent, adult or youth is ready for more. Many program staff report that after their clients feel “ownership” of their living space and develop confidence in their personal control, they often ask for help improving their lives. Increasing their income, connecting with their children’s teachers, and rebuilding relationships with significant people in their lives are their most frequent goals.

Referrals for health, mental health and chemical use are not uncommon requests. The importance of allowing the household to determine new life goals for themselves, at the time and in the sequence they choose cannot be over-stated. Staff who have good working relationships with their clients can certainly observe, advise and recommend life changes. But if the person is unwilling or unable to recognize the need, services may be a waste of time and money.

Using coercion to enforce participation in services may succeed only in achieving participation—without real investment in change. Sanctions certainly can threaten the working relationship. Most people have dreams and aspirations. Those hopes may have been deferred for so long that it takes time to even remember them. When people’s survival and safety needs are met, they often begin to remember or to create dreams of a better life—or at least a reduction in the pain or stress in their current lives. It does not happen for everyone. But when people decide to pursue their own goals, they will often ask a trusted staff member to help them.

Because it is so common for people who have been homeless to want (and need) additional resources after they have obtained housing, staff should be knowledgeable about mainstream programs and services in the community so they can respond to requests and even proactively offer help with the following:

- **Education, Employment and Training**: job search centers offer help with resumes and on-line employment searches. Income is obviously essential to housing stability. Any household receiving rental assistance must increase their income by at least the amount of the subsidy. Otherwise, they cannot successfully transition off the subsidy and maintain their current housing once assistance ends.
- **Family/Natural Supports Reconnection**, particularly for youth who may want to build relationships with family members once they are stabilized. Assisting youth develop positive relationships in their lives is a key role for the Family Reconnect Worker, even if the youth does not go on to live at home again.
- **Schools and Enrichment Programs** where children can enroll or participate in childcare or after school activities.
- **Healthcare and Dental Clinics** where the household can enroll. Helping the household keep or find a primary healthcare provider reduces the use of expensive emergency and urgent care resources and improves health maintenance.
• **Mental Health Resources.** Specializations that will be most helpful: professional assessments for medications (especially for depression and anxiety); counselors or therapists for resolving traumatic events, domestic violence and family conflict. A cooperative agreement for expedited referrals is very helpful.

• **Addiction Treatment.** If more than one provider is available, it is helpful to know which service providers treat which addictions and some basic information about their specialization (such as youth or cocaine) or methods (motivational interviewing, behavioral approaches, etc.). It is easier to link an individual with the right provider at the right time when staff can offer reassurance that the referral is a good match. A cooperative agreement with providers for expedited referrals is very helpful.

• **Legal Services.** Households may or may not have unresolved legal issues when they move into housing, but they may also face legal problems after move-in. When legal services are helpful or essential, staff should know which organizations offer pro bono (free) or very low-cost legal assistance, particularly with housing law.

• **Budgeting and Credit Repair.** All households should receive at least a review of their income and expenses. All staff should be able to offer ideas for reducing expenses, supplementing income with in-kind resources, and accessing assistance programs such as lower-payment utility programs. By connecting the client to more specialized credit counseling services, the household may obtain a lower interest rate on participant debt, negotiate partial payments for larger debts, or consolidate loans. In many cases, this can substantially reduce a household’s monthly expenses, making it possible to pay the rent—and perhaps even save for an emergency fund.

**Program Exit**

HPRR programs have a special challenge: at what point is the housing crisis over? It is impossible to eliminate all risks of housing loss. Instead, programs should focus on eliminating this risk, to this household, at this time.

A HPRR program should resolve the immediate crisis and provide linkages to services provided by others to prevent a recurrence of the housing crisis or to mitigate the long-term risk of homelessness. This means the program must define outcomes and set reasonable boundaries to guide what program staff will and will not do.

Every program should develop criteria for success and criteria for closing cases (whether or not success was achieved). The agency’s mission and intended outcomes help drive these criteria. Knowing that it will not always be possible to clearly define crisis resolution, a good program develops processes to help with the ambiguous case situations that will certainly occur.

Graduation is defined as the time that the client has successfully completed the case management portion of the program.

To be eligible clients graduating, participants also have:

1. Demonstrated ability to pay his/her portion of rent (6 months consecutive) via landlord reference
2. Completion of a money management or financial planning
3. A landlord reference
4. A case manager reference (including goals that have been met as part of case plan)
5. Proof of income (Bank Statement, Previous year’s tax assessment, confirmation letter of employment).
6. Government Identification
7. A current tax assessment
8. Bank Account
9. Verification of submitted social housing
10. VAT assessment demonstrating improvements in participant’s situation.

Other criteria required to be designated a graduate include:

1) VAT scores that indicate increased and maintainable stability
   - Client scores show a decrease in acuity after approximately 3-6 year of intervention.
   - Client housed for at least 3 months and does not have a major risk for housing instability without case management.

2) Access to essential community based supports have been created
   - Individual has accessed income supports as a source of income or has acquired full or part time work to accommodate long term housing
   - A custom crisis plan is in place, which includes emergency numbers, shelter information 24hr emergency hotlines, including the Mental Health Crisis Line.
   - Some examples of community based supports may be:
     - Food bank hours and accessibility information
     - Support groups
     - Transit routes and fees
     - Family doctor
     - Volunteer services
     - In home supports

3) Client and Case Manager mutually agree that follow up supports are no longer required
   Case file summary for client demonstration indicators of stability which includes:
     - Recent VAT results indicating housing health and stability
     - Rent of current housing
     - All required community supports/services are active to ensure long term stability
     - Income source is stable

CFY’s Moving Forward Program 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. It is recommended that the HPRR programs review this exit package with a view to developing a similar package.

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
- Applications for schooling
- Application for Advanced Education and Skills funding

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

Follow-Up

Follow up calls to the participant and the landlord should be made every three months to document ongoing stability for performance tracking and to identify potential areas of need. Participants who move without notifying the program or who have been evicted and are unable to secure alternate accommodations and meet ongoing eligibility criteria will be discharged from the program.

Participants who have been accepted in social housing would need to be re-assessed for financial supports from the program, or once they have confirmed increased income from various sources.

The process to support clients through eviction, where client remains in program and is rehoused or discharge/eviction guidelines and procedures which ensure all reasonable actions have been taken by the program to prevent eviction/discharge into homelessness. If the client requires case management,
the program will make all reasonable attempts to connect the participant with his/her former case management program.

Participants should have the ability to come back into the program if necessary, suggestions for how this can be handled are included in the appendices to ensure consistency in operations.

Continuous Improvement

Designing and implementing a new program can be a daunting experience. There are so many decisions to make, and each decision has ramifications for all the other decisions. Many decisions will be modified as experience dictates; eventually, the program must simply begin to operate. The program must be flexible but not arbitrary in responding to actual experience. Changes should be made thoughtfully, based on fairly clear evidence.

Programs that flourish and become more effective over time are programs that are well-connected to their community resources, listen to their clients, and use their data to monitor results, to increase program effectiveness, and to communicate their successes to others.

A program that periodically does the following will become more and more successful over time.

- **Evaluate data.** Do the people you serve successfully avoid homelessness? Is the program too successful? You should expect some failures and for some people to come back for help more than once. If not, you may be targeting people who aren't really at risk, or you may be providing more assistance than is necessary. Compare the clients you are serving to people you do not serve and who are becoming homeless. Are they similar? If not, you may not be targeting clients most likely to become homeless. How much does your program cost per client? Can you successfully serve more people by providing less assistance to some clients?

- **Talk to clients.** What about your programs works for them, and what does not work? If your program is not providing a service well, is there somebody else that can provide it better?

- **Talk to landlords.** What about your program works for landlords? What does not work? Where do landlords think improvements can be made?

- **Revisit program rules and procedures.** What rules and procedures work well? Which do not? Programs generally accumulate rules and procedures. Eliminate those with little or no benefit.

- **Rethink program design.** Think about the decisions you made when you designed your program. Should they be adjusted? Are the right things being measured and evaluated? How have other prevention programs evolved and adjusted their approach over time? What did they learn and what did they do about it?

Housing First Fidelity

To ensure alignment with foundational Housing First principles, the following provides a suggested set of standards and functions relevant to the HPRR program. Fidelity assesses the extent to which implementation reflects the actual ideas, principles and practice of a model are actualized in practice.
A HF fidelity scale\(^9\) 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 adapted for the HPRR approach and was proposed for application for the ICM Front Step program as well. All areas highlighted in blue represent modification of the original ICM standards from At Home/Chez Soi.

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<td><strong>HOUSING CHOICE AND STRUCTURE</strong></td>
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<tr>
<td>1. Housing Choice. Program participants choose the location and other features of their housing.</td>
<td>Participants have no choice in the location, decorating, furnishing, or other features of their housing.</td>
<td>Participants have little choice in location, decorating, and furnishing, and 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 much choice in location, decorating, furnishing, and other features of their housing.</td>
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<td>2. Housing Availability. Extent to which the program helps participants move quickly into units of their choosing.</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>3. Permanent Housing Tenure. Extent to which housing tenure is assumed to be permanent with no actual or expected time limits, other than those defined under a standard lease or occupancy.</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>4. Affordable Housing. Extent to which participants pay a reasonable amount of their income for housing costs.</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>5. Integrated Housing. Extent to which program participants live in scatter-site private market housing which is otherwise available to people without psychiatric or other disabilities.</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>6. Privacy. Extent to which program participants are expected to share living spaces, such as bathroom, kitchen or dining room with other tenants.</td>
<td>N/A</td>
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<td>7.</td>
<td>No Housing Readiness. Extent to which program participants are not required to demonstrate housing readiness to gain access to program supports.</td>
<td>Participants have access to program services only if they have successfully completed a period of time in transitional housing or outpatient/inpatient/residential treatment.</td>
<td>Participants have access to program services 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 program services only if they meet 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 program services only if they meet 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>No Program Contingencies on Supports. Extent to which continued support is not linked in any way with adherence to clinical, treatment, or service provisions.</td>
<td>Participants can receive supports only by meeting many requirements, 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 supports with some requirements for continued tenancy, such as participation in formal services or treatment activities (attending groups, seeing a psychiatrist).</td>
<td>Participants can keep supports 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>Standard Tenant Agreement. 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 (such as 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>
<td>Participants have a written agreement (such as a lease or occupancy agreement) which specifies the rights and responsibilities of typical tenants in the community and contains no special provisions other than agreeing to meet with staff three times a month.</td>
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<td>10.</td>
<td>Commitment to Re-Housing. 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 offers participants who have lost their 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>
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<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>
<td>Social and clinical service providers are based off-site, do not maintain an office on-site, but are capable of providing mobile services to locations of participants’ choosing.</td>
</tr>
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<td>13.</td>
<td>Service choice. Extent to which program participants choose the type, sequence, and intensity of services on an ongoing basis.</td>
<td>Services are chosen by the service provider with no input from the participant.</td>
<td>Participants have little say in choosing, modifying, or refusing services.</td>
<td>Participants have some say in choosing, modifying, or refusing services and supports, but program staff determinations usually prevail.</td>
<td>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.</td>
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<td>14.</td>
<td>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.</td>
<td>All participants with psychiatric disabilities are required to take medication and participate in psychiatric treatment.</td>
<td>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.</td>
<td>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.</td>
<td>Participants with psychiatric disabilities are not required to take medication or participate in formal treatment activities.</td>
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<td>15.</td>
<td>No requirements for participation in substance use treatment. Extent to which participants with substance use disorders are not required to participate in treatment.</td>
<td>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).</td>
<td>Participants who are using substances or who have not achieved a specified period of abstinence must participate in substance use treatment.</td>
<td>Participants with substance use disorders whose use has surpassed a threshold of severity must participate in substance use treatment.</td>
<td>Participants with substance use disorders are not required to participate in substance use treatment.</td>
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<td>16.</td>
<td>Harm Reduction Approach. Extent to which program utilizes a harm reduction approach to substance use.</td>
<td>Participants are required to abstain from alcohol and/or drugs at all times and lose rights, privileges or services if abstinence is not maintained.</td>
<td>Participants are required to abstain from alcohol and/or drugs while they are on-site in their residence or participants lose rights, privileges or other services if abstinence is not maintained.</td>
<td>Participants are not required to abstain from alcohol and/or drugs, but staff work with participants to achieve abstinence not recognizing other alternatives that reduce harm.</td>
<td>Participants are not required to abstain from alcohol and/or drugs and staff work with participants to reduce the negative consequences of use according to principles of harm reduction.</td>
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<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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<td>18.</td>
<td><strong>Assertive Engagement.</strong> Program uses an array of techniques to engage difficult-to-treat participants, including (1) motivational interventions to engage participants 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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<td>19.</td>
<td><strong>Absence of Coercion.</strong> Extent to which the program does not engage in coercive activities towards participants.</td>
<td>Program routinely uses coercive activities with participants such as leveraging housing or services to promote adherence to clinical provisions or having excessive intrusive surveillance of participants.</td>
<td>Program sometimes uses coercive activities with participants and there is no acknowledgment that these practices conflict with participant autonomy and principles of recovery.</td>
<td>Program sometimes uses coercive activities with participants, but staff acknowledge that these practices may conflict with participant autonomy and principles of recovery.</td>
<td>Program does not use coercive activities such as leveraging housing or services to promote adherence to clinical provisions or having excessive intrusive surveillance with participants.</td>
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<td>20.</td>
<td><strong>Person-Centered Planning.</strong> Program conducts person centered planning, including: 1) development of housing plan ideas based on discussions driven by the participant’s goals and preferences, 2) conducting regularly scheduled housing plan meetings, 3) actual practices reflect strengths and resources identified in the assessment.</td>
<td>Less than 54% of housing plans and updates satisfy all 3 criteria.</td>
<td>55 - 69% of housing plans and updates satisfy all 3 criteria.</td>
<td>70 - 84% of housing plans and updates satisfy all 3 criteria.</td>
<td>At least 85% of housing plans and updates satisfy all 3 criteria.</td>
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<td><strong>21. 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><strong>22. 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 goal of enhancing self-determination).</td>
<td>Program directs participant’s 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><strong>23. 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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<td><strong>24. 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>Integrated Addiction Treatment. Program successfully links participants who need addictions 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 participants in need of addiction treatment with agencies that provide such treatment.</td>
<td>Program successfully links 55 - 69% of participants in need of addiction treatment</td>
<td>Program successfully links 70 - 84% or more of participants in need of addiction treatment with agencies that provide such treatment.</td>
<td>Program successfully links 85% or more of participants in need of addiction treatment with agencies that provide such treatment.</td>
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<td>26.</td>
<td>Supported Employment Services. Supported employment services are provided directly or brokered by the program. Core 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>Less than 30% of participants in need of services are receiving them from the team (receiving 1 &amp; 2 or 1 &amp; 3).</td>
<td>30 - 44% of participants in need of services are receiving them from the team (receiving 1 &amp; 2 or 1 &amp; 3).</td>
<td>45 - 59% of participants in need of services are receiving them from the team (receiving 1 &amp; 2 or 1 &amp; 3).</td>
<td>60% or more of participants in need of services received supported employment services (receiving 1 &amp; 2 or 1 &amp; 3).</td>
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<td>27.</td>
<td>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>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>28.</td>
<td>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)</td>
<td>Less than 54% of participants in need of services are receiving support for social integration. (At least 1 service)</td>
<td>55 - 69% of participants in need of services are receiving support for social integration. (At least 1 service)</td>
<td>70 - 84% of participants in need of services are receiving support for social integration. (At least 1 service)</td>
<td>85% of participants in need of services are receiving support for social integration. (At least 1 service)</td>
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<td>29.</td>
<td>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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<tr>
<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>
</tr>
<tr>
<td>31.</td>
<td>Client Selection and Assessment. Extent to which program prioritizes enrollment for individuals who are appropriate target group.</td>
<td>Program demonstrates consistent application of appropriate screening, assessment, and prioritization criteria to ensure target population is being serviced for less than 60% of participants.</td>
<td>Program demonstrates consistent application of appropriate screening, assessment, and prioritization criteria to ensure target population is being serviced for 65 - 74% of participants.</td>
<td>Program demonstrates consistent application of appropriate screening, assessment, and prioritization criteria to ensure target population is being serviced for 75 - 89% of participants.</td>
<td>Program demonstrates consistent application of appropriate screening, assessment, and prioritization criteria to ensure target population is being serviced for 90% or more of participants.</td>
</tr>
<tr>
<td>32.</td>
<td>Low Participant/Staff Ratio. Extent to which program consistently maintains a low participant/staff ratio, excluding the psychiatrist and administrative support.</td>
<td>50 or more participants per 1 FTE staff.</td>
<td>36-49 participants per 1 FTE staff.</td>
<td>21-35 participants per 1 FTE staff.</td>
<td>20 or fewer participants per 1 FTE staff.</td>
</tr>
<tr>
<td>33.</td>
<td>Contact with Participants. Extent to which program has a minimal threshold of non-treatment related contact with participants.</td>
<td>Program meets with less than 60% of participants 3 times a month face-to-face.</td>
<td>Program meets with 60 - 74% of participants 3 times a month face-to-face.</td>
<td>Program meets with 75 - 89% of Participants at least 3 times a month face-to-face.</td>
<td>Program meets with 90% of participants at least 3 times a month face-to-face.</td>
</tr>
<tr>
<td>34.</td>
<td>Team Approach. Extent to which program staff function as a multidisciplinary team; clinicians know and work with all program participants.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>ITEM</td>
<td>CRITERION</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
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<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>35.</td>
<td>Frequent Meetings. Extent to which program staff meet frequently to plan and review services for each program participant.</td>
<td>Program meets at least once every two weeks but does not review each participant each time, or meets less than once a week</td>
<td>Program meets at least once every two weeks and reviews each participant each time, and conducts case conferences.</td>
<td>Program meets at least once a week, but does not review each participant each time, and conducts case conferences monthly.</td>
<td>Program meets at least once a week and interviews each participant each time, even if only briefly, and conducts case conferences monthly.</td>
</tr>
<tr>
<td>36.</td>
<td>Weekly Meeting (Quality): 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>Peer Specialist on Staff. 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>Participant Representation in Program. 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>

Safety Planning

The following Safety Planning Guidelines\(^\text{10}\) were adapted from the work of the Calgary Homeless Foundation. They provide a useful overview of measures that can be taken by HPRR programs with respect to safety.

1. **Safety policies, procedures and protocols.** Programs should have clearly written policies, procedures and protocols which take into account staff safety and security. Program protocols include: staff check-ins at pre-determined intervals; staff access to cell phones; staff attending 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. **Documentation.** It is important for programs to maintain detailed documentation in client files related to safety. The documentation should provide adequate details with respect safety concerns, case management support and intervention relating to such concerns, and ongoing monitoring and reporting regarding safety issues.

3. **Staff support.** With frequent exposure to expressions and/or acts of aggression and violence in the sector, it is important for staff and supervisors to be aware of adverse emotional and psychological impacts. Impacts may result in increased tolerance or de-sensitivity to acts of client aggression and violence, which may put both staff and clients at risk. This is particularly a concern in housing couples and families whose history of discord is intensified due to mental health, addiction and/or financial stressors.

4. **Program structure and staffing resources.** 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. **Risk assessment.** It is important that programs have tools and/or processes in place to assess behavior that may put the client or staff risk. The assessment of risk should minimally include consideration 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 including the police and correctional services to gather information to complete a full assessment.

6. **Safety plans for clients.** It is important for programs to develop safety plans with clients who may be at risk. A safety plan is an individualized plan developed to reduce the identified risks. Safety plans are developed with the client and are interactive, practical, relevant and frequently reviewed. In cases where domestic violence is a concern, particulars of each plan vary depending on the client’s unique situation – whether the client is living with the abuser, separated from the abuser, plans to leave the abuser, plans to stay with the abuser, as well as what resources are available to them. Plans will change as life circumstances change and they should be reviewed and edited 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. Activities should also address client self-harm and suicide attempts.
Responding to Serious Incidents

Part of our work in a Housing First context also entails handling incidents and related grievances from clients, the public, system and agency partners. While we may have always managed such concerns, the level of severity and frequency can increase significantly when handling complex clients.

Serious incidents and related grievances can include situations or processes that programs are believed to be responsible for and can come from a number of sources; with respect to safety, they may include some of the following:

- Clients concerned with unwanted guests threatening their housing stability or potentially their safety;
- Client threatens harm to self or others in presence of program staff;
- Neighbours of a Housing First client in private market housing complaining about noise, traffic and possible illegal activity in the building;
- Police concerns regarding the high number of complex clients in one particular building leading to concerns regarding illegal activity, such as drug dealing or sex trade;
- Agency leadership concerns about a particular program’s capacity to serve complex client load and manage safety concerns, impacting overall capacity to meet contractual obligations and client/staff safety needs;
- CE staff observations of consistent non-compliance in a particular program to safety protocols;
- Funder (HPS) receives of direct reports of client safety incidents requiring immediate action.

Having a clear and consistent process to respond to serious incidents and grievances is critical to the program’s work. The serious incident policy of the program should enable consistent assessment of incidents according to its severity to determine response.

The program should also have a process to escalate incidents that are unresolved or through further investigation are determined to be of higher severity. All incidents should be recorded in a consistent manner and analyzed on a regular basis to determine trends across programs. Regular monitoring should include questions about grievances and incidents to determine how these are handled at the program-level and assess whether remediation is occurring for lower severity issues.

At the system-level, programs can develop strategies to conduct risk assessments and safety planning. CEs can leverage expertise within the homeless-serving sector and partner systems (health, police, etc.) to achieve better safety standards by working with agencies with expertise in domestic violence, risk assessment and safety planning to offer staff training.
<table>
<thead>
<tr>
<th>Rating</th>
<th>High Priority</th>
<th>Moderate Priority</th>
<th>Lower Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examples</strong></td>
<td>Abuse allegations&lt;br&gt;Death or serious injury&lt;br&gt;Self-harm/suicide attempt&lt;br&gt;Health and safety&lt;br&gt;Violent threat or action&lt;br&gt;Imminent harm&lt;br&gt;Fire or flood&lt;br&gt;Privacy breach</td>
<td>Major legal or contractual breaches&lt;br&gt;Financial mismanagement&lt;br&gt;Unplanned program discharge</td>
<td>Consistently poor program performance&lt;br&gt;Lack of reporting&lt;br&gt;Failing to meet service standards requirements</td>
</tr>
<tr>
<td><strong>Response</strong></td>
<td>Investigation within 12-24 hours of report receipt by funder&lt;br&gt;Inform appropriate authorities and funder within 24 hours&lt;br&gt;Report and remediation actions with timelines within 24-48 hours&lt;br&gt;Follow-up with agency on progress on remediation actions within 1 week</td>
<td>Investigation within 48-36 hours of report receipt by funder&lt;br&gt;Inform appropriate authorities and funder within 24 hours&lt;br&gt;Report and remediation actions with timelines within 1-2 weeks&lt;br&gt;Follow-up with agency on progress on remediation actions within 4 weeks</td>
<td>Investigation within 48-72 hours of report receipt by funder&lt;br&gt;Report and remediation actions with timelines within 4 weeks&lt;br&gt;Follow-up with agency if required&lt;br&gt;Inform funder during regular monitoring</td>
</tr>
</tbody>
</table>

**Data and Performance Management**

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. An integrated 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.  

Expected outputs and outcomes for the HPRR program will need to be aligned with the overall community targets set out in the HPS Community Plan.

It is important to note that these targets are proposed and should be reviewed in implementation, once the funding model is finalized. They should be considered as indicators of progress, rather than rigid benchmarks that prompt further investigation into the reasons behind a program meeting/not meeting them. It would be unreasonable to expect this performance without matching funds for client financial supports, for instance, or if a change in policy or housing markets impact operations. These targets should lead to conversations that promote continuous improvement, rather than taken as punitive on particular programs.

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### HPS Performance Targets

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of HF clients who remained housed at six months (minimum target of 80%)</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Percentage of HF clients who remained housed at twelve months (minimum target of 80%)</td>
<td>80%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>Number of days for HF clients to move into permanent housing after intake</td>
<td>12</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Percentage of HF clients who require re-housing (minimum target of less than 30%)</td>
<td>20%</td>
<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>Improvement to housing situation (no target needed)</td>
<td>70-90</td>
<td>70-90</td>
<td>70-90</td>
</tr>
<tr>
<td>Number of people who increased their income or income stability</td>
<td>70-90</td>
<td>70-90</td>
<td>70-90</td>
</tr>
<tr>
<td>Number of people who increased their employment stability or started part-time or full-time employment</td>
<td>40-50</td>
<td>40-50</td>
<td>40-50</td>
</tr>
<tr>
<td>Number of people who started a job training program</td>
<td>30-40</td>
<td>30-40</td>
<td>30-40</td>
</tr>
<tr>
<td>Number of clients who receive life skills development</td>
<td>40-50</td>
<td>40-50</td>
<td>40-50</td>
</tr>
<tr>
<td>Number of clients who receive Services to improve social integration</td>
<td>70-90</td>
<td>70-90</td>
<td>70-90</td>
</tr>
<tr>
<td>Number of clients who receive culturally relevant responses to help Indigenous clients</td>
<td>20-30</td>
<td>20-30</td>
<td>20-30</td>
</tr>
<tr>
<td>Number of clients who are connected to education and supporting success</td>
<td>30-40</td>
<td>30-40</td>
<td>30-40</td>
</tr>
<tr>
<td>Number of clients who receive Liaising support and refer to appropriate resources</td>
<td>70-90</td>
<td>70-90</td>
<td>70-90</td>
</tr>
<tr>
<td>Number of clients who receive housing loss prevention services</td>
<td>70-90</td>
<td>70-90</td>
<td>70-90</td>
</tr>
</tbody>
</table>

In terms of data management, NLSA is providing support to EHSJ and NL Housing to assist 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. HPRR should be included in the rollout of HIFIS 4.0 to this end.

It is recommended that Newfoundland and Labrador Statistics Agency (NLSA) work with HPRR programs to ensure data elements align with program needs. Key data elements should include those outlined in the following documents:

- **Intake Assessment**
- **3-Month Follow-Up Assessment**
- **Exit Assessment**

As in the case of Front Step, use of HIFIS for the HPRR program will ensure that a robust, coordinated and well-designed data collection and reporting is in place to ensure:

- 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.
HIFIS will need to be tailored to HPRR to ensure the following data elements are tracked at intake, 3 month intervals, program exit and follow-up to assess:

- % of clients served who access resources and services they are referred to through program.
- % participants were in permanent housing at program exit
- % of participants who were stably housed at any given reporting period
- % of participants who exit program for positive reasons
- % participants engaged in mainstream services
- % change in system interactions for those participating in program
- % with treated or untreated ongoing mental health condition/addiction/physical health issue at intake vs. program exit.
- % participants engaged in education.
- Basic needs reported at intake, by type vs. exit.
- # individuals and families served by program area during evaluation period
- # of contacts/type/length for each program participant during length of stay in program
- # program spaces added during evaluation period
- # days from referral to intake assessment
- Average length of stay in program
- # of referrals made and by type of referral
- % occupancy in program
- # knowledge dissemination activities by type and audience
- # of partnerships built with outside organizations to strengthen network of support for youth
- Use VAT acuity assessment at intake, 3/6/9/12 and program exit to assess % change in acuity scores across domains participants.

In addition, the program will align its performance management activities with the directions outlined in the System Coordination Framework. To this end, the following target performance measures have been outlined relevant to the program type. HIFIS, as the data collection system in use, will need to ensure appropriate data collection to populate these measures. Note that these are proposed measures, and in practice may need adjustment based on program implementation.

The same proviso around using these targets as indicators rather than hard-set benchmarks applies to the chart below.
## Prevention/ Rapid Rehousing Performance Measures

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity</td>
<td># point-in-time case load capacity; annual # of clients served</td>
</tr>
<tr>
<td>Occupancy</td>
<td>90%</td>
</tr>
<tr>
<td>Length of Stay/ Stabilization</td>
<td>90% households are stably housed at 6 months. 75% households remain stably housed at 12 months. 50% households remain stably housed at 24 months.</td>
</tr>
<tr>
<td>Destinations at Exit</td>
<td># Clients referred are diverted from shelter (i.e., they would have become homeless otherwise) due to prevention assistance. 85% of clients leaving program go to positive housing destinations</td>
</tr>
</tbody>
</table>
| Return to Homelessness           | Less than 5% of clients return to shelter/rough sleeping  
Clients do not enter shelter system within 180 days (6 months) following the provision of prevention assistance.                                                                                           |
| Income/Education                 | 85% of clients have an increase in income at program exit  
# individuals who had positive income transitions  
# individuals who had positive employment transitions  
# individuals who began a part-time or full-time education program  
# individuals who began a job skills training program  
# individuals who completed a job skills training program                                                                                                                                       |
| Interaction with Public Institutions | Intake and Exit comparison of: EMS interactions, Hospital days, days in jail/prison etc.                                                                                                                  |
| Program-Specific                 | 90% households provide improved family environment for children (e.g., improved school attendance).                                                                                                         |

The Family Reconnect Worker requires additional measures to ensure the value-add is captured effectively. Using standard survey at Intake, 3 mo./ program exit and follow up, the program can track change in % of youth/families accessing program who report:

- Having a better understanding of their needs, goals and plans to address them.
- Having increased knowledge of community and mainstream supports available to them.
- Enhanced knowledge on medical and mental health resources and support to access these.
- Having a good relationship with program staff
- Being satisfied with support received from program.
- Being able to identify with natural supports.
- Feeling less stressed
- Feeling healthier
- Being more stable
- Having more connections with positive natural supports
- Feeling they are part of a community
- Having more stable family relationships
- Positive changes in key relationships
- Fewer unmet needs
Once the VAT is adjusted for youth and families, it should be used as appropriate at program intake, follow up and exit to assess changes across acuity domains.

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.

- Sustainability for 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 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.

HPRR program is focused on moving clients onto mainstream benefits whenever possible. As the length of stay is an average of 6 months, the same risk associated with funding loss in higher intensity programs is not relevant to the same extent for HPRR. Clients essentially graduate, with attrition being the key means of reducing case load in the case of funding loss.

Nonetheless, every effort to orient clients into mainstream services is very important to ensure that programming effectively moves clients toward self-sufficiency.\textsuperscript{12}

At the systems level, HPRR will contribute to advocacy efforts via EHSJ’s work to advance long term funding and remove barriers to housing stability.

HPRR Standards of Practice Program Manual

It is recommended that rather than starting from scratch, the HPRR program, EHSJ and the City of St. John’s review existing standards of practice to adapt these to the local context. A number of program and system standards are considered essential to well-functioning homeless-serving systems, though these will need to still be carefully reviewed and supported through capacity building and monitoring.

This section of the program model provides HPRR programs with a set of standards that align with the Canadian Accreditation Council’s standards of practice for Calgary Homeless Foundation Housing First programs. These have been adapted from the first Housing First Rapid Rehousing program in Canada, Rapid Exit (now Keys), operated by CUPS in Calgary since 2008 accredited under these standards. Again, these can be adapted further by the programs in practice.

Note that these standards are provided as guidance and are not meant to replace current policy in organizations; rather, they are resources where policy/procedures don’t exist or act as examples to compare current practice with to support continuous improvement.

1.0 STAFFING
1.1 Staffing & Recruitment
1.1.1 Recruitment Reflective of Clients

HPRR will actively recruit employees and volunteers who are reflective of the diversity of participants in which the Program serves. We work with a diverse population, to qualify for the program you must be homeless and have a VAT score of 15+. That being said our participants are male, female, Indigenous, non-Indigenous, pregnant, single, couples, over 16yrs and our staff are equally diverse in ethnicity, age, gender, family composition, etc.

Procedure
Employees and volunteers must prior to their start date:
- Submit application form and or resume;
- Screened/interview as being suitable for volunteering/working;
- Clean criminal record check including child welfare and working with vulnerable populations.

Criminal record check including child welfare and working with vulnerable populations must be done every three years. The employee is responsible for any costs.

Employment

Current HPRR Participants: HPRR will not employ any individuals who are current participants in any HPRR programs and services.

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**Past HPRR Participants:** HPRR will not employ any individuals who have history of accessing HPRR programs and services within the past 2 (two) years.

**Volunteers**

HPRR will recruit volunteers whom are active participants in programs and services or from the community. Volunteers will not have any access to any participants’ personal information.

1.1.2 Indigenous Staff

HPRR is an equal opportunity employer who endeavors to recruit and retain Indigenous staff dependent upon job suitability and job description. Recognizing the over representation of Indigenous people accessing programs and services, HPRR will be mindful if serving ≥15% Indigenous clients (of total clients within the last year) to retain a minimum 10% complement of full time equivalent (FTE) Indigenous staff.

**Procedure**

HPRR will endeavor to employ a minimum ratio of ten (10%) percent Indigenous staff. Indigenous applicants can self-identify as Indigenous. Jobs are posted in specific locations such as but not limited to HPRR website, post-secondary institutions and online (i.e. Charity Village) in order to actively recruit Indigenous applicants.

**HPRR Staff List**

- Name – Position, Start Date

1.2 Training and Core Competencies

1.2.1 Orientation

All employees will have a job description attached to offer of employment prior to starting. A copy of both the offer and job description will remain with HR until employees first day, at which time; will be transferred into their personnel file.

All staff must complete the following orientation package which includes HPRR orientation checklist & working alone safely within 10 business days of working with participants and will complete the remaining on boarding checklist as outlined in *Appendix A – Orientation Checklist.*

1.2.2 Working Alone Safely

HPRR recognizes the importance of providing a safe environment for all employees and volunteers. Staff must orient themselves with the processes of working alone safely within 10 working days of working with participants. The purpose of these guidelines is to promote worker awareness and facilitate work safety when working alone.
Working alone means employees are working by themselves in a HPRR facility or in the community providing outreach or home visits when required by specific programs where assistance, in the event of injury, violence, illness or emergency, is not readily available to the employee.

Employees will follow the following processes to ensure personal safety when performing community/home visits either accompanied or unaccompanied by a colleague. Employees will be provided with a cell phone and an electronic monitoring system which indicates employee location upon check-in and checkout. Employees are to call 911 for assistance if they believe they are at imminent risk of harm.

Procedure

- If working in the community Case Manager will check in with XXX immediately upon arrival and departure at each location with pin provided by manager. Record your mileage and clearly state where you are (the more precise the better as this indicates where you are if necessary) If more time is required to complete home visit employee will call XXX and extend time as needed.
- An unanswered call to the employee from XXX reminding them to checkout or extend time will escalate up to program coordinator, manager, director, etc. The next in line within this chain will contact that case manager by text or phone reminding them to check out. If no response is received within ten (10) minutes, supervisor looks up location on XXX website and attends to location indicated accompanied by another employee, to assess situation and determine if police will be involved.
- When arranging the home visit, make sure the participant knows the purpose of the home visit and ask that they minimize distractions like having friends over at that time or being intoxicated.
- If you enter the home, assess for your own safety. If your intuition tells you something is not ok, listen to it and reschedule visit.
- If there are people aside from your client present, you are not to remain in the home. End the home visit immediately and leave the premises. Rebook the visit at a time when they don’t have other guests.
- If you arrive at a home, and it is obvious that the client and/or houseguests are under the influence of drugs or alcohol, excuse yourself and leave immediately. If children are present in the home, call 911; explain who you are and the purpose of the call. Make sure they understand that children are at risk. Let the police handle it. If this situation arises, please inform program coordinator immediately.
- Reschedule visit if the physical environment is hazardous or visual presence of weapons
- If participant becomes unusually agitated, verbally abusive, or threatening end meeting and reschedule.
- When conducting a home visit, keep your phone and keys on your person and know where the exits are. Try and situate yourself so you can leave quickly if needed. You may choose to keep your shoes on during the visit. Wipe them well before entering the client’s home and just let them know that it is a safety requirement that you keep your shoes on.
- If at any time during the home visit you feel at risk, leave immediately and contact program coordinator.
- No employee will see a client alone during off time within HPRR facilities.
• Elevator usage while working alone is strictly prohibited.
• Building Maintenance staff must notify Facilities Manager within ½ hour of shift completion to inform exit of building on Saturdays. If call has not been received within the ½-hour time allotted HPRR Facilities Manager will be dispatched to facility to check in.
• Volunteers to HPRR programs are prohibited to be left alone in any HPRR facility at any time.
• All employees must have a cell phone (business or personal) on their person at all times when entering a HPRR facility during off hours; in the event of planning to work when the facilities are not in operation, or conducting regular scheduled home visits with clients. The employee must notify the designated buddy (Program Directors, and or Coordinators to determine and inform Human Resources of buddies and phone numbers within their area) of their scheduled start/end time in facility or scheduled client home visit. All employees must call their respective “buddy” upon arrival and departure.
• When employees are on a HPRR designated site after regular working hours, weekends, holidays, etc., the employee must inform direct supervisor and Facilities Manager of the intent to be in HPRR facility.

1.2.3 Safe Work Site Practices

HPRR strives to maintain safe working conditions for all employees. Safety can only be achieved through a combination of individual responsibility and teamwork. Each employee should practice safety awareness by thinking defensively, anticipating un-safe situations and reporting any un-safe conditions to the Facility Manager immediately. Employees are required to attend continuing education and training surrounding workplace safety that form part of the regularly scheduled staff meetings.

HPRR Worker’s Compensation Insurance Policy covers injuries sustained while working and is offered at no cost to the employee. If an employee is injured, no matter how slightly, he/she must report the incident to their immediate supervisor so that they may receive proper treatment and the necessary reports can be submitted to the Provincial Worker’s Compensation Board.

Panic and Emergency Evacuation & Protocols

Please note that evacuation procedures in the event of fire or other emergency are posted throughout HPRR facilities and in Fire Manual. Staff will familiarize themselves with these procedures.

Appendix B – Emergency Protocols for Panic Button & Fire Evacuation

Occupational Health and Safety Committee and Handbook

HPRR has an Occupation Health and Safety Committee which meets quarterly and has representation from each department to ensure risks in all areas of HPRR are identified and safe work practices are brought back to each program and implemented.

The purpose of this separate handbook (creation – winter 2013, continually being updated) is to set out the method of response that will be used in various emergency situations (perceived and identified) in
order to protect the safety and health of employees, contractors, and clients that utilize HPRR and our services.

1.2.4 Crisis Intervention/De-escalation
Within the first six (6) months of hire staff will be trained in crisis intervention/de-escalation techniques by a qualified trainer. (NVCI, CPI, TCI, PACE, etc.) Certification must be kept current, renewed minimum every three (3) years.

**Procedure**
If employees do not have the required certification, HPRR and the employee will be responsible to arrange training within the first six (6) months of employment, along with recertification every three (3) years minimally on an on-going basis. A copy of the certification will be sent to HR and kept in the employees personnel file.

1.2.5 Suicide Intervention Training
Within the first six (6) months of hire staff will be trained in suicide intervention by a qualified trainer. (ASIST, etc.) Certification must be kept current, renewed every three (3) years minimally.

**Procedure**
If employees do not have the required certification, HPRR and the employee will be responsible to arrange training within the first six (6) months of employment, along with recertification every three (3) years minimally on an on-going basis. A copy of the certification will be sent to HR and kept in the employees personnel file.

1.2.6 First Aid and CPR Training
Within the first six (6) months of hire staff will be trained in Standard Level First Aid and CPR/AED by a qualified trainer. Certification must be kept current, renewed every three (3) years minimally, unless otherwise identified by the training provider. (Eg. Yearly renewal)

**Procedure**
If employees do not have the required certification, HPRR and the employee will be responsible to arrange training within the first six (6) months of employment, along with recertification every three (3) years minimally (or otherwise indicated) on an on-going basis. A copy of the certification will be sent to HR and kept in the employee’s personnel file.

1.2.7 Disease Prevention and Universal Precautions
Within the first six (6) months of hire staff will be trained in basic disease education and prevention techniques. Training must be renewed every three (3) years minimally.

**Procedure**
If employees do not have the required training, HPRR and the employee will be responsible to arrange this within the first six (6) months of employment, along with renewal every three (3) years minimally on
an on-going basis. A copy of the training certificate will be sent to HR and kept in the employee's personnel file.

1.2.8 Indigenous Awareness Teachings
Within the first nine (9) months of hire staff will receive six (6) hours of Indigenous Awareness Teaching and four (4) hours annually thereafter.

Procedure
HPRR and the employee will be responsible to arrange six (6) hours of teachings within the first nine (9) months of employment, and a minimum four (4) hours annually thereafter. Documentation of the teachings will be sent to HR and kept in the employee’s personnel file.

1. This learning may be individualised to accommodate program needs and staff’s previous experience, current knowledge and/or involvement within the Indigenous community. Learning may include a combination of:
   - Attendance at cultural/education events
   - Learning from historical interpretive centres
   - Attending lectures/workshops
   - Experiential Learning
   - Meeting with an elder or other knowledge-keeper
   - Having guest speakers address staff functions

2. Staff new to the field or who are not aware of Indigenous history have on-going training that addresses some or all of the following topics:
   - History of Indigenous peoples
   - Definitions of who is Indigenous
   - Effects of colonization and government policies (i.e. residential schools, 60’s Scoop, Jordan’s Principle)
   - Current issues and realities of Indigenous peoples on and off reserve;
   - Impact of the Indian Act
   - Systemic racism and its’ impact on individuals and communities
   - Effects of intergenerational trauma

3. Annually staff will complete a minimum four (4) hours of on-going learning. Documentation of teachings will be sent to HR and kept in the employee’s personnel file.

1.2.9 Diversity/Cross Cultural Training

Within the first nine (9) months of hire staff will receive six (6) hours of Diversity/Cross Cultural training and four (4) hours annually thereafter.
HPRR recognizes that awareness, understanding and acceptance of diversity and the cultural norms of the participants are an essential part of working effectively with individuals who identify with a particular group (gay/lesbian/transgender, ethnic groups, religious groups, deaf community, etc.) Diversity training is based on the population the program has served within the past year, pulled by HIFIS specialist bi-annually to inform staff of demographic trends. This training should also recognize the diversity of staff and attempt to remove barriers through educational opportunities. The training can be completed over a period of time or with an in-service training session.

**Procedure**

Annually, HIFIS specialist will compile aggregate of participants served to inform staff of demographic trends. HPRR and the employee will be responsible to arrange six (6) hours of training within the first nine (9) months of employment, and a minimum four (4) hours annually thereafter based on these trends. Staff are encouraged to present on topics of their expertise. Documentation of the trainings will be sent to HR and kept in staff file.

**1.2.10 Specialized Training**

Specialized trainings may be internal and/or external, including continuing education, conferences, courses, or certificates are required to increase awareness and knowledge. Where possible HPRR will provide relevant in-house training and development opportunities to ensure staff are up-to-date on best practices and possess the knowledge/skills to effectively serve program participants.

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

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 HPRR 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 HPRR
- Administering and analyzing a variety of assessment tools
- ASIST/Suicide prevention
- Landlord Relations & tenancy act
- Case notes and record keeping
- Client engagement techniques
- Trauma-informed practice
- 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

**Procedure**
HPRR and the employee will be responsible to arrange and attend in house mandatory training including but not limited to Motivational Interviewing, Mental Health First Aid, Working with You is Killing Me and Everybody Wins within the first twelve (12) months of hire. Trainings must be kept current and renewed every three (3) years at minimum.

Documentation of these trainings will be sent to HR and kept in the employee’s personnel file. This learning may be individualized to accommodate program needs and staff’s previous experience and knowledge.

**Case Management Activities**

**2.1 Referral and Placement**
Coordinated Access is a process for people to access housing services. CA Workers trained across St. John’s agencies work with individuals and families are assessed through the Vulnerability Assessment Tool to determine needs and acuity. Program referral and intake is determined through CA Referral Guide and System Map. (See St. John’s System Coordination Framework).
The HPRR program acts as a ‘door’ for the CA process. As such, staff receive training and agree to provide referrals, conduct assessments, prioritize and triage clients according to the System Coordination Framework. Staff also receive referrals from other participating agencies, and agree to follow community protocols in such instances.

2.1.1 Notification of Housing Placement Match - CA Referrals

Once the referral is made through the CA process to the HPRR program, staff receiving referrals should make every effort to connect with the participant within 5 days of receipt. The participant will be notified of the successful program match and given a choice of direct contact with the receiving agency or a warm transfer.

If the client chooses a warm transfer the referring agency worker will coordinate the details of the warm transfer including the date, time, location and people involved in the transfer of service. The date of the transfer should not exceed ten (10) days from the time the match is made. The exception would be if the program the client is entering has pre-determined date.

They should also communicate the outcome of the referral to the referring provider and the EHSJ System Planner within 5 days of receipt and again within 5 days of connecting with the participant. If connection with the participant is not realized after 3 documented attempts and 30 days from original receipt, the participant can be reported as MIA to EHSJ and to the referring agency.

This information must be documented.

Procedure

HPRR participates and accepts referrals made through the CA process.

When a match is confirmed staff will contact the individual within two (2) working days to notify them of a successful placement match. Within seven days, a minimum of two attempts will be made to contact the client, each time using all means of contact provided by the client. (ie. Phone, email, shelter or third party contact info).

All efforts made to notify the client will be documented in HIFIS client case notes. HPRR will hold onto the “Matched participant” for an extra week in attempt to connect with the individual. If a participant refuses placement by an agency the rational will be documented in HIFIS and returned back to CA triage list.

2.1.2 Referrals – Non CA Referrals

All referrals to HPRR that come outside the CA process will be treated in the same manner as those within as outlined in 2.1.1.
2.2 Consents

2.2.1 Consent to Receive Services

Clients are provided with clearly defined program expectations at the time of intake, which include:

1. What services the program delivers
2. What the expectations are of the client
3. Which portion (if any) of the program is optional
4. Discharge processes (both planned and unplanned)

Procedure

Staff are to review these expectations verbally and offer a written copy to the participant at the time of intake. Consent is provided voluntarily by the participant and can be revoked at any time. A signed and dated copy of the consent is kept in the client file.

Appendix C – Consent to Receive Services

2.2.2 Client Rights

Clients are informed of their rights at the time of intake, which include:

1. Being treated with dignity and respect
2. Involvement with the program
3. Involvement in Housing Planning
4. Establishing/setting long term goals
5. Confidentiality
6. Grievance procedures
7. Information sharing
8. Advocacy
9. Cultural connection

Procedure

Staff are to review these rights verbally and offer a written copy to the participant at the time of intake. A signed and dated copy is kept in the client file.

Appendix D – Clients Rights

2.2.3 Re-Informed of Rights

Client rights are:

1. Posted or accessible to clients (eg. Handbook, brochure)
2. Reviewed and documented as part of (or within the same timeframe - every 90days) the update of Housing Plan
3. Reviewed following any incident that may have impacted the rights of the client (searches, disclosures, etc.)
**Procedure**

Staff are to review these rights verbally as part of, or within the same timeframe (every 90 days) as updating Housing Plan also following any incident that may impact participant’s rights. A signed and dated copy is kept in the client file.

**2.2.4 Searches**

A search of the residential premise is the responsibility of the Landlord and falls under the guidelines of the Residential Tenancy Act. Personal searches and bag searches are not permitted in this program.

**Procedure**

The program outlines in the intake that within the first year of tenancy landlord, case manager and participant will complete a walkthrough of the unit (within same timeframe as updating Housing Plan, every 90 days) to document/monitor damages.

Staff may also initiate a search of a participant’s rental unit to ensure the safety of a participant. A 24-hour notice to enter must be posted on or slid under door to inform participant of the reason for the search. A search of a participant’s rental unit would be completed with the landlord (ideally the participant is present) and falls under the Guidelines of the Residential Tenancy Act. If staff believes there is eminent risk to a participant a Welfare Check will be requested through Police Service. If the participant is not present when a search is conducted they will be made aware of the findings of the search and informed of their right to initiate a grievance. The findings of the search will be documented.

An incident report must be completed for all searches that are not part of the regular walkthroughs (within the first year) of programming. Submit to program supervisor and kept in client file

If the participant is not present during a search the following is documented in participant file and a copy offered:

- The reason for the search
- The findings of the search
- Their right to initiate a grievance

**2.2.5 Data Collection**

The program has a written consent form that discusses the protection of privacy and confidentiality of client information and must include:

1. Purpose of the information being collected
2. Reason for collection of information
3. Use of information
4. Access to information
5. Secure storage of information
6. Length of time information will be stored
**Procedure**
Staff will review this consent verbally and offer a written copy to the participant at the time of intake. Consent is provided voluntarily by the participant and can be revoked at any time. A signed and dated copy of the consent is kept in the client file.

*Appendix E – Consent and Permission form*

**2.2.6 Release of Information**

The program has written policy and procedures that address the obtaining, sharing and/or release of confidential information. This must include:

1. Sharing with the client the purpose of release/accessing the information
2. Obtaining the informed, written consent of the client
3. Documenting
   a. To whom the information will be released
   b. From whom the information will be accessed
   c. The purpose of sharing the information
   d. The timelines, including dates, the release is valid (not to exceed one year)

**Procedure**
Staff are to review the ROI form verbally and provide a written copy to the participant. Consent is provided voluntarily by the participant and can be revoked at any time. A signed and dated copy of the consent is kept valid in the client file with an expiry date not to exceed one year.

*Appendix F – Consent and Permission Form*

**2.3 Supports**

**2.3.1 Crisis Support**

Participants are advised at intake of how to access 24 hour, 7 day/week crisis support and will be provided with a list of these resources. Crisis supports can be provided either by telephone or in person.

**Procedure**
Staff of HPRR is available to assist participants either by phone or in person during work hours Monday – Friday 8am-4pm. Participants are advised at intake of how to access 24 hours, 7 days per week crisis support. Staff will provide a copy of these resources to the participant at the time of intake. A signed and dated copy is kept in client file.

*Appendix G – Crisis Support*

**2.4 Assessment**
The following standards apply to all programs, regardless of referral stream in alignment with the System Coordination Framework.

**2.4.1 Assessment Tools**
Following the intake of a client, HPRR will use an evidence based assessment tool to inform Housing Planning goals and priorities.

**Procedure**

HPRR will use the VAT, as outlined in the System Coordination Framework. VAT is endorsed and widely used by many agencies as a comprehensive approach designed to prioritize which clients should receive what type of service, the intensity of service and encourages reflection and depth of need when establishing Housing Plan goals and priorities.

*Appendix H – VAT Assessment Tool*

**2.4.2 Initial Assessment**

An initial assessment will be completed within 7 days of intake. A copy of the completed assessment is kept on the client file. The client is offered a copy of the assessment upon completion.

**Procedure**

The Case Manager will complete the VAT assessment within 7 days of a participant intake. The completed assessment will be kept in the participant’s file and a copy will be offered to them.

**2.4.3 Ongoing Assessment**

An assessment will be completed every ninety (90) days following the initial assessment, up to and including thirty (30) days prior to discharge. Copies of the completed assessment are kept on the client file. The client is offered a copy of each assessment upon completion.

**Procedure**

Staff will use the VAT as an ongoing assessment tool every ninety (90) days. This is extended to every six (6) months after two (2) years of service. Staff will review the assessment with participant identifying strengths and areas of higher acuity. This assessment will be completed in conjunction with the Housing Plan review and is used to inform goals and priorities outlined in the Housing Plan. Copies of the completed assessment are kept on the client file. The client is offered a copy of each assessment upon completion.

**2.4.4 Final Assessment**

If an assessment has not been completed within thirty (30) days prior to discharge, a final assessment will be completed within ten (10) days after program discharge. If a final assessment is unable to be completed (e.g. unforeseen, unplanned discharge), documentation of the reason why is maintained on the client file. A copy of the completed final assessment is kept on the client file. The client is offered a copy of the final assessment.

**Procedure**
Staff will complete a VAT within ten (10) days of discharge if the assessment has not been completed within the past thirty (30) days of discharge. A copy of the completed final assessment is kept in the client file. The client is offered a copy of the final assessment. If this assessment is unable to be completed (e.g. unforeseen, unplanned discharge), documentation of the reason why is maintained in participant’s file.

2.5 Planning

2.5.1 Person-Centered Housing Planning

Housing Planning goals will be informed through assessment but determined by the client. Housing Plans should include others as determined by the client.

Procedure

Using a person-centred approach, Housing Plans will be completed and reviewed in collaboration between staff and participant. Other service providers and/or informal supports should be included in the Housing Plan as identified by the participant to provide integrated services. A strengths based approach is used alongside the VAT assessment to inform goals and the activities to achieve these goals as determined by the participant.

2.5.2 Housing Plan Components

The program will ensure that there is one integrated and complete Housing Plan for each client, which includes the following components:

1. The goals to be achieved
2. Strengths of the client that support the goals
3. The tasks/activities/strategies required to meet the identified goals
4. The measures of success used to determine the progress made towards goal achievement
5. Timelines for review
6. Signature of staff, client and any additional involved parties

Participants are offered a copy of the Housing Plan and a signed and dated copy is kept on the client file. Alternately, if services are voluntary, attempts to engage clients in Housing Planning are documented in circumstances where client does not want to participate.

Procedure

Staff and participant will both sign off on the Housing Plan. If possible, external service providers involved will also sign off on Housing Plans. The Housing Plan will be made a permanent record held for 7 years in the participant’s file and a copy will be provided to the participant. Housing Plans will be updated to maintain relevance.

Upon completion of the VAT assessment staff will, in collaboration with the participant:

- Identify and discuss the participant’s goals, strengths, and current support systems
- Explore needs, concerns, values and choices;
• Avoid service duplication – discuss service providers currently involved and/or future involvement
• Identify potential risks
• Gain consent to share/gather information with other service providers
• Contact the participant in a manner preferred by them
• Ensure Housing Plan reflects goals, strengths, measures of success and timelines of participant

Appendix I – Housing Plan

2.5.3 Initial Housing Plan – Timelines

The initial Housing Plan will be completed within 15 days of intake. Staff will complete the initial and all future Housing Plans in collaboration with the participant. A signed and dated copy is kept in participant file and a copy offered to participant.

2.5.4 Housing Plan Review

The Housing Plan is reviewed with participants every three (3) months to ensure its continued relevance and to identify goals achieved and/or goals and timelines to be adjusted.

Procedure
Staff and participant will schedule Housing Plan reviews minimally every three (3) months to discuss and update Housing Plan goals and determine next steps necessary for a successful planned discharge from program.

Timeline
• Initial Housing Plan review: Within 15 days of intake
• Ongoing Housing Plan reviews: every 3 months minimally
• Final Case Plan review: Thirty (30) days prior to planned discharge

Documentation staff will utilize for Housing Plan reviews:
• The VAT assessment to inform Housing Plan priorities
• Initial Housing Plan established by participant

These updated documents will be kept in the participant’s file.

2.5.5 Final Housing Plan Review

A final review of the Housing Plan occurs thirty (30) days before the planned discharge date.

Procedure
Staff and participant will meet to discuss progress (ensuring goals have been met and participant is ready to disengage from the program), further supports if needed to ensure success within the community and information of how to re-access program services in the future if they choose. A final Housing Plan review will be completed thirty (30) days prior to the planned discharge.
2.6 Client Referrals
2.6.1 Support to Access Referrals

If referral to outside services is part of the Housing Plan, and the client agrees or requires it, staff will offer to accompany the participant to the needed service the first time to help ensure successful engagement.

Procedure
Staff will offer to accompany participants to the first meeting with an in/external service to assist with intake and successful engagement. Staff must have verbal consent from participant and service provider to attend appointment.

Support to access referrals includes providing participants with:
- Referral information
- Assistance completing applications/referral forms, including serving as the professional contact for in/external services
- Accompany participants to their first appointment to ensure successful connection and determine roles and assignment of tasks
- Follow-up with the service providers to monitor progress

2.7 Serious Incident Reporting
2.7.1 Serious Incidents

Staff are required to verbally inform their supervisor of a serious incident. All serious incidents must be documented within twenty-four (24) hours of the occurrence using the Serious Incident Report which must be signed by senior management and notify the funder (City of St. John’s/EHSJ).

Note that the reporting such incidents to the funder should be reviewed and clarified in light of EHSJ/CE capacity to undertake this work as part of monitoring.

Serious incidents are those events involving the following:
1. Attempted suicide/self-harm
2. A medical or other kind of emergency, serious illness or accident
3. A dangerous situation (e.g. threats of violence, weapons, etc.)
4. Risk to Public Safety (e.g. criminal charges related to violent/dangerous offences such as armed robbery, etc.)
5. Suspicions and/or allegations of abuse, either within or outside the program
6. Use of restrictive procedures (e.g. restraints, unlocked confinement)
7. Searches which are not part of regular programming
8. Death
9. Inappropriate use of strategies to influence client behaviour
10. Staff and or Landlord safety (e.g. Threats)
11. Inappropriate and/or coercive behaviors used by employee to influence other staff, volunteers; students; contractors, and participants
12. Any event resulting in significant physical injury and/or emotional distress

2.7.2 Documentation Required – Serious Incidents

In the event of a serious incident, it is a requirement to be documented and reviewed

1. Documentation must include:
   a. Who is reporting the incident
   b. A history of the events or circumstances leading up to the incident
   c. Behaviour of the client that required intervention, if applicable
   d. Timeline of the intervention used, if applicable
   e. Description of actions taken by staff and/or others involved (e.g. police, medical personnel, etc.)
   f. Follow-up actions and recommendations
   g. Funder has been informed as applicable/required
2. Follow-up after the incident to include:
   a. Debriefing with the client and others who might have been affected
   b. Client was informed of their rights (e.g. to initiate a grievance, contact an advocate, etc)
3. Senior agency personnel have signed the Serious Incident Report
4. The appropriate authorities have been informed within 24 hours of the incident occurring (e.g. police, funder, legal guardian)

Procedure

In the event of a serious incident, whether it is involving a participant or staff the following steps are to be taken by staff involved/witness to the event:

1. Notify supervisor immediately
2. Complete Serious Incident Report Form – documentation will be factual, clear, professional and detailed
3. Submit Report to your supervisor and Human Resources for signatures
4. Notify City of St. John’s within 24 hours
5. Human Resources will notify staff involved of any follow-up needed
6. Case Manager and Supervisor will debrief incident and formulate follow-up plan for participants
7. A copy of the incident report will be filed in staff and/or participant file
8. The program supervisor will submit a copy to Occupation Health and Safety Committee (if required)
9. OHS committee will review the incident report to determine if any preventive measures are needed.
Staff are to complete the Serious Incident Report form and submit it to their supervisor, Human Resources and City of St. John’s within the 24 hours of the incident. Notification to funder (City of St. John’s) is required if pertaining to a participant in program. HR will file a copy of the incident report as a permanent record in staff personnel file and a copy will be provided to him/her after the end of the Serious Incident Procedure. Participants will be informed of their rights (to initiate a grievance or contact an advocate) a copy of the serious incident report will be kept in their file. Any employee reprimand recommendations will be blacked out due to infringement upon staff human resources privacy policies. Any employee reprimand or consequences will be shared only with the employee’s supervisor and not with any other parties involved.

Appendix J – Serious Incident

2.7.3 Review of Serious Incident Reports

All Serious Incident Reports are reviewed on a case by case and semi-annually (at minimum) on a program basis to:

1. Ensure the completeness of the information included
2. Identify trends (e.g. number of incidents with a particular client, staff, particular circumstances – time of day/month/season, related issues, etc.)
3. All Serious Incidents are reviewed, by the team or supervisor, on a case-by-case and program basis (e.g. identifying trends in frequency, effectiveness of intervention, corrective action required, follow-up, etc.)
4. Address corrective action required (e.g. training needs identified, etc.)
5. Ensure reporting requirements are being met (e.g. members of the service team, senior management, guardian, funder, police, etc.)

Procedure

Serious incident reports are reviewed by the team and supervisor every six (6) months, minimally with outcomes and recommendations submitted to the Occupational Health and Safety Committee. Each program will have one representative attend. The OHS Committee will be responsible for reviewing, addressing all serious incidents, bringing forward recommendations, and implementing changes to safety and health policies and procedures within HPRR. All occupational and safety policies and procedures revisions must be approved at the senior management level prior to implementation.

Appendix K – Serious Incident Biannual Review

2.8 Discharge Process

2.8.1 Extended Supports

HPRR program is a one-year prevention and rapid rehousing program. If further supports are needed, a continuation of the service can be negotiated or referrals can be made to other services based on participant need.
Procedure
If a participant requires continuation of services beyond the one-year graduation date, staff will consult with supervisor and advocate for continuation of services. Determining if the participant is to continue receiving services through the program or be referred to other appropriate services offered in the community. If participant continues to receive services with HPRR, a new consent form will be signed and Housing Plan updated reflecting negotiated terms for continuation. If program services are discontinued, the Case Manager will make all attempts to locate and bridge the participant into an alternative community resource.

2.8.2 Planned Discharge
Before a planned discharge from the program, staff will ensure that:

1. Client is ready to disengage from the program
2. A review of the Housing Plan occurs with the client to ensure goals have been met
3. A final assessment is completed, utilizing the same evidence-based tool as at intake
4. Client is informed of how to re-access services in the future, if they choose to

Procedure
The participant and staff will prepare and work towards a planned discharge. It is evident the individual is ready to disengage from the program when the following have been addressed to ensure housing stability going forward (as outlined in consent form):

1. You and your case manager mutually agree that you are stable in your housing
2. You have maintained housing at the same residence for at least 3 months
3. You have successfully met the goals outlined in your Housing Plan
4. You have completed and submitted an application for social housing (NL Housing)
5. You have a bank account
6. Your taxes are up to date
7. You have photo identification
8. You are connected to your community in a way that is meaningful
9. You have a landlord reference
10. Your VAT score has decreased over time
11. Your case manager has provided you with a formal letter indicating your graduation date as well as how to re-access service in the future if needed

2.8.3 Foreseen, Unplanned Discharged
Before a foreseen, unplanned discharge from the program, staff will ensure all efforts have been made to address behavioural issues and rental arrears through mediation, conflict resolution, landlord/building operator negotiations, and options for housing transfer.

All efforts will be documented and the client will be offered a copy. A copy is kept in the client file.
Procedure

Foreseen unplanned discharge can occur at any time but should occur only as a last resort. Staff will ensure every effort is made to address issues including but not limited to behaviour, rent arrears, property damage before resulting in an unplanned discharge. Staff will serve a warning letter to the participant requesting contact be made within specified timeframe to address the presenting issue.

An unplanned discharge occurs when an individual
- Abandoned unit, with no notice
- Non-compliance with the terms mutually agreed upon in Housing Plan
- Endangers the safety of others. Including but not limited to verbal, physical, sexual threats or assault towards tenants, landlord or staff
- Excessive and ongoing damage to rental unit

The Case Manager will ensure all efforts are made to resolve outstanding issues using:
- Mediation
- Conflict resolution
- Landlord/building operator negotiations
- Options for housing transfer

All efforts made will be documented in the discharge summary and kept in client file. Participant will be offered a copy.

Appendix L – Discharge Summary

2.8.4 Foreseen, Unplanned Discharge – Transfer Efforts

In the event of foreseen, unplanned discharge, staff will ensure all efforts have been made to facilitate transfer to another case management program. This includes:

1. Transfer program contact information
2. Acknowledgement of receipt of referral from receiving agency
3. Proposed date of screening/intake
4. Transfer of client information (with consent)
5. Contact information for re-engagement in the discharging program

This will be documented in the client file.

Procedure

The case manager will:
- Attempt to provide minimum of three (3) referrals to programs that the Participant could transfer to, with the participant’s consent. The three (3) programs are to be focused on housing stability.
- Acknowledge that the referrals have been received by the external program with date of screening/intake, waitlisted, and/or eligibility status
- Transfer of participant information to referred agency with participant consent.
• If Participant refuses or is not interested in receiving three (3) referrals then participant will be discharged from program.
• Make every attempt to prevent participant from having to access shelter, including but not limited to mediation, liaison with housing locator and landlord, and address rent in arrears. Only when no alternative is available should emergency shelter be a final option.
• Provide contact information for re-engagement in HPRR program, if participant is interested in reassessing services in the future.
• Document all efforts in participant file.

2.8.5 Unforeseen, Unplanned Discharge – Discharge Summary
In the case of unforeseen, unplanned discharge, that is immediate and cannot be predicted (client leaves without prior discussion with the case manager, violence toward a staff member/other client, etc.), staff must complete a discharge summary that contains information related to efforts to resolve issues and keeping clients engaged.
This will be documented in the client file.

Procedure
Staff will complete a discharge summary outlining reason for discharge, all efforts made to resolve issues and attempts to keep clients engaged. A copy will be kept in participant file and a copy offered to them.

2.8.6 Re-informing of Grievance Process

Participants will be re-informed of the grievance process at the time of discharge which includes the City of St. John’s.

Clients are to be offered a copy and a signed and dated copy is kept on the client file.

Procedure

Staff will re-inform participants of the grievance process along with all other client rights within the same timeframes as updating the Housing Plan. As well re-informing participants of the grievance process at time of discharge.

Appendix M – Grievance Process

2.8.7 Re-accessing Services
At discharge, the client is advised how to re-access the program if necessary in the future. Should a client choose to formally re-access the program, new consent forms will be signed and a new intake will occur. A new VAT assessment will be completed if the discharge timeframe exceeds 12 months. This standard does not apply to clients who access the program for strengthening sessions/support in an amount of less than 10 hours.
Procedure
Past participants may be able to re-access program services if:
- Necessary, meet program criteria and within **12 months of discharge** (otherwise CA triage process)
- Re-referred by another housing program or internal HPRR program
- Living in shelter or on the street
- Willingness to engage and direct Housing Plan to reflect issues that lead to unplanned discharge

Past participants will be decline services if:
- Past history of violence towards staff or landlords

3.0 Privacy and Information Management
3.1 Data Management
3.1.1 Information Management System
HPRR has several systems include HIFIS to manage information requirements and has written procedures to ensure the completeness of its files and data. This should address:

1. Staff files
2. Client files
3. Outcome and quality improvement monitoring

All information retained by HPRR relevant to staff, client or agency operations will be subject to, and will abide by appropriate privacy legislation. Employees must adhere to the collection of information and its use which are aligned to federal and provincial legislations and regulations and professional guidelines about privacy. Legislation includes the **Privacy Act** (federal), the provincial **Access to Information and Protection of Privacy Act, 2015 (ATIPPA, 2015)** and the **Personal Health Information Act (PHIA)** and any other professional regulatory bodies to which the employee has membership.

1. Staff Files

HPRR collects and maintains personal information about employees in the course of establishing, managing or terminating (collectively, "administering") employment, contract or volunteer relationships with HPRR. Refer to HPRR Employee Handbook Section 1.2 for details on staff training, scheduled performance reviews and documents required in staff files.

Employee Handbook
*Appendix N – Staff file checklist*

2. Client Files

Staff will collect and ensure client files are complete and contain the following documentation:
- VAT(s) – (CA/pre-housed, 30 days after housed, every 90 days {every 6 months if in program longer than 2 years}, within 30 days of Discharge)
- Consent to Receive Services – Welcome Package
• Client Rights
• Grievance Procedures
• Consent of Data Collection
• Release of Information
• Crisis Support List
• Housing Plan – (45 days from intake, reviewed every 3 months {every 6 months if service longer than 2 years}, final 30 days prior to discharge)
• Serious Incidents (if necessary)
• Referrals made
• Budget
• Lease and walk through (3, 6, 9, 12 months)
• Discharge Summary (planned or unplanned)
• Case notes (may be kept in HIFIS)
• Housing/Case Manager Checklist
• City of St. John’s Reporting (Intake, every 3 month f/u, exit)

Appendix O – Participant file checklist

3. Outcome & Quality improvement Monitoring

HPRR is committed to ensuring that Case Managers are providing a high standard of care through agency wide procedures and standards of practice. Outcomes are tracked using standardized reporting, assessment, existing database(s) and file auditing.

Monthly data revisions for HPRR are performed. They include timely data entry, completion of follow-ups due for that month, and revision of new clients entries/exports. This is then submitted to the NLSA for a second review and approval. If everything is in order, those reports are then filed away in our and their database.

To ensure accurate and timely data entry, a preliminary report is run at the beginning of the month, and distribute “data duties” to all Case Managers for that month. A deadline is set which allows her to review all reports before sending them off to City of St. John’s.

Case consultations are conducted on an as needed basis. This is a time for Case Managers to present difficult cases to receive support from colleagues. Once per month staff will complete file audit at random (3 files) of each other’s files. A file audit checklist will be used to ensure that each Case Manager is meeting the same standard regarding documentation and standard of practice.

Appendix P – File Audit Checklist

3.1.2 Access to Files/Data (Staff)

Staff (former or current) have access to their personnel file for review or can request a copy of his/her file. Staff files can be corrected if the individual requests to HR that information be added, changed and/or revised. At no time will any information be deleted. Staff files can be accessed by HR staff and
the person of whom the file belongs to. All documents that are not the property of HPRR will be removed prior to staff receiving/reviewing a copy of his/her file.

Procedure
Staff must submit a formal written request to HR to review or obtain a copy of their personal file. HR has 45 days to respond to request. Staff have the option of reviewing her/his file in the office or receiving a copy. A copy of the staff file will either be sent registered mail or hand delivered. All documents that are not the property of HPRR will be removed prior to staff receiving/reviewing a copy of his/her file.

Upon reviewing her/his file, staff can request changes and/or additions are made by:
1. Meeting with Human Resources to discuss information that (s)he believes is incorrect
2. Human Resources will record that the following changes have been made as per requested by the employee
3. Employee to approve changes to the his/her record
4. At no time will the Department of Human Resources delete any portion of the employee’s record that employee deems incorrect.

Appendix Q - Employee Request to Access File

3.1.1 Access to Files/Data (Clients)

Participants (former or current) will have access to their file for review or request a copy of his/her file. Participants files can be corrected if the individual requests that information be added and/or revised. At no time will any information be deleted. Participant files can be accessed HPRR staff and the person of whom the file belongs to. All documents that are not the property of HPRR will be removed prior to the participant receiving or reviewing a copy of his/her file.

Procedure
- Participant must submit a formal written request to case manager/program supervisor
- Participant has the option of reviewing her/his file in the office or receiving a copy
- A copy of the participant’s file will either be sent registered mail or hand delivered
- All documents that are not the property of HPRR will be removed prior to the participant receiving/reviewing a copy of his/her file.

Upon reviewing her/his file, a participant can request changes and/or additions are made by:

- Meeting with Case Manager/program supervisor to discuss information that (s)he believes is incorrect
- Case Manager will record that the following changes have been made as per requested by the participant
- Participant to approve changes to the participant’s record
- At no time will the Case Manager/program supervisor delete any portion of the participant’s record that participant deems incorrect.
Appendix R – Participant Request to Access Information

Records of Deceased Participants
With written request pertaining to specific and detailed reasoning, an individual can request access to a deceased participant’s records. Deceased participant files can be accessed by HPRR staff and HR. All documents that are not the property of HPRR will be removed prior to the individual receiving/reviewing a copy of the request indicated. HPRR will consider the disclosure of a deceased person’s information for the purposes of investigation, medical emergencies, coroner’s office, legal purposes (ie. Will, executor)

Procedure
- The individual must submit a formal written request (detailed and specific) to access the records of the deceased individual to the Program Coordinator
- The Program Coordinator will consider the disclosure and contact the individual regarding her/his request
- The Program Coordinator will provide a copy of the deceased person’s record as indicated in the request.

Appendix S – Request to Access Deceased Individuals Information

3.1.4 Maintenance of Data
HPRR recognizes the need to ensure reasonable privacy and safety for those whom it serves. Ensuring the confidentiality of confidential and personal information is an important component of responsible and professional service delivery. All personal and health information related to an identified individual must be treated as confidential.

All employees are required to respect the confidentiality of the people served at HPRR as well as the operations of the agency. These confidentiality provisions extend not only for the duration of service with HPRR, but also continue indefinitely once an individual’s relationship with HPRR has ceased. Violation of these confidentiality provisions shall result in significant disciplinary action being taken up to and including dismissal for cause.

All employees will be required to sign an Oath of Confidentiality at time of hire to be placed in their personnel file.

Staff members will have varying levels of access to the participant’s paper and electronic file dependent upon whether access is needed to fulfill job requirements. Past staff will not have continued access to participant’s file unless it is a legal matter.

The participant’s paper file will be the official participant file while the database(s) serves as a secondary file for back-up, if needed. If a participant’s information has been compromised staff must inform their supervisor immediately and the individual must be notified.
1. Transportation of Information

It is necessary for staff to transport and complete required documents with participants off site, staff must ensure that these forms are kept confidential (private) and on their person at all times. When transporting participant documents between HPRR sites they either sent through internal mail system or staff can directly hand over documents to HPRR staff at the alternate site or program. Staff are not to share their file cabinet keys, database(s) password information or computer login with other HPRR staff.

2. Sharing and Reporting of Information

Participant information is to be accessed only by those who are involved in the participant receiving services, signed consent, court subpoena for a specified purpose. Employees will not release additional information above the specified purpose and matter being addressed. The Case Manager must update the Consent and Permission form whenever a service organization becomes a part of the participant’s Case Plan. Staff will only share information about a participant without their consent if the participant is threatening themselves or others, is suspected of, or is known to have harmed a child, or court ordered to do so.

3. Timelines for Storage of Records

Participant paper files and other paper documentation must be kept for minimum of seven (7) years for participants who are not legal guardians of children.

Participant paper files and paper documentation must be kept for minimum of ninety-nine (99) years for families with children (18 years and younger); families with dependent adults; and families with any involvement with child protection services.

Records and data with names of participants and other confidential information are to be stored for the minimum seven (7) years without guardianship or involvement with child welfare. Those participants with guardianship or involvement with child welfare records and data will be kept for minimum of ninety-nine (99) years.

Employee records/files are kept indefinitely.

4. Means of Storage for Open and Closed Files

- Open participant files are to be located in a shared file cabinet that can be assessed by the Program employees. All file cabinet(s) are to be locked in a secure location on-site.
- Open staff files are kept in a locked file cabinet located in HR department.
- Closed staff and participant files are kept in double locked storage.
5. Destruction of Records or Data

Participant paper can be destroyed for single participants after seven (7) years and after ninety-nine (99) years for families. Electronic files will be kept indefinitely.

Participant paper and electronic files can be destroyed after a period of seven (7) years for adult participants without legal guardianship over children or involvement with child protection services.

Records and data with names of participants and other confidential information can be destroyed after a period of seven (7) years. Participant paper and electronic files for families can be destroyed after a period of ninety-nine (99) years.

All paper records and documents containing participant information including but not limited to their name, address, AB Health Care Numbers will be disposed of using a certified document disposal company. A recorded list of participants’ files which has been destroyed will be kept indefinitely in a secured and locked location.

3.1.5 Protection of Confidential Information

HPRR will protect participants’ confidential information.

Procedure
All paper files are kept in a shared file cabinet that can be assessed by the Program employees. All file cabinet(s) are to be locked in a secure location on-site.

Staff transporting participant documents must ensure that these are kept on their persons at all times. Staff are not to share their database(s) password information with other HPRR employees. When transporting participant documents and/or files between HPRR sites are either sent through internal mail system or the employee can directly hand over the file to the HPRR employee at the alternate site or program.

HPRR has an alarm system and fire sprinkler system to protect from theft and fire and participant electronic files are backed up and kept on an external server in case of a power failure, fire, water or other physical damage of paper files. In the event of physical damage, the electronic file will become the primary participant file in lieu of the participant paper file. These electronic files are stored on HIFIS and can be accessed remotely with individual employee password(s).

3.1.6 Electronic Technologies

Electronic technologies will be protected by up to date firewall and virus protection. HPRR uses an Electronic Database (HIFIS) stored remotely and protected by the NLSA. Any electronic information passing through HPRR will be stored in HPRR secure encrypted server, which is protected by password
and changed regularly. All cell phones and databases are protected by a password. Staff are not to disclose their password information to other HPRR employees.

Staff are to change their password if they believe that it there is a risk of unauthorized access or if there has been a breach in the integrity of their password. HPRR employees are to report any unauthorized access to participant information to his/her Supervisor. The HPRR employee member(s)’ direct Supervisor will then take any necessary action to rectify the situation to prevent future incidents. The Department of Human Resources will be contacted if the employee member faces any disciplinary action. If there is email correspondence with another professional about the participant, the participant’s full names are not to be included in the body or subject of the email participants are to be identified by their First Name, Last Initial.

HPRR use of social media sites is overseen and maintained by the Communication Manager. Any posts pertaining to participants of HPRR programming is done with prior written consent of the individual. HPRR does not have official policy around social media, that being said HPRR treats Facebook and other social media as stated in the Employee manual “No employee shall enter into any intimate or otherwise non-professional relationship with a person served by HPRR or behave in a manner that is, or is perceived to be, sexual in nature. No employee shall enter into any intimate or otherwise non-professional relationship with someone who is in a direct reporting relationship with him or her”.

4.0 Service Delivery

4.1 Case Loads

4.1.1 Case Load Determination

Caseloads will be determined based on the complexity of client issues. A guideline range is 1:20 to 1:30 based upon agency capacity and client acuity/need. For example, case managers who work with clients with high needs/acuity should not have a case load that exceeds 1:20, while those who work with moderate acuity needs should have a case load not exceeding 1:20. Lower acuity needs should generally not exceed 1:30.

**Procedure**

The Program Coordinator will determine case load and assignment of participants based on staff current caseloads weighing the acuity (VAT score) of participants and where in terms of housing stability (month of service) they are. Matching of case manager with participants will also take into consideration staff knowledge and skill set along with participant needs. A guideline range is 1:20 to 1:30 should be kept.

4.1.2 Direct Service Provision – Partnerships

Any partnerships and/or processes to provide direct services on site via other organizations should be documented within the program’s protocols along with copies of any partnership agreements or Memorandums of Understanding (MOUs).
Procedure
A Memorandum of Understanding (MOU) is to be signed by the Executive Director and the partnering organization, if possible, upon receiving the partnering organization direct services. Landlords providing serval rental units sign a landlord agreement form.

4.1.3 Move In/Moving Support – Basic Necessities
Upon move in or relocation (rehousing) comprehensive, cost-effective move-in/moving support is arranged by the program via referral to community agencies for basic furniture and necessities at minimum this includes:
   1. Bed (bedbug protection as necessary)
   2. Basic cookware and dishes
   3. Telephone/cell phone
   4. One week’s worth of groceries and toiletries

Procedure
The Case Manager will assist the participant with obtaining or have a plan in place to ensure acquiring these minimum necessities begins within 48 hours and is completed within five (5) business days. Agreements are in place with Interfaith, Foodbank and Canadian Mattress Wholesalers to ensure units are furnished to minimum standards. Also, referrals are made to Foodbank and gift cards can be provided to Safeway or Walmart to ensure a week worth of food/toiletries and or cell phone. If this cannot be accommodated, documentation of the efforts made and reasons why not will be kept in the participant file. (See Participant Checklist)

4.1.4 Relocation/Rehousing
Prior to relocation and/or rehousing, the case manager will support the client in accessing moving services to ensure loss is minimized.

Procedure
In the event relocation/rehousing is necessary the participant will be provided with options of types and locations of housing along with continued service within HPRR unless a transfer of Program is required, see 2.8.4. Either way Case Manager will assist the participant in arranging and accessing moving services so that the basic necessities required are available and to minimize replacement costs. Efforts of these arrangements will be documented in the participant file.
Appendix A – HPRR Orientation Checklist

Things to be completed within the first 10 days:

- New employee training with Program Coordinator (1-hour session to go over job description, role expectations, etc.)
- Meet with Gail Blackwood (HR) for 2-hour meeting
- Review HPRR Employee Handbook with Gail
- Sign up for new employee training through HR
- Get login for Computer, HIFIS
- Sign up for orientation on HIFIS/set up meeting on HIFIS login
- Sign up for VAT training, or youth acuity tool once developed
- Set up time to shadow a home visit, lease signing, intake, VAT assessment
- Set up voicemail (include distress center line and 9-1-1)
- Attend CA Meeting to understand triage (VAT) and client demographic
- Review Plan to End Homelessness in St. John’s
- Review Case Management expectations as per Ending Homelessness Standards of Practice (HPRR Policy & Procedures manual)
- Review practice model utilized within program (Housing First Practice, Critical Time Intervention & Harm Reduction)
- Review Code of Ethics/Ethical conduct
- Review file management and documentation practices
- Review strategies and techniques used to engage participants (participant lead case planning, strength based approach)
- Review Working Alone Safely Protocol
Appendix B – Responding to a Panic Situation

PURPOSE
To outline the standardized panic response used throughout HPRR.

POLICY STATEMENT
HPRR recognizes the importance of a standardized approach in responding to a panic situation. It is the responsibility of all staff and others acting on behalf of HPRR to acquaint themselves with HPRR’ guidelines in response to a panic situation.

APPLICABILITY
All HPRR staff are required to comply with this policy, including volunteers and contracted service providers.

DEFINITIONS
- **Panic Situation**: Any moment in time when staff feels threatened by one or more parties within the building.
- **Overseeing staff**: This refers to any person using the Kantech software to locate the source of the alarm or any person that receives a phone call from distressed staff. The following positions qualify for overseeing staff:
  - Service Coordinator Housing and Community Supports
  - Service Coordinator Family Development Center
  - Service Coordinator
  - Medical Office Assistants
  - Facilities Manager
  - Operations Assistants
  - Trained Senior Directors
- **Dispatch staff**: This refers to staff dispatched by the overseeing staff and has received non-violent crisis intervention training. If needed, any of the positions stated as overseeing staff can act as a dispatched staff. **However, a dispatched staff should be assigned monthly for each floor by Program Coordinators. In other words, a schedule for staff acting as dispatched staff should be created for the year.**
- **Supporting staff**: Any HPRR staff with non-violent crisis intervention training that accompanies the dispatched staff to the panic location. A supporting staff should be assigned monthly for each floor by Program Coordinators. In the event that the dispatched staff are absent at the time the alarm sounds – the supporting staff will take on the role of the dispatched staff, while another qualified staff takes the role of a supporting staff.
- **Staff**: This refers to all other staff in the building, including the staff at the scene and staff that pushed the alarm.
- **External staff**: Staff outside the vicinity of HPRR main site.

** Each floor should have an acting Overseeing, Dispatch, and Supporting staff. In the event that one or more the mentioned staff is absent, Program Coordinators should arrange for a replacement. The replacement should be familiar with the software and have non-violent crisis intervention training.
Do you need to/Can you push the panic button?

Yes

Please see Appendix A (Pg. 4)

No

Pick up phone and call the nearest reception desk communicating the appropriate code found in Appendix B (Pg. 7)
Overview for the panic button:

**Staff should:**

1. Remain calm.
2. If needed/possible evacuate area and dial 911.
3. Other staff members should remain at their present posts unless explicitly asked to assist by overseeing staff or dispatched staff.
Overseeing staff should:

1. Overseeing and dispatched staff assigned for each floor should approach the closest Kantech software. (Each floor should have a computer with the Software as well as a disarming pin close by)
2. Locate the source of the panic alarm on any computer in the building using the Kantech software.
3. Instruct dispatch staff as to where the source of the panic is and send the appropriate individuals to respond. Provide dispatch staff with a pin to disable the alarm.
4. Immediately after sending dispatch staff to the source of the alarm, go to the Kantech software and click on the 1st FLR Control tab (circled in blue on diagram below). Right click on the machine cog icon (circled in red). Click “execute task”, then click “execute task with confirmation”.
5. Overseeing staff will notify all staff through the overhead paging system if there is a need to evacuate the building. An email, with the subject heading reading CODE GREEN, will be sent out to ensure that external staffs are aware. (See Table in Appendix B page 7).

Dispatched staff should:

1. Overseeing and dispatched staff assigned for each floor should approach the closest Kantech software. (Each floor should have a computer with the Kantech Software. with a pin close by). Dispatched staff can proceed to site of panic, only when instructed by overseeing staff.
2. Assess panic situation and try to calm the situation with the help of the supporting staff using concepts from non-violent crisis training. If community services are required, please dial 911 if it has not been done already.
3. When it is safe, disable the panic button at the site where it was pressed. Do not disable if other party is still considered a threat.

Supporting Staff: Provide dispatch staff with necessary/required assistance.

All Staff: It is important to note that anyone coming to HPRR despite the warning does so at their own risk.
This section provides guidelines to responding to panic situations where the panic alarm system may not be appropriate.

1. Call the nearest main reception desk. Consider the following phrases as an example for communicating the emergency codes with the nearest reception desk or any staff member with a HPRR landline:

   *Hi, is Dr. White here today?*

<table>
<thead>
<tr>
<th>Code</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Blue</td>
<td>Cardiac Arrest/ Medical Emergency</td>
</tr>
<tr>
<td>Code Red</td>
<td>Fire</td>
</tr>
<tr>
<td><strong>Code White</strong></td>
<td>Violence/Aggression</td>
</tr>
<tr>
<td>Code Purple</td>
<td>Hostage</td>
</tr>
<tr>
<td>Code Yellow</td>
<td>Missing Person</td>
</tr>
<tr>
<td>Code Black</td>
<td>Bomb Threat</td>
</tr>
<tr>
<td>Code Grey</td>
<td>Shelter in Place/ Air Exclusion</td>
</tr>
<tr>
<td><strong>Code Green</strong></td>
<td>Evacuation</td>
</tr>
<tr>
<td>Code Brown</td>
<td>Chemical spill/hazardous Material</td>
</tr>
<tr>
<td>Code Orange</td>
<td>Mass Casualty Incident</td>
</tr>
</tbody>
</table>

2. **Overseeing staff** should send out the dispatch staff and supporting staff to the appropriate location. Overseeing staff will notify all staff through the overhead paging system if there is a need to evacuate the building. An email, with the subject heading reading **CODE GREEN** will be sent out to ensure that external staffs are aware.

   Overhead paging message: *Attention all staff “CODE GREEN”*

3. **Dispatched staff** should assess the panic situation and try to calm the situation with the help of the supporting staff using concepts from non-violent crisis training. **If community services are required, please dial 911 if it has not been done already.**

4. **Supporting Staff:** Provide dispatch staff with necessary/required assist.
HOUSING FIRE/EMERGENCY EVACUATION PROCEDURE

ALL STAFF WORKING IN THE HOUSING AREA AS NOTED ON THE LOWER LEVEL FLOOR PLAN
VACATE OUT THE BACK ENTRANCE

FIRE WARDEN: XXX
ALTERNATE: XXX

When the fire alarms sounds:

- Check the back stairwell. If unsafe, use the front stairwell – inform staff immediately of any changes to evacuation plan
- Inform any guests, clients, or staff in the Multi-purpose room and kitchen of need to exit building
- Complete an inspection starting at the front entrance and advance to the back entrance - close doors to all offices - Do Not Lock Doors
- Provide relevant information to the Supervisory Personnel that will be located outside at the main entrance
- Proceed to the muster point
- Supervisory Personnel or the Fire Department Commander will inform staff when and if they can enter the building
Appendix C – Consent to Receive Services

Welcome to HPRR Housing Program

What the Program Offers:
As part of St. John’s Plan to End Homelessness our program provides supports to those at risk of or experiencing homelessness with the goal of maintaining rental market housing and increase quality of life through

- access to housing with no barriers or housing readiness
- developing individualized Housing Plans,
- enhancing life skills, addressing health and mental health needs
- building social and community connections by engaging in activities that are meaningful to you

Your participation in this program is voluntary. HPRR is a maximum 1-year program.

The staff will use the search criteria you provide and assist you in finding housing. You are welcome to look for housing on your own, refer to the form “Guidelines for Searching on Your Own” for simple strategies and FAQ’s.

Due to low vacancy rates we try our best to accommodate housing options but ask if you’re shown three properties and choose not to accept any of them, you take the responsibility of finding the housing you want and our housing locator will inspect it to ensure health & safety standards. A lease agreement will be signed between you and the Landlord.

HPRR program staff will provide damage deposit, first months’ rent and tenant insurance for up to one year. A monthly rent subsidy is also provided as we work towards housing stability. You and your Case Manager will work together to strengthen the skills and resources needed to maintain your housing past your planned discharge date from this program.

Once housed, you and your assigned Case Manager will develop a Housing Plan outlining

- monthly subsidy,
- home visit schedule and
- personal goals determined by you to maintain your housing past your planned discharge date from this program

Role of your case manager:

- Provide information and referrals for community supports such as basic needs, health services, mental health and addiction services.
- Assistance with finding and maintaining housing
- Complete home visits
- Collaborating with you in identifying and achieving the goals established in case plan
- Assistance with getting identification, bank accounts, job training and/or education goals.
- Help you set up a budget so that you can pay all of your household expenses.
- Explore funding options from AES or other sources. If you are eligible, your Case Manager can help you with applications
- Assist you in engaging in other community and recreational resources
- Cultural Connections
- Advocacy
• **We cannot assist in any way to take legal action against landlord**

**Your role in our program**
• Pay your rent on time
• Be a respectful neighbor
• Keep open communication with your Case Manager. This is important! Not only if issues arise, but on a regular basis as we are a Harm Reduction Program and are concerned for your wellbeing.
• Keep scheduled home visits/appointments, as this time is dedicated to you to meet your goals.
• Meet with your Case Manager to complete a VAT assessment every 3 months
• Meet with your Case Manager to review and update your Housing Plan every 3 months
• Be present for walkthrough of your unit every 3 months, for first year active in the program
• Work towards independence from the program by connecting back into your community

**Confidentiality**
• Your personal information is kept confidential unless your written consent is provided to share/receive specific information
• Who the information will be shared with and why will be explained as needed
• This consent is voluntary and can be stopped at any time.
• Exceptions to Confidentiality would be:
  1) File subpoena to court
  2) Disclosure of unreported or suspected abuse of a minor
  3) Imminent harm to yourself or others
  4) Medical Emergency

**Data Collection**
Any information collected is kept in a secure location at HPRR. You will also be asked to sign a form titled “Release of Information (ROI) Form Authorization to Share Personal Information in the HIFIS” which gives us authorization to store your information in a database. Please be aware that the information being shared to the homeless foundation as well as the province is non identifiable (your name is not used only an ID number). Several agencies use the HIFIS database however they will not have access to my information unless I agree to disclose information to them. If you feel your confidentiality isn't being respected, refer to the grievance procedure provided at intake.

**Reasons you can be evicted:**
• Excessive damage (extent of damage is determined by the landlord)
• Non-payment of rent, or rent consistently being paid late
• Threatening or assaulting other tenants or the landlord
• Any illegal activities
• Consistent noise complaints from other people
• Having other people live with you when they are not on the lease
• **Not all eviction notices are 14 days; some can be as soon as 24 hours**

**If you get evicted maintain regular contact with your Case Manager so we can work together to find another housing option**

**Reasons for unplanned discharge from our program**
• Abandons unit, with no notice to Case Manager
• Endangers safety of others (Including but not limited to verbal, physical, sexual threats or assault towards tenants, landlord or staff)
• Excessive and ongoing damage to rental unit

The Case Manager will ensure all efforts are made to resolve issues prior to an unplanned discharge, through:
  • Mediation
  • Conflict resolution
  • Landlord/building operator negotiations
  • Options for housing transfer

Threats or violence towards any HPRR staff will not be tolerated and will result in discharge from program.

When will I be ready to Graduate/Planned Discharge?
  • You and your case manager mutually agree that you are stable in your housing and do not require case management
  • You have maintained housing at the same residence for at least 3 months
  • You have successfully met the goals outlined in your case plan
  • You have completed and submitted an application to Calgary housing. Calgary Housing is the ultimate affordable housing option. If accepted to Calgary Housing HPRR can no longer provide subsidy.
  • You have a bank account
  • Your taxes are up to date
  • You have photo identification
  • You are connected to a meaningful activity identified by you
  • You have a landlord reference
  • Your VAT score has decreased over time
  • Your case manager has provided you with a formal letter indicating your graduation date as well as other pertinent information outlined in Discharge Summary

By signing this form you understand the expectations of this program and that HPRR is a voluntary program and your consent to receive services can be revoked at any time.

__________________________________________  _________________________________________
Participant Name(print)                       Case Manager Name (print)

__________________________________________  _________________________________________
Participant Signature                          Case Manager Signature

__________________________________________  _________________________________________
Date                                           Date

Copy offered, declined ☐
Appendix D – Clients Rights

HPRR Housing Program

Participant Rights

Individuals participating in HPRR Housing Program have the right to...

- Be treated with dignity and respect
- Be treated with sensitivity towards their cultural beliefs and connected to appropriate resources
- Keep their personal information confidential unless written consent is provided to share/receive specific information. This consent is voluntary and can be stopped at any time. Exceptions to this would be: 1) File subpoena to court, 2) Disclosure of unreported or suspected abuse of a minor, 3) Imminent harm to yourself or others, 4) Medical Emergency
- Meet with their case manager in a safe and comfortable environment
- Receive service voluntarily and/or Exit the program at any time
- File a complaint, grievance, appeal (please see Grievance Procedures Form)
- Direct their own Housing Plan and set personal long term goals
- Have support (advocacy) to access referrals to other services

<table>
<thead>
<tr>
<th>Participant Signature</th>
<th>Date (mm/dd/yy)</th>
<th>Case Manager Signature</th>
<th>Date (mm/dd/yy)</th>
<th>Offered Copy, Declined (✓)</th>
</tr>
</thead>
<tbody>
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</table>
Appendix E – Consent and Permission form

Release of Information (ROI) Form
Authorization to Share Personal Information in HIFIS

The use of the HIFIS to manage client information is subject to the protection of personal information provisions of the Access to Information and Protection of Privacy Act, 2015 (ATIPPA, 2015). A copy of the HIFIS Privacy Policy and further reading describing the privacy practices is available upon client request.

<table>
<thead>
<tr>
<th>Client Name (Print)</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
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Dependent children, if any (first and last names and dates of birth) who are receiving services and for whom the parent is providing consent:

<p>| | |</p>
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I UNDERSTAND THAT:

- My consent to share information is voluntary, and that failure to provide consent will not result in any adverse decision about my rights, benefits or services, other than limiting the ability of the organizations to work together on my behalf.
- I have been asked to disclose my individually identifying program information, and have been informed of the risks or benefits of consenting, or refusing to consent, to such disclosure. I further understand that I may revoke this consent at any time, in writing, and no new information will be shared.
- I may consent to the sharing of personal information on behalf of minor children for whom I have legal guardianship, or for other persons for whom I am a legal representative.
- I may ask for my record to be inactivated at any time whereby it will no longer be visible to participating agencies.
- I have a right to see a current list of HIFIS Participating Agencies. I understand that additional agencies may join the Calgary HIFIS at any time, but these agencies will not have access to my information unless I agree to disclose information to them.
- This consent to share information will end in 3 years.
- Hard copies of your information will be kept confidential in a secured area of HPRR for a minimum of 7 years and on HIFIS electronic database indefinitely.

☐ I do consent to the use and disclosure of my personal information for the participation in the Calgary HIFIS.

Dated and effective as of __________________________ (Day/Month/Year)

<table>
<thead>
<tr>
<th>Signature of Client</th>
<th>Print Client’s Full Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Witness</th>
<th>Print Witness’s Full Name</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

I hereby authorize:

<p>| |</p>
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<tr>
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</thead>
</table>
HPRR Case Management

to use and disclose my individually identifying personal information from my client file to and between the service providers below:

☐ ____________________________  ☐ ____________________________
☐ ____________________________  ☐ ____________________________
☐ ____________________________  ☐ ____________________________
☐ ____________________________  ☐ ____________________________
☐ ____________________________  ☐ ____________________________

Check the information you wish to share:
☐ Share everything with Agency(s) listed above
☐ Client Record (Name, Alias) [if not shared, other items cannot be shared]
☐ Client Demographics (Date of Birth, Gender, Ethnicity)
☐ Universal Data Elements (Postal Code, Neighborhood, Immigration/Citizenship, Primary Residence, Prior to Program Entry, Disabling Condition)
☐ Program entry/exit dates
☐ Case Manager Details
☐ Case Plans: Notes, Goals, Action Steps
☐ Program Assessments

ATIPPA DISCLAIMER

This personal information is being collected under the authority of Section 33(c) of the Freedom of Information and Protection of Privacy Act (the “ATIPPA Act”) and/or in accordance with any applicable agreements in place. All personal information collected during the registration process, during the course of the client’s stay, and for participation in any programs will be used to provide services and ensure a safe and secure environment of all our clients. All personal information stored on the HIFIS will be treated in accordance with the privacy provisions of Part 2 of the ATIPPA Act. Limited, de-identified information may be provided to the Minister, AES for the purpose of carrying out programs, activities or policies under his or her administration (e.g. research, statistical analysis) or for receiving provincial and/or federal funding. If you have any questions, contact HPRR at XXXX.

Statement of Use:
The Calgary Homeless Management Information System (HIFIS) is a web based, electronic client management information system providing a standardized assessment of client needs, individualized Housing Plans and service records. The Calgary community utilizes the HIFIS to understand the nature of homelessness, develop policies and initiatives to address homelessness, and coordinate case management services. The HIFIS is managed by the NLSA. Personal information that is collected will be used only for the purpose of providing counseling and intervention services. Services will be delivered primarily by the service providers. Where services need to be delivered by extended service providers, information will only be disclosed to them with consent. Information will not be used for any other purpose, unless required by law, and will only be disclosed to external parties with the consent of the individual to whom it pertains.

Authority:
ATIPPA s.33(c), the personal information is being collected on behalf of the Government of NL AES or another ATIPPA public body, and it is necessary for the operation of homeless programs being delivered on behalf of those public bodies. This consent to share information will expire 3 years from the date of signing.
Appendix F – Consent and Permission Form

Participant Consent & Permission

It may be necessary to share information with other care providers for the purpose of providing support services, and/or case management services, and reporting to the funder(s). This consent gives permission for HPRR staff to collect, release, and gather your personal information. HPRR staff will not release additional information above the specified purpose and matter being addressed. Hard copies of your information will be kept confidential in a secured area of HPRR for a minimum of 7 years and on HIFIS electronic database indefinitely.

This consent will expire 1 year upon signing and you can withdraw your consent at anytime. The case manager must update the consent whenever a service organization not mentioned below becomes a part of your case plan.

If you are at risk of self-harm, suicide, harm to others, or if there are child protections concerns, then HPRR must contact the appropriate authorities under the law or your file is subpoenaed for court.

I, _______________________________ (full name), Date of Birth: ______________, consent to the release of information recorded and gathered related to the services received at HPRR Health and Education Centers for myself and my child(ren) (full names) to the following:

<table>
<thead>
<tr>
<th>Participant Initials:</th>
<th>Examples</th>
<th>Who: (If applicable)</th>
<th>Reason:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPRR Housing Support Worker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal Friendship Centre</td>
<td></td>
<td>Any information that may assist in accessing/maintain cultural connections.</td>
<td></td>
</tr>
<tr>
<td>AES</td>
<td></td>
<td>Income support information or any information that may assist in accessing benefits.</td>
<td></td>
</tr>
<tr>
<td>Food Bank</td>
<td></td>
<td>Any information that may assist in accessing food.</td>
<td></td>
</tr>
<tr>
<td>NL Housing</td>
<td></td>
<td>Wait list information or any information that may assist in accessing either housing or subsidy.</td>
<td></td>
</tr>
<tr>
<td>Landlord/Property Management Company</td>
<td></td>
<td>Any information pertaining to lease agreement/accessing and maintaining housing.</td>
<td></td>
</tr>
<tr>
<td>Neighbourlink/Interfaith/Care Connect</td>
<td></td>
<td>Any information that may assist in accessing furniture and/or other basic needs.</td>
<td></td>
</tr>
<tr>
<td>Medical Clinic and/or Women’s Health Clinic</td>
<td></td>
<td>Any information that may assist in accessing/maintaining your mental and physical well-being.</td>
<td></td>
</tr>
</tbody>
</table>

And/Or
<table>
<thead>
<tr>
<th>Participant Initials:</th>
<th>Other (please list names and/or organizations, e.g. child welfare, probation, police, private practitioners, family doctor, family/friends, etc.)</th>
<th>Reason:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Date: ______________________________  Witness: ___________________________

Participant Signature: ________________  Witness Signature: ________________

Guardian/Relationship to participant: ___________________________________________________

*HPRR will make every reasonable effort to protect the confidentiality of your personal information under Privacy Act (federal), the Personal Information Protection and Electronic Documents Act (PIPEDA), the Freedom of Information and Protection of Privacy (ATIPPA) Act. Your information will be shared with City of St. John’s as per HPRR funding agreement(s). If you have any concerns, please contact the HPRR Privacy Officer at 403-221-8787.*
Appendix G – Crisis Supports

Date____________________

Participant Signature (Received copy) ________________________________

Insert System Coordination Referral Guide
Appendix H – VAT Assessment Tool

VAT SUMMARY

Participant: __________________________
Offered a copy, if declined (please check) □
Date: __________________________
Initial, Housed, 3, 6, 9, 12, Final (Please Circle)
Completed By: __________________________

<table>
<thead>
<tr>
<th>Item</th>
<th>Dimension</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Survival Skills</td>
<td></td>
<td><strong>Vulnerability, safety, dependency on others, ability to maneuver independently in safe manner, judgment</strong></td>
</tr>
<tr>
<td>1.1</td>
<td>No evidence of vulnerability</td>
<td>1</td>
<td>Strong survival skills; capable of networking and self-advocacy; knows where to go and how to get there; needs no prompting regarding safe behavior</td>
</tr>
<tr>
<td>1.2</td>
<td>Evidence of mild vulnerability</td>
<td>2</td>
<td>Has some survival skills; is occasionally taken advantage of (e.g. friends only present on paydays); needs some assistance in recognizing unsafe behaviors and willing to talk about them.</td>
</tr>
<tr>
<td>1.3</td>
<td>Evidence of moderate vulnerability</td>
<td>3</td>
<td>Is frequently in dangerous situations; dependent on detrimental social network; communicates some fears about people or situations; reports being taken advantage of (e.g. gave $ to someone for an errand and person never returned or short changed)</td>
</tr>
<tr>
<td>1.4</td>
<td>Evidence of high vulnerability</td>
<td>4</td>
<td>Is a loner and lacks &quot;street smarts&quot;; possessions often stolen; may be &quot;befriended&quot; by predators; lacks social protection; presents with fearful, childlike or helpless demeanor; has marked difficulty understanding unsafe behaviors; is or was recently a DV victim; may trade sex for money or drugs</td>
</tr>
<tr>
<td>1.5</td>
<td>Evidence of severe vulnerability</td>
<td>5</td>
<td>Easily draws predators; vulnerable to exploitation; has been victimized regularly (e.g. physical assault, robbed, sexual assault); often opts for the street to shelters; no insight regarding dangerous behavior (e.g. solicitation of sex/drugs); clear disregard for personal safety (e.g. walks into traffic)</td>
</tr>
</tbody>
</table>

Additional Comments

<table>
<thead>
<tr>
<th>2</th>
<th>Basic Needs</th>
<th></th>
<th>Ability to obtain/maintain food, clothing, hygiene, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>No Trouble Meeting Needs</td>
<td>1</td>
<td>Generally able to use services to get food, clothing, takes care of hygiene, etc.</td>
</tr>
<tr>
<td>2.2</td>
<td>Mild Difficulty Meeting Needs</td>
<td>2</td>
<td>Some trouble staying on top of basic needs, but usually can do for self (e.g. hygiene/clothing are usually clear/good)</td>
</tr>
<tr>
<td>2.3</td>
<td>Moderate Difficulty Meeting Needs</td>
<td>3</td>
<td>Occasional attention to hygiene; has some openness to discussing issues; generally poor hygiene, but able to meet needs with assistance (e.g. prompting and I&amp;R (Information and Referral))</td>
</tr>
<tr>
<td>2.4</td>
<td>High Difficulty Meeting Needs</td>
<td>4</td>
<td>Doesn’t wash regularly; uninterested in I&amp;R or help, but will access services in emergent situations; low insight re. needs</td>
</tr>
<tr>
<td>2.5</td>
<td>Severe Difficulty Meeting Needs</td>
<td>5</td>
<td>Unable to access food on own; very poor hygiene/clothing (e.g. clothes very soiled, body very dirty, goes through garbage &amp; eats rotten food) resistant to offers of help on things; no insight</td>
</tr>
<tr>
<td>3</td>
<td>Indicated Mortality Risks</td>
<td>Mortality Risks</td>
<td></td>
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<td>--------------------------------------------------------------------------------</td>
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<tr>
<td>3.1</td>
<td>Has none of the 8 identified risk factors</td>
<td>1. More than three hospitalizations in 12 months; 2. More than three ER visits in previous three months; 3. Aged 60 or older; 4. Cirrhosis of the liver; 5. Renal disease;</td>
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<tr>
<td>3.3</td>
<td>Has 2 of the identified risk factors</td>
<td></td>
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<tr>
<td>3.4</td>
<td>Has 3 of the identified risk factors</td>
<td></td>
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<tr>
<td>3.5</td>
<td>Has 4+ of the identified risk factors</td>
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Additional Comments

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<tr>
<th>4</th>
<th>Medical Risk</th>
<th>Medical conditions that impact person’s ability to function.</th>
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<tbody>
<tr>
<td>4.1</td>
<td>No Impairment</td>
<td>No health complaints; appears well; would likely access medical care if needed</td>
</tr>
<tr>
<td>4.2</td>
<td>Minor or temporary health problem(s)</td>
<td>Cast or splint but able to take care of daily activities; recovering from minor surgery and doing well with self-care; acute medical problem such as a respiratory or skin infection but takes medications; follows up with medical provider</td>
</tr>
<tr>
<td>4.3</td>
<td>Stable significant medical or physical issue(s), or chronic medical condition(s) that is being managed</td>
<td>Chronic but stable medical problems such as diabetes, emphysema, high blood pressure, heart disease, seizure disorder, Hepatitis C or B, HIV disease; cancer in remission; has clinic or doctor and takes meds more often than not; smaller or larger stature/size making person vulnerable; sight or hearing impaired; has not been in hospital for overnight stay in last 3 months; OR over 60 years old w/o reported conditions but does not access care even for routine checkups</td>
</tr>
<tr>
<td>4.4</td>
<td>Chronic medical condition(s) that is not well-managed or significant physical impairment(s)</td>
<td>Poorly managed diabetes or hyper-tension, undergoing treatment for Hep C; needs home oxygen; liver failure; kidney failure requiring dialysis, sleep apnea requiring C-PAP; HIV disease not adequately treated; dementia; severe arthritis affecting several joints, pregnancy, frequent asthma flares, recurrent skin infections, cancer. Symptoms without known explanation: swelling, untreated open wounds, shortness of breath, recurrent chest pain, unexplained weight loss, chronic cough, cognitive impairment, incontinent of urine or stool. Not taking meds as prescribed or frequently loses them; can’t name doctor or last time seen; hospitalized in last 3 months; illiterate or non-English speaking.</td>
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<td>4.5</td>
<td>Totally neglectful of physical health, extremely impaired by condition, serious health condition(s)</td>
<td>Untreated AIDS, terminal illness that is worsening; missing limb(s) with significant mobility or life activity issues; obvious physical problem that is not being cared for such as large sores or severe swelling. Blind, deaf and/or mute, severe dementia, uncontrolled diabetes, refuses to seek care; breathing appears difficult with activity; can’t name or doesn’t seek regular medical care; more than one hospitalization in past year.</td>
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Additional Comments

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<thead>
<tr>
<th>5</th>
<th>Organization/Orientation</th>
<th>Thinking, developmental disability, memory, awareness, cognitive abilities – how these present and affect functioning.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>No impairment</td>
<td>Good attention span; adequate self-care; able to keep track of appointments</td>
</tr>
<tr>
<td>5.2</td>
<td>Mild impairment</td>
<td>Occasional difficulty in staying organized; may require minimal prompting re: appointments; possible evidence of mild developmenta l disability; dementia or other organic brain disorder; some mild memory problems</td>
</tr>
<tr>
<td>5.3</td>
<td>Moderate impairment</td>
<td>Appearance is sometimes disorganized; has a significant amount of belongings making mobility challenging; occasional confusion w/ regard to orientation; moderate memory or developmental disability problems</td>
</tr>
<tr>
<td>5.4</td>
<td>High impairment</td>
<td>Disorganized or disoriented; poor awareness of surroundings; memory impaired making simple follow-through difficult</td>
</tr>
<tr>
<td>5.5</td>
<td>Severe impairment</td>
<td>Highly confused; disorientation in reference to time, place or person; evidence of serious developmental disability, dementia or other organic brain disorder; too many belongings to</td>
</tr>
<tr>
<td></td>
<td><strong>Mental Health</strong></td>
<td><strong>Issues related to mental health status, MH services, spectrum of MH symptoms &amp; how these impair functioning.</strong></td>
</tr>
<tr>
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<td>-----------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>6.1 No MH issues</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>6.2 Mild MH Issues</td>
<td>2</td>
<td>Reports feeling down about situation, circumstances; (e.g. situation depression)</td>
</tr>
<tr>
<td>6.3 Moderate MH issues</td>
<td>3</td>
<td>Reports having MH issues, but does not talk about them; reports having service connection already in place; may be taking prescribed medications</td>
</tr>
<tr>
<td>6.4 High MH issues</td>
<td>4</td>
<td>Tenuous service engagement; possibly not taking medications that are needed for MH; not interested in services due to mental illness / low insight</td>
</tr>
<tr>
<td>6.5 Severe MH needs</td>
<td>5</td>
<td>No connection to services (but clearly needed), extreme symptoms that impair functioning (e.g. talking to self, distracted, severe delusions/ paranoia, fearful/phobic, extreme depressed or manic mood); no insight regarding mental illness</td>
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</tbody>
</table>

**Additional Comments**

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<tr>
<th></th>
<th><strong>Substance Use</strong></th>
<th><strong>Issues related to substance use, services, spectrum of substance use &amp; how use impairs functioning</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 No or Non-Problematic Substance Use</td>
<td>1</td>
<td>No substance use or strictly social – having no negative impact on level of functioning.</td>
</tr>
<tr>
<td>7.2 Mild Substance Use</td>
<td>2</td>
<td>Sporadic use of substances not obviously affecting level of functioning; is aware of substance use, still able to meet basic needs most of the time</td>
</tr>
<tr>
<td>7.3 Moderate Substance Use</td>
<td>3</td>
<td>Ninety (90)-180 days into addiction recovery; COD w/o any follow-up care; relapse risk still present. OR Substance use affecting ability to follow through on basic needs; has some support available for substance use issues but may not be actively involved; some trouble making progress in goals (e.g. could be a binge user.)</td>
</tr>
<tr>
<td>7.4 High Substance Use</td>
<td>4</td>
<td>In first 90 days of CD treatment or addiction recovery; still enmeshed in alcohol/drug using social group; high relapse potential. OR Use obviously impacting ability to gain/maintain functioning in many areas, (e.g. clear difficulty following through with appointments, self-care, interactions with others, basic needs); not interested in support for substance use issues but this may be due to low insight or other reasons (e.g. mental illness)</td>
</tr>
<tr>
<td>7.5 Severe Substance Use</td>
<td>5</td>
<td>Active addiction with little or no interest in CD treatment involvement. Obvious deterioration in functioning (e.g. MH, due to Sub Use); severe symptoms of both substance use &amp; mental illness; low or no insight into substance use issues; clear cognitive damage due to substances; no engagement with substance use support services (and clearly needed)</td>
</tr>
</tbody>
</table>

**Additional Comments**

<table>
<thead>
<tr>
<th></th>
<th><strong>Communication</strong></th>
<th><strong>Ability to communicate with others, when asked questions, initiating conversations.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1 No communication barrier</td>
<td>1</td>
<td>Has strong and organized abilities; no language barriers; able to communicate clearly with staff about needs</td>
</tr>
<tr>
<td>8.2 Mild communication barrier</td>
<td>2</td>
<td>Has occasional trouble communicating needs; language barrier may be an issue; occasionally reacts inappropriately when stressed</td>
</tr>
<tr>
<td>8.3 Moderate communication barrier</td>
<td>3</td>
<td>Poor attention span; withdrawn but will interact with staff/service providers when approached; pressured speech; very limited English</td>
</tr>
<tr>
<td>8.4 High level communication barrier</td>
<td>4</td>
<td>Physical impairment making communication very difficult (e.g. hearing impaired &amp; unable to use ASL); unwilling/unable to communicate w/ staff (e.g. shy, poor or no eye contact); doesn’t speak English at all</td>
</tr>
<tr>
<td>8.5 Severe communication barrier</td>
<td>5</td>
<td>Significant difficulty communicating with others (e.g. mute, fragmented speech); draws attention to self (e.g. angry talk to self/others); refuses to talk to staff when approached; may leave to avoid talking to provider</td>
</tr>
<tr>
<td>Additional Comments</td>
<td>Ability to tolerate people &amp; conversations, ability to advocate for self, cooperation, etc.</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>9</strong> Social Behaviors</td>
<td>1 Has a hx of predatory behavior; is observed to be targeting vulnerable clients to “befriend”; uses intimidation to get needs met (e.g. threatening and menacing to staff/clients); more than adequately advocates for own needs, if not overly so</td>
<td></td>
</tr>
<tr>
<td>9.1 Predatory behaviors, and/or no problems advocating for self</td>
<td>2 Mostly “gets along” in general; if staff need to approach person, s/he can tolerate input &amp; respond with minimal problems; may need repeated approaches about same issue even though it seems s/he “gets it”</td>
<td></td>
</tr>
<tr>
<td>9.2 Mildly problematic social behaviors</td>
<td>3 Has some difficulty coping with stress; sometimes has angry outbursts when in contact with staff/others; some noncooperation problems at times</td>
<td></td>
</tr>
<tr>
<td>9.3 Moderately problematic social behaviors</td>
<td>4 Often has difficulty engaging positively with others; withdrawn and isolated; has minimal insight regarding behavior and consequences; has few social contacts; negative behavior often interferes with others in surrounding; often yells, screams or talks to self</td>
<td></td>
</tr>
<tr>
<td>9.4 Has some difficulty coping with stress; sometimes has angry outbursts when in contact with staff/others; some noncooperation problems at times</td>
<td>5 Responds in angry, profane, obscene or menacing verbal ways; may come across as intimidating and off-putting to providers; may provoke verbal and physical attacks from other clients; has significantly impaired ability to deal with stress; has no apparent social network</td>
<td></td>
</tr>
<tr>
<td><strong>10</strong> Homelessness</td>
<td><strong>Length of Time Homeless</strong></td>
<td></td>
</tr>
<tr>
<td>10.1 At imminent risk of homelessness</td>
<td>1 Populations at imminent risk of homelessness are defined as individuals or families whose current housing situation end in the near future (i.e. within 2 months) and for whom no subsequent residence has been identified. These individuals are unable to secure permanent housing because they do not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or a public or private place not meant for human habitation (HPS definition).</td>
<td></td>
</tr>
<tr>
<td>10.2 Transitionally homeless</td>
<td>2 Transitionally homeless persons may be homeless for the first time (usually for less than three months) or has had less than two episodes in the past three years.</td>
<td></td>
</tr>
<tr>
<td>10.3 Episodically homeless</td>
<td>3 Episodically homeless refers to individuals, often with disabling conditions, who are currently homeless and have experienced 3 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 inhabitable location (HPS definition)</td>
<td></td>
</tr>
<tr>
<td>10.4 Chronically homeless</td>
<td>4 Chronically homeless refers to individuals, often with disabling conditions (e.g. chronic physical or mental illness, substance abuse problems), who are currently homeless and 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) (HPS definition)</td>
<td></td>
</tr>
<tr>
<td>10.5* Length of time homeless (#years)</td>
<td>Total number of years homeless; * Addition for St. John’s only.</td>
<td></td>
</tr>
<tr>
<td>Additional Comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Appendix I – Housing Plan

<table>
<thead>
<tr>
<th><strong>Housing Plan</strong></th>
<th><strong>Goal 1</strong></th>
<th><strong>Goal 2</strong></th>
<th><strong>Goal 3</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial, 3, 6, 9, 12, 15, Final (Please Circle) Planned Discharge Date:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengths/Improvements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural &amp; Professional Supports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant Responsibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Manager Responsibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time Frame to be completed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective met? Y/N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If no, will goal be continued? What changes if any need to be made? What percentage completed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Date</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Case Manager Signature</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Participant Signature</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix J - Serious Incident

### Serious Incident Report

<table>
<thead>
<tr>
<th>Incident Date &amp; Time</th>
<th>Location of Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Report Completed By**

**Name(s) of Participants**

**Names of all other workers and volunteers involved**

911 contacted?  YES / NO

**Incident Type (circle)**

- Health
- Safety
- Medical
- Other (Describe)________________

**Training Required**  YES/NO

**Restrictive Procedures**  YES/NO/NA

(If yes, describe in S.3)

**City of St. John’s Informed**  YES/NO/NA

**Legal Guardian Informed**  YES/NO/NA

---

1. List the history of events or circumstances leading up to the incident: Include a description of the setting, any indicators of the impending incident, and preventative measures taken.

2. Description of Incident: Include physical description of those involved, and observations of participants behavior that required intervention [if applicable]. Attach an additional sheet if needed.

3. Action Taken: Description of actions taken by staff and/or others involved (eg. Police, medical personal, etc.) Include those who were notified, timeline of the intervention used [if applicable]

4. Follow-up actions and recommendations

---

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5. Follow up: Recommendations for OSH committee

<table>
<thead>
<tr>
<th>Signatures</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Name:</td>
<td></td>
</tr>
<tr>
<td>Supervisor Name:</td>
<td></td>
</tr>
<tr>
<td>Senior Director:</td>
<td></td>
</tr>
</tbody>
</table>

RETURN TO HR and Inform City of St. John’s WITHIN 24 HOURS

<table>
<thead>
<tr>
<th>HR Office Use Only:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitted to OSH Committee</td>
<td></td>
</tr>
</tbody>
</table>

Follow-up with participant after incident

<table>
<thead>
<tr>
<th>Follow-up Date</th>
<th>Completed By</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Debrief with participant and others who might have been affected: Document debriefing outcomes, recommendations)</td>
<td></td>
</tr>
<tr>
<td>2. Inform participants of their rights (eg. To initiate a grievance, contact an advocate, etc.)</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix K - Serious Incident Bi-Annual Review

<table>
<thead>
<tr>
<th>Date</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In Attendance</td>
<td></td>
</tr>
<tr>
<td>Regrets</td>
<td></td>
</tr>
</tbody>
</table>

**Discussion:**

1. **Any issues with the completeness or accuracy of information? How is it being corrected?**
   - Notes here

2. **Were there any trends among the incident reports?**
   - (i.e. incidents with particular clients, staff, circumstances – time of day/month/season, etc.)
   - Notes here

3. **Any training or refreshers demonstrated as needed by the incident reports?**
   - Notes here

4. **Have reporting requirements been met?**
   - Notes here

**Other comments:**

Submitted to OHS? (circle) YES NO
## Appendix L – Discharge Summary

### Discharge Summary

| Case Manager: ____________________________ | Participant Name: ____________________________ |
| Discharge Date (M/D/Y) _____________________ | Participant offered copy of this form - Yes/NO |

### Reason for Discharge (please check):

- [ ] Planned – Participant is ready to disengage from program
  - review Housing Plan and complete VAT
  - Re-accessing service and grievance process
- [ ] Unplanned – complete remaining questions and inform re-access and grievance process
  - Abandonment
  - Non-compliance with the terms mutually agreed upon in Housing Plan
  - Endangers the safety of others. Including but not limited to verbal, physical, sexual threats or assault towards tenants, landlord or staff
  - Excessive and ongoing damage to rental unit
  - Other ________________

Please prove details of reason for **unplanned** discharge:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

### Efforts made to address issues leading to unplanned discharge (please check):

- Mediation
- Conflict resolution
- Landlord/building operator negotiations
- Options for housing transfer
- Other

Please provide details of efforts made to address/resolve issues leading to unplanned discharge:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

### If transferring to another case management program please includes:

- Transfer program contact information
  a) ____________________________
  b) ____________________________
  c) ____________________________

Acknowledgement of receipt of referral from receiving agency

Proposed Date of screening/intake with transfer program ________________

Transfer of client information (with consent)

**If you choose to re-access services provided by HPRR Housing and Supports Mainline at 403-717-0922**
Appendix M – Grievance Process

HPRR Complaints/Grievance

If at any time during your involvement with HPRR you feel that you have a serious issue, or feel that you have been treated unfairly, there is a procedure available to you.

**Step One:** Contact your Case Manager to speak with him or her about any issues that you may be having, and try to come to an agreement with them. If this does not answer your questions or concerns, or you feel that your issue has not been addressed you can:

**Step Two:** Contact the Program Coordinator at XXXX. The Program Coordinator will meet with you and your Case Manager to discuss the situation; this meeting will occur within 10 business days to help make a decision to resolve your complaint. There will be notes kept from this meeting, which will remain on your file. If this meeting does not resolve your issue, you can contact the Director of Housing within 30 days following your meeting:

**Step Three:** Appeal the decision: Contact the Director of Housing (Richard Mugford) at 403-717-0922. The Director of Housing will respond to your complain within 10 business days. A meeting will occur between the Manager, the Director of Housing, and yourself. There will be notes kept from this meeting, which will remain on your file. If within 30 days you are not satisfied with the decision made during this meeting you can:

**Step Four:** Fill out the Participant Complaint form. The Participant Complaint form can be picked up at the HPRR main site at front lobby reception desk.

**Step Five:** Submit the form in a sealed envelope. Address the envelope to the Senior Director of Operations at the HPRR main site. Give the sealed envelope to the front lobby reception desk to hand over the Senior Director of Internal Operations.

**Step Six:** You will receive follow up with a phone call from the HPRR Senior Director of Operations after one week of handing in your Participant Complaint form.

**Step Seven:** If you are not satisfied with the results from Step Five, Complete the Appeal form and follow up with the Executive Director at 403-221-8782.

**Step Eight:** If you are still not satisfied with the results, contact the City of St. John’s at XXXX.

_________________________  ________________________
Employee signature  Date

Copy Offered, Declined □

Participant Signature
Appendix N – Staff file checklist

<table>
<thead>
<tr>
<th>Employee:</th>
<th>Employee Number:</th>
<th>Start Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position:</td>
<td>Program:</td>
<td>End Date:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Y/N/NA</th>
<th>Date(s)</th>
<th>Comments (renewal dates etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resume</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Acceptance Letter</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Employment Contract</td>
<td></td>
<td></td>
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<tr>
<td>Criminal Record Check(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registration/Practice License(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driver’s Abstract</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Driver’s License</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business Car Insurance ($1 million minimum)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Review(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incident Reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Letter(s) of Reprimand</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Complaints</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appeals/Grievances</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Professional Development** (Log in Training & Development Excel Form – All Staff)

<table>
<thead>
<tr>
<th>Conference/Workshop/Certificate</th>
<th>Date(s)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
## Participant File Checklist

<table>
<thead>
<tr>
<th>Participant</th>
<th>Housed Date</th>
<th>Case Manager</th>
<th>Graduation/Discharge Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Case Management Task</th>
<th>Date Completed</th>
<th>Case Manager Initials</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intake</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Release of Information/Consent</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• HIFIS/ATIPPA Consent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• HPSS Consent &amp; Permission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Grievance/Procedure, Clients Rights</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• At Intake</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• At 3 months</td>
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<td></td>
<td></td>
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<tr>
<td>• At 6 months</td>
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<td>• At 9 months</td>
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<td></td>
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<tr>
<td>• At 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• At 15 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• At Discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Client Welcome Package (signed, review verbally offer copy)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Subsidy/Service Agreement &amp; Proof of Income (photocopy)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Initial</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• At 3 months</td>
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<td></td>
<td></td>
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<tr>
<td>• At 6 months</td>
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<td>• At 9 months</td>
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<td>• At 12 months</td>
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<tr>
<td>• At 15 months</td>
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<td></td>
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<tr>
<td>• At Discharge</td>
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<tr>
<td><strong>VAT</strong></td>
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<td></td>
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<tr>
<td>• Initial</td>
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<tr>
<td>• Move in (within 30 days)</td>
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<td></td>
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<tr>
<td>• 3 months</td>
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<tr>
<td>• 6 months</td>
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<td>• 9 months</td>
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<td>• 12 months</td>
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<tr>
<td>• 15 months</td>
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<td></td>
</tr>
<tr>
<td><strong>Case Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Initial (w/in 45 days of intake)</td>
<td></td>
<td></td>
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<tr>
<td>• At 3 months</td>
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<td></td>
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<tr>
<td><strong>At 6 months</strong></td>
<td><strong>At 9 months</strong></td>
<td><strong>At 12 months</strong></td>
<td><strong>At 15 months</strong></td>
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<tr>
<td>------------------</td>
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</tr>
<tr>
<td><strong>Final (within 30 days of grad/planned discharge)</strong></td>
<td></td>
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</tr>
</tbody>
</table>

**Important Contact List**

**Budget**

**Reporting**

- At 3 months
- At 6 months
- At 9 months
- At 12 months
- At 15 months
- Exit

**Completion of Services Letter**

**Discharge Summary** provide copy

**Copy of Cheque Requests & Invoices**

**Case Notes**

**Lease/Acknowledge of tenancy**

**Walk Through**

- Initial
- At 3 months
- At 6 months
- At 9 months
- At 12 months
- At 15 months

**Tenant Insurance**

**Landlord/Tenant/CM Agreement**

**Landlord Agreement**

**Rehouse Request (as needed)**

**Critical Incident Report (as needed) *Re-inform rights**

**Move in Requirements**

- Basic necessities
- Cell phone
- 1 week of groceries
- Mattress
Appendix P – File Audit Checklist

Case Manager – File Audit

Date:_________________________ HIFIS#_________________________ Housed Date________________

Case Manager:______________________ Client Name:__________________________

Required Documents In Each File:

**ROI**
- HIFIS/ATIPPA
- HPRR Consent

**Intake**

**Client Welcome Package – Signed (copy provided)**

**Grievance Procedure**
- Intake
  - 3 months
  - 6 months
  - 9 months
  - 12 months
  - 15 months

**Client’s Rights**
- Intake
  - 3 months
  - 6 months
  - 9 months
  - 12 months
  - 15 months

**Subsidy/Service Agreement & Income Verification**
- Initial
- 3 months
- 6 months
- 9 months
- 12 months
- 15 months

**VAT**
- Initial
- Housed (w/in 30 days)
- 3 months
- 6 months
- 9 months

**Case Plan**
- Initial (w/in 45 of intake)
- 3 months
- 6 months
- 9 months
- 12 months
- 15 months
- Final (w/30 days of Grad)

**Reporting:**
- 3 months
- 6 months
- 9 months
- 12 months
- 15 months
- Exit

**Walk-through**
- Move - in
- 3 months
- 6 months
- 9 months
- 12 months
- 15 months
Community Support Wheel

Budget

Safety Plan (if needed)

Client Contact Sheet

Important Contacts

Copy of Cheques Request

Re-housing Request (if applicable)

Client Graduation Letter

Discharge Summary

Graduation Letter for the LL

Lease/ Acknowledgement of Lease

Client Housing Agreement Letter

LL Agreement

Tenant Insurance

Participant file checklist

Check HIFIS – Entry/Exit Tab, completion of 3, 6, 9, VAT/reporting, etc

Critical Incident Reports Kept in

File

Comments:_____________________________________________________________________________________
_____________________________________________________________________________________

Signed_____________________                  Completed by_________________________
Appendix Q - Employee Request to Access File

Last Name: ______________________  First Name: ______________________

Mailing Address: ______________________________________________________

Telephone Number: __________________

Would you like to:
   a) Receive a copy _____
   b) Review it in office _____
   c) Review with the Department of Human Resources present _____
   d) Review without the Department of Human Resources present _____

What specific documentation and/or information are you requesting access to? Please provide as much detail as possible, including which program and date to be reviewed by.

Reason for why you would like to access this documentation and/or information:

Only HPRR documentation will be available as per ATIPPA legislation. Any disagreements with information in the file, can be corrected by contacting the Department of Human Resources. The Department of Human Resources will add a notation in your file showing what change(s) were made as requested.

Participant’s Signature: ______________________  Date: ______________________

Approved by: ______________________  Date: ______________________

HPRR Representative: ____________________

Print Name
Appendix R – Participant Request to Access Information

I, __________________________(Full Name, PRINT) am requesting access to my records.

I would like either:

○ Review with an agency representative
○ Copy of my file
○ Copy of the following documents:
  __________________________________________________________
  __________________________________________________________
  __________________________________________________________
  __________________________________________________________

For the purpose of:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

I would like my file copy or requested documents either:

○ Mailed to me via registered mail
○ Delivered in person.

__________________________________  ______________________________
Signature                                      Date
Appendix S – Request to Access Deceased Individuals Information

Person Requesting Access to Documentation/Information: ____________________________

Last Name: ____________________________  First Name: ____________________________

Mailing Address: ____________________________
________________________________________________________________________________

Telephone Number: _______________________

Deceased Name’s Records Requesting Access: ____________________________

Date of Birth of Deceased: ____________

Relationship of Person Requesting Access to Documentation/Information to the Deceased: __________________________________________________________
________________________________________________________________________________

I would you like to:

a) Receive a copy _____
b) Review it in office _____
c) Review with the Department of Human Resources present _____
d) Review without the Department of Human Resources present _____

What specific documentation and/or information are you requesting access to? Please provide as much detail as possible, including which program and date to be reviewed by.

Reason for why you would like to access this documentation and/or information:

Only HPRR documentation will be available as per ATIPPA legislation. Any disagreements with information in the file, can be corrected by contacting the Department of Human Resources. The Department of Human Resources will add a notation in your file showing what change(s) were made as requested.

Your Signature: ____________________________  Date: ____________________________

HPRR Representative: ____________________________  Date: ____________________________

HPRR Representative Signature: ___________________________________
Appendix T - Choices & Stella’s Memorandum of Understanding

BETWEEN:

**Stella’s Circle**
(Hereinafter called “SC”),

-and-

**Choices for Youth**
(Hereinafter called “CFY”).

This Memorandum of Understanding (MOU) between SC and CFY outlines the commitment between the two parties regarding the provision of coordinated Homelessness Prevention and Rapid Rehousing (HPRR) programming as outlined in respective service agreements with the City of St. John’s.

1. **TITLE**
Coordinated Homelessness Prevention and Rapid Rehousing (HPRR) Program Delivery

2. **BACKGROUND**

The 2014-2019 St. John’s Community Plan to End Homelessness calls for the development of Rapid Re-Housing and Prevention program interventions targeting approximately 300 individuals or 200 households at risk or experiencing transitional homelessness.

EHSJ’s Plan estimates that approximately $1.2M will be needed to realize these targets starting in Year 3 of the Plan (2016/17). Of these, $592,811.25 have been earmarked in the Plan using Homelessness Partnering Strategy (HPS) funds from 2016/17 to 2018/19.

The contract for the implementation of the Prevention/Rapid Rehousing is for about a year and a half (from September 2016 until March 2018) with the possibility of extension to March 2019 in accordance with the duration of the 5 year EHSJ Community Plan.

Building upon the existing EHSJ’s investment in Intensive Case Management (Front Step), Choices for Youth (CFY) and Stella’s Circle (SC) will partner in delivering the HPRR programming in community via respective funding agreements with the City of St. John’s. The primary delivery mechanisms for each agency will be the Brian Martin Housing Resource Centre (BMHRC) at SC and the Outreach and Youth Engagement Program (OYEP) at CFY.

The HPRR initiative will provide prevention and rapid rehousing supports on a continuum across the two agencies, recognizing fluid nature of housing instability in the target population. Staff will provide short-term assistance to individuals and families at risk of becoming homeless, or who are considered transitionally or episodically homeless. Financial supports (first-months’ rent, damage deposits,
rental/utility arrears) will be provided on a case-by-case basis, alongside landlord-tenant relations and housing location services.

The underlying rationale behind the two agencies delivering HPRR is to harmonize existing programming and leverage services already in place to build on a continuum of supports that already exists. Both SC and CFY have well documented histories of serving a high volume of clients who fit the target population for rapid rehousing and prevention. As a result, both the BMHRC and OYEP already oversee a continuum of services ranging from emergency shelter, prevention and rapid rehousing, permanent supportive and transitional housing, and intensive case management.

The HPS funds will be used to enhance current programming at OYEP and BMHRC. This will not only add additional capacity to serve the target population, but also stimulate re-alignment of current programming at the two sites towards alignment with the System Coordination Framework, adding significant value to the HPS investment.

3. PURPOSE

The purpose of this MOU is intended to outline each party’s intent to collaborate and coordinate activities in the fulfillment of their respective responsibilities in relation to the delivery of HPRR programming.

Both parties agree to:

a) Engage in as needed, ongoing, collaborative review and planning in regards to the HPRR project, in order to ensure a systematic approach to ending homelessness in St. John’s;
b) Operate the project in a manner aligned with the End Homelessness St. John’s System Coordination Framework;
c) Participate in coordinated access and assessment, performance management, and quality assurance activities as outlined in the St. John’s System Coordination Framework;
d) Participate in the Homeless Individual and Families Information System (HIFIS).
e) Work with EHSJ to secure matching resources, either matching funding or in-kind contributions from community and system partners, to deliver on the HPRR targets outlined in the Plan to assist approximately 200 households (300 individuals); the final outcome of these efforts will be reflected in respective service agreements with the City of St. John’s.
f) Work together to develop partnerships reflected in MOUs as appropriate with service providers and public systems in support of advancing HPRR objectives, particularly Thrive Youth Community Network, The Gathering Place, Salvation Army, and the Downtown Health Care Collaborative.
g) In addition, SC will be responsible for:
   i) Supporting HPRR from SC and CFY programs clients and staff with housing location and tenant-landlord relations support via existing staffing at the Brian Martin Housing Resources Centre Housing Support Workers and Landlord-Relations Specialists and Front Step Housing Support Workers.
   ii) Referring younger clients (16-24 years) in need of HPRR supports as appropriate to the CFY OYEP.
iii) Make a specific contribution to the HPRR project of senior staff to provide high-level strategic leadership and support in-kind.
iv) Clarifying the roles of current BHMRC staffing in relation to the HPRR component and reflecting this in revised job descriptions by December 31, 2016.

h) In addition, CFY will be responsible for:
   i) Supporting HPRR from SC and CFY programs clients and staff with housing location and tenant-landlord relations support via existing staffing at Front Step Housing Support Workers.
   ii) Ensuring all HPRR program staff and clients have priority access to the HPRR Family Reconnect Worker’s supports.
   iii) Referring adult clients in need of HPRR supports as appropriate to the SC BHMRC.
   iv) Make a specific contribution to the HPRR project of senior staff to provide high-level strategic leadership and support in-kind.
   v) Clarifying the roles of current OYEP staffing in relation to the HPRR component and reflecting this in revised job descriptions by December 31, 2016.

4. PARTNER LIAISON

The SC contact for this project is Gail Thornhill, Program Director.

The CFY contact for this project is Sheldon Pollett, Executive Director.

5. EFFECTIVE DATE AND TERMS OF THE MOU

   i) This MOU takes effect upon signature by authorized representatives of both the CFY and SC. The terms and conditions of this MOU will end on March 31, 2019.
   j) This agreement will be in effect from September 1, 2016 to March 31, 2019.
   k) This MOU may be amended, during the period of the MOU, with the mutual consent of both parties. Any amendment shall be in writing and signed by the parties hereto within the duration of the MOU.
   l) Both parties have the right to terminate the MOU for any reason upon sixty (60) days written notice to the other Party.

LIABILITY

   m) This MOU is not intended to create, and does not create, any legally binding obligations between the parties and no party shall have any liability to each other with respect to the matters set out in this Agreement.
   n) The parties agree and acknowledge that no joint venture or partnership or legal relationship of any kind is intended to be created by this MOU. Moreover, no party is an agent of the other and
except as otherwise provided herein, no party has authority to represent the other as to any matters, including those referred to in this MOU.

o) The parties acknowledge and agree that nothing contained in this MOU shall limit the right of each party to make decisions with regards to the governance, operation and management or any other aspect of their respective organizations.

p) Each party agrees, at all times, to indemnify and save harmless the other party’s employees or agents from and against all claims and demands, loss, costs, damages, actions, suits or other proceedings by whomsoever made, brought or prosecuted in any manner based upon, occasioned by or attributable to the execution of this MOUs or any action taken or things done or maintained by virtue hereof, or the exercise in any manner of rights arising hereunder, except claims for damage resulting from the negligence of any officers, servants, employees, or agents of each party while acting within the scope of their duties or employment.

If you are in agreement with the following terms and conditions, please have the original and one copy of this MOU signed by the appropriate delegated authority.

Stella’s Circle

___________________________________________ Date: ________________
Name, Position

Choices for Youth

___________________________________________ Date: ________________
Name, Position
End Homelessness St. John's (EHSJ)/City of St. John’s Prevention/Rapid Rehousing Program Call for Expressions of Interest

Released: March 8, 2016

The deadline for submission of all Expressions of Interest form and accompanying proof documents is **4PM, March 18, 2016.**

Please email all final Expression of Interest forms (see pg.6) and relevant attachments to Judy Tobin (709-576-8317) at jtober@stjohns.ca.

**Background**


**Rapid Rehousing** provides targeted, time-limited financial assistance and support services for those experiencing homelessness in order to help them quickly exit emergency shelters and then retain housing. The program targets clients with lower acuity levels using case management and financial supports to assist with the cost of housing. The length of stay is usually less than one year in the program as it targets those who can live independently after receiving subsidies and support services.

**Prevention** programs provide assistance to individuals and families at risk of becoming homeless. Prevention programs couple financial support (rent and utility arrears, damage deposit etc.) with case management to achieve housing stabilization. These programs stabilize those at imminent risk for homelessness using supports and connecting program participants to financial assistance; programs divert clients at the shelter door and connect clients to financial assistance.
Prevention and Rapid Rehousing programs tend to target lower acuity clients with less frequent homelessness lengths of stay and episodes (transitionally homeless). The elements of these program types can be combined to ensure a continuum of supports is in place for those at imminent risk and/or transitionally homeless. The aim is to shorten the time homeless as much as possible, where preventing a homelessness episode is not possible.

In some communities, these types of programs are delivered separately and may be specifically focused further on sub-populations (families, youth, singles being discharged from public systems, etc.). For these programs to be effective, they will need to be tailored to meet the priority needs of the St. John’s community and leverage its strengths effectively.

**Budget & Timelines**

End Homelessness St. John’s (EHSJ’s) Community Plan estimates that approximately $1.2M will be needed to realize these targets starting in Year 3 of the Plan (2016/17). Of these, $592,811.25 have been earmarked in the Plan using Homelessness Partnering Strategy (HPS) funds from 2016/17 to 2018/19.

The contract for the implementation of the Prevention/Rapid Rehousing programs is for about a year and a half (from September 2016 until March 2018) with the possibility of extension to March 2019 in accordance with the duration of the 5 year EHSJ Community Plan.

<table>
<thead>
<tr>
<th>Prevention/Rapid Rehousing Budget Projections</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HPS</strong></td>
<td>$174,356.25</td>
<td>$209,227.50</td>
<td>$209,227.50</td>
<td>$592,811.25</td>
</tr>
<tr>
<td><strong>Matching Contribution Needed</strong></td>
<td>$174,356.25</td>
<td>$209,227.50</td>
<td>$209,227.50</td>
<td>$592,811.25</td>
</tr>
<tr>
<td><strong>Combined</strong></td>
<td>$348,712.50</td>
<td>$418,455.00</td>
<td>$418,455.00</td>
<td>$1,185,622.50</td>
</tr>
</tbody>
</table>

The aim is to secure matching resources, either matching funding or in-kind contributions from community and system partners, to deliver on the targets outlined in the Plan to assist approximately 200 households (300 individuals) over the course of the investment.

EHSJ will work with selected proponents to secure additional matching resources; the final outcome of these efforts will influence the final service agreements.
Engagement Process

End Homelessness St. John's (EHSJ) has retained the services Dr. Alina Turner (Turner Research & Strategy) to facilitate the development of a Prevention/Rapid Rehousing Program model and related funding proposals for approval by EHSJ by May 31, 2016. Pending Board approval, this will result in service delivery commencing by Fall 2016 by selected community-based partners.

Dr. Turner and the local coordinator for EHSJ’s Housing First System Coordination project, Andrew Harvey, have already completed a best practices and jurisdictional review of similar program models and are in the process of consulting with key stakeholders over the coming weeks, including those with lived experience.

Expressions of Interest

Based on this early engagement phase, Dr. Turner facilitated a one-day session on March 2, 2016 during the Provincial Housing First Forum with interested community and system partners. On February 25, 2016, prior to the March 2nd session, EHSJ invited frontline agencies and system partners to inform us of their potential interests to serve in a primary or secondary role on in EHSJ's Prevention & Rapid Rehousing service model.

*Primary roles* refer to agencies engaged in the actual service delivery for the project. These agencies would hold a service delivery agreement with the City of St. John’s as the CE. Those with *secondary roles* can include agencies who may be a source of referral into the program or who provide access to their existing services to clients in the program. It can include public system partners (health, addiction treatment, corrections) who partner with the program in some fashion, or it can include a funder.

During the March 2nd session, findings from the research and consultations were shared and key elements of the Prevention & Rapid Rehousing program model for St. John’s were presented. Attendees also engaged in a discussion on next steps for implementing the model locally and some self-identified as potentially playing a primary or secondary role in implementation.
On March 8, 2016, an Expression of Interest (EOI) form was distributed by the City of St. John’s to organizations that self-identified to play either a potential primary or secondary role. The EOI form should be completed by interested potential primary providers and submitted to Judy Tobin, Housing Manager, Community Services Department, City of St. John's jtobin@stjohns.ca (T 709-576-8317) by 4pm, March 18, 2016. See Appendix 1 below for the Expression of Interest form.

Selection Process

A Sub-Committee made up of non-conflicted members of the EHSJ Board and/or additional system partners will be struck to review the Expression of Interests and make a recommendation for funding. The consultant will work with the recommended proponent(s) to flesh out the proposed direction.

An update on the results of this selection process will be shared with stakeholders during EHSJ's follow-up community forum session on System Coordination (May 3-4, 2016 at City Hall); additional community input from the Forum will be incorporated in the program development. Once finalized, the program model and necessary documents, including service agreements, will be brought to the EHSJ Board for approval on May 31, 2016.

Evaluation Criteria

Proposals will be evaluated as per the table below.

<table>
<thead>
<tr>
<th>Evaluation Criteria</th>
<th>Weight</th>
<th>Rating (1-10)</th>
<th>Score (from 1000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Proposed Program Model</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1. Alignment with Plan to End Homelessness objectives.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2. Rationale for program design and focus (data on current trends, other proof points).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3. Alignment with principles of evidence-based prevention/rapid rehousing practice in a Housing First context.</td>
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<td></td>
<td></td>
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<tr>
<td>1.4. Role of proposed program in broader homeless-serving system.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5. Proposed budget/staffing model.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Proponent(s) Relevant Experience and Qualifications</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1. Experience working with target population/delivering proposed services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2. Proposed partnerships and resources leveraged.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2.3. History of successfully delivering services with similar intent.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Innovation and Value Added</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1. Creativity in proposed approach advancing goals of community plan to end homelessness, system coordination, systems/policy change.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2. Innovative approaches to service delivery proposed.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Proposals will be evaluated and ranked according to the outline below. The evaluation will be based on a 0 to 10 scale.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Exceeds expectations; Proponent clearly understands the requirement, excellent probability of success.</td>
</tr>
<tr>
<td>8</td>
<td>Somewhat exceeds expectations; high probability of success</td>
</tr>
<tr>
<td>6</td>
<td>Meets expectations; Proponent has good understanding of requirement, good probability of success.</td>
</tr>
<tr>
<td>4</td>
<td>Somewhat meets expectations; minor weakness or deficiencies, fair probability of success.</td>
</tr>
<tr>
<td>2</td>
<td>Does not meet expectations or demonstrate understanding of the requirements, low probability of success.</td>
</tr>
<tr>
<td>0</td>
<td>Lack of response or complete misunderstanding of the requirements, no probability of success.</td>
</tr>
</tbody>
</table>
Relevant Resources

The following listing of relevant resources was shared with delegates prior to and during the March 1-3, 2016 Provincial Housing First Forum (including delegates representing organizations which had responded to EHSJ's February 25, 2016 email soliciting interest in serving in a primary program delivery role or in a secondary program supports role).

1. Homeless Prevention & Rapid Rehousing excerpt and resources from Provincial Housing First Forum Participants Guide
2. Homelessness Prevention & Rapid Rehousing presentation from Provincial Housing First Forum
End Homelessness St. John's (EHSJ)/City of St. John's Prevention/Rapid Rehousing Expressions of Interest Form

Instructions:
Please complete this form as a potential primary provider for EHSJ's prevention & rapid rehousing services.

Ensure the form is submitted by 4PM, March 18, 2016 to Judy Tobin, Housing Manager, Community Services Department, City of St. John's – jtobin@stjohns.ca; 709-576-8317.

Submit any additional ‘proof points’ to support your application, such as administrative data demonstrating demand, existing policies and procedures showing current practice model, etc.

If you are proposing to deliver the model in partnership with another organization(s), you may fill out one Expression of Interest form together; please ensure you are clear about each partner’s roles throughout the following questions.

1. Applicant Information (name, role, organization, contact number and email).

2. Proposed Program. Please briefly describe your proposed prevention/rapid rehousing program and ensure you address the following points:
   - Clarify whether you are proposing to deliver the program as prevention or rehousing, or both.
   - If you are applying as part of a partnership, clarify each partner’s roles.
   - Identify target population(s) of your proposed program.
   - Describe the types of services your proposed model would provide. If part of a partnership, ensure each partner’s roles in service delivery is clearly articulated.

3. Rationale. Provide a rationale for your proposed approach and your organization(s) role. Ensure you address the following points:
   - The strengths your organization(s) brings to this program: expertise/experience, partnerships or existing/in-kind resource you leverage.
   - Evidence supporting proposed approach (administrative data on client demand and trends, policies and practice manuals confirming service philosophy, etc.).
- Role of proposed program in the broader St. John's Homeless-Serving System. How does the program fit within existing network of services and public system supports?
- Describe any system/policy changes you see as potential longer term outcomes the program can contribute towards, such as shifts to income assistance, discharge planning practices, etc.

4. What are the estimated target numbers of clients served yearly by the program? Ensure you are clear whether you are referring to households of individuals.

<table>
<thead>
<tr>
<th>Rapid Re-Housing/Prevention Projections</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>Total Hshds/Individuals</th>
</tr>
</thead>
</table>

5. Please describe the proposed staffing model for the program. If part of a partnership, ensure each partner’s staffing is clear.

6. a) What is the preliminary budget of the program? If part of a partnership, ensure each partner’s share is clearly articulated. Ensure you articulate the budget details in terms of proportion proposed yearly for staffing, client costs (damage deposits, rental assistance, utility assistance, moving and set-up costs) and administration, etc. Below is an example template.

<table>
<thead>
<tr>
<th>Item</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing (2 FTE Case Managers @$40K, .5 Housing Locator @$40K)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Costs - Damage Deposits, Short-Term Rental Assistance, Moving costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration Costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

b) Ensure you are clear about the eligibility of these activities under HPS Directives and have reviewed these in preparing this application. We understand there are limits placed by HPS funds that may impact the final budget pending EHSJ and selected proponent(s)’ success securing matching funds. http://www.esdc.gc.ca/eng/communities/homelessness/funding/directives.shtml

If some items in your proposed budget are not eligible, can you suggest potential sources of complementary funding/in-kind supports?