



PROGRAM POLICY	
Policy #4	Engagement
Effective Date: January 1, 2011	

Policy:

Engagement refers to the process of receiving referrals through the City of Hamilton Approved Men’s Emergency Shelters, the Wesley Centre Drop-In and through providing services at the Elizabeth Fry Resource Centre and through self-referrals. These activities are defined through a service agreement between Transitions to Home and each agency-program.

Engagement in the Hamilton-Wentworth Detention Centre with adult men and women takes place when the facility’s staffs identify that an inmate could benefit with speaking to a Life Transitions Therapist and the person is willing to participate.

The primary goal in engagement is to begin the development of a trust based relationship that facilitates the long term shelter users’ or individuals’ at risk abilities to begin contemplating change. The primary changes are those involved with moving from long term shelter use to finding and maintaining stable, affordable housing. Engagement seeks the commitment of the individual to case management visits, have housing as their primary goal and their formal acceptance into the T2H program.

Long term shelter use is defined as more than 42 continuous or non-continuous nights of shelter use accumulated in a 12 month period. 42 nights in a shelter has been the accepted limit of a stay in one shelter under City of Hamilton policies. Shelter stays may now be extended beyond 42 nights at the discretion of the shelter.

Being at risk of long term shelter use is defined when two or more of the following risk factors apply to the individual:

- Lack of stable housing
- Poor Health prospects – mental and/or physical health issues
- A history of exclusion, institutionalization and/or abuse
- Behaviour and control difficulties
- Skills deficit-unemployment and poor educational achievement
- Addictions

Transitions to Home is a voluntary program, individuals must be advised they are being referred and willing to have this occur. Individuals living in an emergency shelter may also refer

themselves to the program. The absence of a referral does not prevent the Transitions to Home Case Manager from speaking with all residents in shelters, explaining the program and developing relationships. A referral signifies the willingness of an individual to formally talk about the program and contemplate change and participation.

A trust based relationship is comprised of a series of complex factors that can be simplified into three components:

1. Achieving Results

The Case Manager ensures that they fulfill the obligations and commitments they make to participants. This requires the Case Manager/Clinician entering into agreements and making commitments that they are convinced that they can follow through on. As well, agreements and commitments are not made that require agreement from the broader team and/or Supervisor/Director prior to the Supervisor, Case Manager/Clinician gaining this agreement.

2. Acting with Integrity

Integrity is demonstrated through honesty in ones' words and consistency in actions. Transitions to Home as a program does it's best according to it's resources to do what it says it will do in regards to its' commitments and obligations to participants, landlords and other programs. Supervisors, Case Managers/Clinicians reflect this through following the programs policies and fulfilling agreements both formal and informal with participants and partners.

3. Demonstrating Concern

Individuals and organizations trust those who they believe understand their concerns and will act in a manner that meets and accommodates or at least does not conflict with their needs.

Transitions to Home (T2H) will also advocate and reflect the concerns and needs of the broader group of low income individuals that are living with unstable housing. As well the program works for the better interests of individuals who have experienced trauma in their lives and/or present with symptoms of addictions, mental illness, brain injuries. This involves advocacy within the service system and raising difficult questions when these arise.

Transitions to Home strategies in developing relationships are trauma informed and are designed to be non-authoritative. The program is voluntary, it's actions seek to empower the individual, reconnect them and from the participant's perspective, differentiate itself from past experiences with social service agencies. Further, the Case Manager breaks down the program process into small achievable steps for the participant.

Abandon No One

Policy 1-Program Principles introduces the Hamilton Emergency Services Integration and Coordination Cmt. principle of Abandon No One. This Committee defines this principle s application as no one is left unconnected to services . Under this principle if T2H is unable to provide service to an individual it is obligated to ensure that the individual finds access to the appropriate service or services.

Current Application:

Referrals

Individuals may self refer or be voluntarily referred to Transitions to Home by program partners. A copy of the referral information that is collected is provided in the Appendix of this policy. The program views the potential participant as being in a stage of pre-contemplation to T2H and housing supports when they are referred. It is the goal of the engagement stage for the Case Manager to move with the participant through a stage of contemplating change to making a formal commitment to change through the creation of a case plan.

Through service agreements formal referrals to Transitions to Home are accepted from the Salvation Army, Mission Services and Good Shepherd Centres Inc. shelter programs and the Wesley Urban Ministries Drop-In program. Case Managers will strive to form relationships with all shelter residents and discuss the program. Shelter workers from time to time may request that the Case Manager make contact with an unwilling individual to provide program information and begin to develop a relationship in order to encourage future participation.

Other partners, specifically Elizabeth Fry, Mental Health Street Outreach Team and Housing Help Centre from time to time will refer individuals or elect to “share the case” that meet the T2H mandate of long term shelter use or at risk.

City of Hamilton Approved Hostel Services Providers

Engagement and referral services are provided to City approved hostels and the Wesley Urban Ministries Drop-In through service agreements. Assigned T2H staff are expected to insert themselves into the shelter routines according to these agreements for the full time specified. As soon as possible the referred individual is contacted in the shelter by a T2H representative and queried about participation in the program. This is a short conversation. If the individual is interested a follow up meeting is scheduled to begin the engagement process. A Case Manager will be assigned to the individual at the next team meeting.

Elizabeth Fry Resource Centre

A Case Manager is attached to the Elizabeth Fry Resource Centre every Monday. No referral is required contact is made on a drop-in basis between 11 am and 4 pm.

Hamilton-Wentworth Detention Facility

The Bridge program attached to Hamilton-Wentworth Detention facility refers incarcerated individuals to Transitions to Home – Clinical Services who have a history of shelter use, are at risk of homelessness upon release and intend to reside in the City of Hamilton. The purpose of a referral is for the individual to speak with a Life Transitions Therapist to discuss change and/or choose to enter a course of therapy while incarcerated.

Case management services to inmates who will be released are most often provided by the Housing Help Centre (men) and the Elizabeth Fry Society (women), having in some circumstances T2H Case Managers will also provide assistance.

Engagement

The process of engagement is described in the Appendix B.

Length of Shelter Stay

In general the maximum length of stay in any one shelter is set at 42 nights by City of Hamilton policy. This can be extended according to the following:

- Individual shelter users can be extended beyond 42 days, in consultation with T2H and the hostel managers, on a case by case review.
- The expectation is that long term clients are engaged with T2H, fulfilling responsibilities they have within the shelter and the T2H involvement / case plan are being discussed with the hostel representatives.

It is important for T2H and the City to understand who is being extended, and reasons noted in case files, so that the extended length of stay does not work against evaluating the basic shelter services as this may impact on performance measures.

Approval:

Signature & Title	Date Approved



REFERRAL TO TRANSITIONS TO HOME

Organization:

- Organization selection checkboxes: Good Shepherd Men's, Mission Services, Elizabeth Fry, Housing Help Centre, Wesley Drop-In, Good Shepherd Mary's Place, Salvation Army, Mental Health Outreach Team (MHOT), Other.

PARTICIPANT INFORMATION

Referral Date: Last Name: First Name:

DOB (dd/mm/yy): SIN: Gender:

Languages Spoken: Housing Status:

Source of Income: Ontario Works ODSP Other

Length of Time Spent in Shelters in the previous 12 months (# of Nights):

If less than 42 nights, complete the following:

Risk Factors - individual has at least two of the following characteristics:

- Risk factor checkboxes: Lack of stable housing, A history of exclusion, institutionalization and/or abuse, Behaviour and control difficulties, Skills deficit-unemployment and poor educational achievement, Addictions.

Referring Worker: Date:

COMMENTS:

PARTICIPANT SELF-STATEMENT INFORMATION

I need help with the following (please tick all that apply):

- Self-statement checkboxes: Housing, Budgeting, Shopping, Cooking, Laundry, Education, Getting Disability, Relationships, Medical Treatment, Transportation, Personal Care, Employment/Income, Dental Treatment, Social Recreation, Alcohol Use, Drug Use, Other (Specify).

Signed Consent to Share Information of File

Shelter Assessment Completed

Appendix B

Engagement Steps

Assessment-Referral Stage

1. Engagement visit at shelter
2. Referral received from shelter
3. Initial contact made with individual that day
4. Referral contact provided back to shelter on that day before CM leaves
5. Referral is input into T2H-COTS
6. If individual interested in exploring case management-housing, client is assigned a Case Manager
7. If individual is without income verify with OW Worker that individual is eligible for OW and that he/she does not have an active address
8. Creating the T2H-COTS File
 - Refer to COTS User Handbook, CO-07-01 Data Entry Order, At referral and At Initial Client meeting, complete all steps

Contemplation Stage

8. Use Participant Profile Working Assessment as guide to collecting information in draft form
9. Begin to elicit change
10. Raise Doubts
 - Query extremes- what is the worst that may happen-what are the best things that may happen
 - What helps, what doesn't help?
 - What is important to them?
 - Are they satisfied with life?
11. Come along side – “join”, side with ambivalence – perhaps these (living in the shelter, getting high, drinking etc.) are so important to you that you won't give it up no matter the costs or benefits
12. Establish benchmarks through scaling
13. Explore goals and values– what are their guiding values, what do they want in life
14. Through course of engagement meetings create case plan
15. Case Presentation - report back to T2H team on participant's commitment to T2H

Individual Becomes a T2H Participant

16. A case plan is in place or nearing completion demonstrating the individual is committed to Case Management – confirmed at a team meeting-Profile information collection is completed
17. Case Plan and participant Profile Assessment information are input into COTS
18. Insure individual is transferred to a T2H OW Worker
19. Verify OW – ODSP income amount with OW Worker
20. Discuss with shelter staff if an extension will be required
21. Assess feasibility-desire for shared accommodation or single room
22. Explain housing allowance system and availability
23. Explain unit availability and process
24. Complete Access to Housing Paperwork paper work during a meeting
25. Deliver *Access to Housing* paperwork to ATH
26. Progress to housing as quickly as possible based on existing housing resources (on average no longer than 4 months from referral date to move date)
27. Check with Life Transitions Therapist regarding shared client, concerns-strengths regarding housing