Memorandum of Understanding

Coordinated Intake and Referral Pilot – Community/Research Partnership

June 2017 to May 2018

Background and Intent

The community of Abbotsford, through a contribution agreement with Service Canada-Homelessness Partnering Strategy, Research and Innovation funding stream, was provided with the opportunity to design, implement and evaluate a coordinated intake and referral model adapted to local needs of individuals experiencing chronic and episodic homelessness. It is an opportunity to work on an aspect of a community-wide systems approach to responding to homelessness. Evidence –based research and literature on homelessness suggest that coordinated intake and referral is an important aspect of a system response to homelessness to ensure more timely and effective options to prevent, interrupt and end homelessness for people.

Challenges considered in design development:

- The low vacancy rate, rental increases and loss of rental stock housing with rents that people can afford.
- Increase in homelessness due to changing housing market, such people experiencing first time homelessness, including families and seniors.
- Limited housing supports to help those experiencing chronic and/or episodic homelessness acquire, maintain and retain housing.
- Increased chronic and complex health and social needs of vulnerable populations

The goal of this project will be to advance the Abbotsford Homelessness and Prevention and Response system by creating a sustainable foundation for the Housing First approach. Related objectives of the project include:

- Aligning existing intake and referral activities to better connect homeless populations to appropriate service, including Housing First support services that are identified as being necessary.
- Promoting partnerships among key stakeholders – including landlords and intentionally work collectively and collaboratively toward better alignment of services
- Establishing a community-wide tracking system or database and performance management system.

The focus for this project is employing a Social-Community infrastructure approach that shifts from programmatic/emergency response to a community-wide systems approach to prevent/divert people from becoming homeless and focus on bringing people into service that have not historically been connected (chronic/episodic homeless). Coordination will improve access and support for system navigation. The assessment process will prioritize individuals with the highest need, with referral, during the pilot project, to the Interagency Housing Allocation and Healthcare Team

Operational Definitions/Contextual Definitions, for purposes of the pilot

Abbotsford Homelessness Prevention and Response System – using the Integral Strategy Roadmap process, the response system was developed through collaborative, cross-sectoral input. The roadmap reflects the strategies of the Homelessness Action Plan and the guide to activating a system of care in response to homelessness.

Homelessness defined by Canadian Observatory on Homelessness and Homelessness Partnering Strategy:

- Describes the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioural or

physical challenges, and/or racism and discrimination. Most people do not choose to be homeless, and the experience is generally negative, unpleasant, stressful and distressing.

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

Housing First - an approach that provides housing first and combines the housing with supportive treatment services in the areas of mental and physical health, substance abuse, harm reduction, education, employment and other services that support the goals of the individual.

Three Streams of Services for Addressing Homelessness - community supports and health services are categorized according to mandate of services in the following categories: prevention, emergency response and housing accommodation and supports:

Prevention– refers to policies, practices, and interventions that reduce the likelihood that someone will experience homelessness. It also means providing those who have been homeless with the necessary resources and supports to stabilize their housing, enhance integration and social inclusion, and ultimately reduce the risk of the recurrence of homelessness.

Emergency Response – refers to providing emergency supports like shelter, food and day programs while someone is homeless.

Housing Accommodation and Supports - refers to the provision of housing and ongoing supports as a means of moving people out of homelessness.

Coordinated Intake and Referral - standardized systems approach to ensure those with greatest need are served first, matches people experiencing homelessness with best service available to meet their needs and to access services they need and are eligible, for without having to call or visit multiple social service programs. Elements of Coordinated Intake and Referral include:

Coordinated Access – processes that facilitate access to housing and services for people experiencing homelessness or are at-risk of homelessness. It may also be referred to as no wrong door, single entry to services. A hybrid model of access includes a hub location as well as satellite locations to meet unique needs of specific groups of people experiencing homelessness.

Coordinated Assessment – processes to determine the appropriate level, intensity and frequency of supports. The Vulnerability Assessment Tool will be used as a part of the process, to collectively assess the need of individuals at intake for matching to level of support.

Assignment – Within the pilot project term, assignment will be a referral to the Interagency Housing Allocation and Health Care Team for final decision.

Data Systems – Within the pilot project, data systems will be used to collect information for referral management, progress tracking, system monitoring and performance management.

Intake Function – a single point of entry to access to housing and health and social supports, prevention and diversion services and liaison to Assertive Community Treatment

Interagency Housing Allocation and Health Care Team – a cross-sectoral team providing case planning and wraparound supports to people who hard to reach and most vulnerable among those experiencing homelessness. This is the service for referral during the pilot project.

Guiding Principles

Pathways that lead into homelessness are as varied as the people who experience homelessness and pathways out of homelessness are unique to each individual. It is acknowledged that there is a need for strategies to interrupt homelessness through flexibility, responsiveness and support of the goals and desires of the person experiencing homelessness and sticking with them however long or how many times it takes. The housing first philosophy and principles that support the Abbotsford Prevention and Response to Homelessness System include no wrong door approach, immediate access to housing with no readiness conditions, a person's right to self-determination and choice, individualized, person driven supports, recovery orientation, including harm reduction, and social and community integration.

The following values are intended to be reflected in services and supports to people experiencing homelessness and the collaborative work of the service providers and community that come together in this project.

- Continuity and consistency in the spirit of collaboration
- Inclusionary language
- Collaborative in nature and action
- Use of collective impact conditions – common agenda, shared measurement system, mutually reinforcing activities, continuous communication and backbone organization
- Covenant of relationships/ mutual engagement
- Sustainable cultural shift to systemic approach
- Alignment of service activities
- Shared client-centred outcomes
- Client's voice and personal agency are acknowledged and incorporated

Eligibility Determination:

Participation by persons served is voluntary. Through the intake function, people who have experienced chronic or episodic homelessness, will access the assessment process to prioritize the vulnerability needs of individuals for referral to the Interagency Housing Allocation and Health Care team. If not referred to Interagency Housing Allocation and Health Care Team, individuals will be connected to other support services

The pilot project will focus on outreach for hard to reach individuals of moderate to high acuity level. They will likely experience:

- complex care needs that include persistent addictions,
- may have concurrent mental health disorders
- may have frequent utilization or impact to services such as hospitalization, police, city services, business and community
- may require support with activities of daily living (social integration/self-sufficiency)

Scope of Service

The pilot project will test coordinated access and assessment processes for referrals specifically to the Interagency Housing Allocation and Health Care Team. Individuals referred to the Interagency Housing Allocation and Health Care Team will be provided with client-based case planning and wraparound supports for housing, health care and social integration. Other supports will be offered to persons who are eligible, but not able to accept the referral, and to those not eligible.

Roles and Responsibilities:

A) Partners:

In the pilot project, system contact points will include places where individuals make service connections – drop-ins and shelter and outreach services, as delivered by the partners to this agreement. Through client engagement staff will identify individuals for referral. A common prescreening checklist will assist front line workers of partner agencies with initial screening of moderate to high acuity individuals to the Intake function (single system entry point). Included with the prescreening checklist will be basic referral information. To avoid duplication, if a partner has administered a VAT assessment, the assessment score will be included with the checklist

Other roles for partners include:

- providing additional background information as appropriate for the coordinated assessment,
- participation in the wraparound supports of the Interagency Housing Allocation and Health Care team where indicated,
- accepting referrals for support service to individuals not prioritized to the Interagency Housing and health Care team,
- participation in the pilot project evaluation and
- development of the privacy protocol for use during the pilot

B) Intake Function:

For the pilot project, the role of the Intake Function is coordination of assessments and referral packages for the Interagency Housing Allocation and Health Care Team. The Vulnerability Assessment Tool will be used to collectively assess the need of individuals at intake for matching to level of support. Assessment will also include other factors such as homelessness history, suitability of person and program match, person's preferences. Where a VAT assessment has not been completed in another setting, it will be administered by Intake. The Intake function will complete the data entry relating to the coordinated intake and referral process.

The VAT score include 3 divisions – low (transitional homeless), moderate (likelier to be episodic homeless) and high (likelier to be chronic homeless). Individuals prioritized to The Interagency Housing Allocation and Health Care Team will be in the moderate to high acuity range. Intake will manage referrals for individuals who are not prioritized to other supports. Where indicated, prior to the assessment process, individuals will be offered prevention or diversion supports where indicated (low acuity).

One of the key roles of the Intake function will be to enter, track, monitor and report data from this system (e.g. housing placement rates, housing retention rates, health support connections, income stabilization, and social integration connections. Data will be maintained on the number and type of referrals, as well as, client-centred outcomes regarding the engagement and retention rates of the housing, services and support connections.

Shared Outcomes

The Coordinated Intake and Referral capability outcomes identified in the Prevention and Homelessness Response Roadmap are:

IR-1 Access is well-coordinated across all service providers

IR-2 Intake and Referral clients have their needs addressed quickly and efficiently

IR-3 Intake and Referral are managed in a seamless and integrated manner

IR-4 A personalized care plan is developed with each Person experiencing homelessness

IR5 Care for each person experiencing homelessness is tailored to their individual needs and situation

Key indicators to the above outcomes are:

1. Number of persons housed.
2. Housing retention at 3, 6, 9, 12 and 18 month mark.
3. Number of persons rapidly re-housed (In this case we can track how quickly CIR is able to re-house.)
4. Number of persons prevented from becoming homeless
5. Progress toward community/social integration

Funding

- Service Canada HPS –Research and Innovation Funding –contribution agreement for CIR Research
- HPS BC Rural and Remote – Intake Function and Housing with Abbotsford Rental Connect
- FHA/BC Housing - core services for Interagency Housing and Community Care Team

Term June 1, 2017 to May 31, 2018

Ian Pollard, Executive Director, Salvation Army Date: AUG 2 /2017	Shayne Williams, Executive Director, Lookout Society Date: July 18, 2017
Kari Hackett, Executive Director, Positive Living Fraser Valley Date: July 11, 2017	Monika Verma, Executive Director, SARA For Women Date: July 21, 2017
Mayor Henry, Braun City of Abbotsford Date JUL 2 1 2017	Bill Flitton, ~~Director, Legislative Services, City of~~ Abbotsford Date: JUL 2 1 2017 WILLIAM FLITTON Corporate Officer
Sharon Forbes, Co-Director, Raven's Moon Date: July 20, 2017	Jeanette Dillabough, Co-Director, Raven's Moon Date: July 20/17
Neil Stark, Director, Abbotsford Community Services Date: July 14, 2017	Mark Dunstan, Pastor Salvation Army Date: AUG 2, 2017

ADDENDUM

March 15, 2018

Cyrus Centre Ministries serve homeless youth at Cyrus Centre Abbotsford. Staff of Cyrus Centre has been working collaboratively with the Coordinated Intake and Referral pilot project and has requested to be signed on to Memorandum Understanding, Coordinated Intake and Referral Pilot – Community/Research Partnership – above

Other partners of the Memorandum of Understanding include: City of Abbotsford, Lookout Society, Positive Living of Fraser Valley, Raven's Moon, SARA for Women and Salvation Army.

Les Talvio, Executive Director, Cyrus Centre Ministries Date:	