Ministry of Social Development and Social Innovation

Ministry of Justice

IOM/HIP Pilot Project

Evaluation and Final Report

Winter 2013/2014

Attributions

The final report was completed by the Ministry of Social Development and Social Innovation, Ministry of Justice and BC Housing with the evaluation (Section 3) completed by the Performance, Research and Evaluation (PREv) unit of the Strategic Operations Division of the Corrections Branch, Ministry of Justice, British Columbia.

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Executive Summary

In February 2010 the Homelessness Intervention Project (HIP) Deputy Ministers/Chief Executive Officers Leadership Team reviewed the progress of the Homelessness Intervention Project and recognized the project's accomplishments as a solid success. The Leadership Team also identified the need to strengthen integration of services and community teams to benefit other vulnerable populations including those with acquired brain injuries (ABI) and Fetal Alcohol Spectrum Disorder (FASD).

In June 2010, the Ministry of Social Development and Social Innovation (formerly Ministry of Housing and Social Development) consulted with the HIP Community Program Leads and HIP key partners to explore transition point and discharge planning opportunities. [1] These consultations led to a partnership to establish the Integrated Offender Management/HIP (IOM/HIP) pilot project for the sentenced adult population participating in the IOM program at three BC Correctional facilities.

The two year IOM/HIP pilot project was launched in April 2011 at Fraser Regional Correctional Centre (FRCC) and Alouette Correctional Centre for Women (ACCW). With an Addendum to the Memorandum of Understanding (MOU) signed in December 2012 the IOM/HIP pilot project was expanded to the Vancouver Island Regional Correctional Centre (VIRCC) in Victoria and the pilot was extended to March 31, 2014. This initiative brought together the Ministries of Social Development and Social Innovation (SDSI), Justice (formerly the Ministry of Public Safety and Solicitor General) and Health (HLTH) along with BC Housing, Provincial Health Services Authority (PHSA), Community Living BC (CLBC) and the local health authorities, Fraser Health (FH), Vancouver Coastal Health (VCH) and Island Health (VIHA).

Overall, the outcomes shows support for the IOM/HIP pilot with 57 IOM/HIP clients provided with either subsidized or market housing on release from a correctional centre and the data suggests a considerable reduction in the seriousness of IOM/HIP client offences which may be a promising result for future evaluations.

An impact analysis of IOM/HIP client recidivism depends on a matched comparison sample, which was not possible, given the variable nature of these clients' needs and profiles, however it is worthwhile noting that the recidivism rate for IOM/HIP clients was 35% compared to 61% re-offence rate of medium and high risk IOM participants, as found in the recent IOM impact analysis (both rates at two years, excluding breaches). Additionally, differences between the seriousness of index and recidivating offences were determined by comparing the most serious offence (MSO) two years before IOM/HIP enrollment and up to two years post-IOM/HIP custody exit. 78% of recidivating clients had less severe MSO rankings, and 13% had increased MSO rankings after IOM/HIP, suggesting a considerable reduction in the seriousness of IOM/HIP client offences and may be promising result for future evaluations.

[1] HIP key partners included: Ministries of Health and Justice; BC Housing and Community Living BC.

Section 1 – Project Background

A. Background – HIP Pilot Project and IOM Program

1. HIP Pilot Project

Launched in 2009, the Homelessness Intervention Project was a cross-government initiative that focused on housing the chronically homeless in the five pilot communities of Prince George, Kelowna, Surrey, Victoria and Vancouver. The goal of the project was to reduce the occurrence of homelessness, particularly for individuals with severe mental health issues and problematic substance use, and to ensure access to housing, income assistance and health services to meet the needs of this vulnerable population. Partnerships were established between SDSI, BC Housing, HLTH, PHSA, local Health Authorities and community agencies.

The project's outstanding results include housing nearly 4,000 chronically homeless individuals over approximately two years, with 85 percent that remained stably housed. HIP was the recipient of the National Excellence in Public Service Delivery Award in recognition of the project's commitment to client service through integrated service delivery.

2. IOM Program

The Integrated Offender Management Program (IOM) became a full operational program (rather than a pilot project) in 2010 after an impact analysis of the IOM Pilot project showed significant reduction in recidivism.

The Corrections Branch's IOM program is used to enhance collaborative case management between correctional centres and community probation offices to support the successful reintegration of offenders. The program is administered by a team of IOM Case Coordinators (comprised of a Correctional Supervisor and a Probation Officer) who provide structure and coordination in the development of case supervision plans for high-risk offenders who are currently incarcerated and transitioning to community supervision.

Offenders who voluntarily participate in the program are engaged in the planning for their release to the community. Criteria for inclusion in the program includes; a minimum sentence of 135 days for men and 90 days for women, high risk assessment (medium where caseload allows); minimum of six months community supervision to follow release from custody, and a previous admission to custody or community corrections.

An impact analysis on the pilot sites from 2006 to 2010 was completed in 2011. The analysis, with over 525 offenders who participated in IOM, determined recidivism rates were reduced by 48% over an 18 month period. These are significant reductions in re-offending and clearly contribute to enhanced public safety.

The IOM program is currently offered at Fraser Regional Correctional Centre, Alouette Correctional Centre for Women, Vancouver Island Regional Correctional Centre and in June 2013 was expanded to the Prince George Regional Correctional Centre (PGRCC).

B. HIP in Partnership with the IOM Program

1. IOM/HIP Project Purpose

In June 2010, building on the success of HIP, the Ministry of Social Development and Social Innovation held consultations with key partners including representatives from the Ministries of Justice (JAG) and HLTH, BC Housing and CLBC around opportunities to strengthen transition points for vulnerable populations such as the homeless or those at risk of homelessness, those with acquired brain injuries (ABI) and Fetal Alcohol Spectrum Disorder (FASD).

The consultations led to the development of the Integrated Offender Management/Homelessness Intervention Project (IOM/HIP) pilot project in the Lower Mainland and in Victoria. A Memorandum of Understanding and Addendum were approved and signed between SDSI and the following key partners of the IOM/HIP pilot: JAG, HLTH, BC Housing, CLBC, PHSA and the regional Health Authorities, FH; VCH; and VIHA.

With the support of key partners and agencies providing integrated services and resources the intended outcomes of the IOM/HIP pilot project include: increasing housing stability, reducing recidivism, increasing connections to the community and increasing employability, self-sufficiency and well-being.

2. IOM/HIP Authority, Roles and Responsibilities

Major partners provide support services and resources to IOM/HIP clients. For instance BC Housing provides funding for the Homeless Outreach Program (HOP) Outreach Workers in addition to IOM/HIP client access to supportive housing; Community Living BC provides funding for adaptive functioning assessments and PHSA provides funding for full FASD diagnostic assessments as part of the provincial CLBC-led Personal Supports Initiative (PSI). Fraser Health, Vancouver Coastal Health and Island Health will continue to provide resources and services such as access to acquired brain injury assessments and other mental health services. Specific services and supports provided by key partners include:

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The HIP Key Worker, in close consultation with the IOM Case Coordinators, provides input into the Case Supervision Plan primarily focusing on the components of the transition and community releasing plans beginning 60-90 days prior to release from custody into the community. This requires coordination in the delivery of integrated services between the IOM program and community partners including access to housing, income assistance, referrals to health services and an introduction to employment planning.

Additionally, once the client is released into the community, the HIP Key Worker provides ongoing support to coordinate clients' integrated case plans with designated partners to leverage existing relationships such as Community Program Leads; other SDSI offices; Employment Assistant Workers, HOP outreach workers; community Probation Officers and after care services.

The SDSI IOM/HIP Project Manager (PM) lead provides ongoing project management oversight and coordination. The PM works collaboratively and in consultation with key partners around the Implementation Plan to ensure accountabilities are clear, timeline is reasonable and the plan is consistent with the requirements of government priorities and direction.

The SDSI PM works collaboratively and in consultation with JAG to establish IOM/HIP data collection process and tools for the Performance Measurement and Evaluation Framework under the HIP component.

The SDSI PM engages in joint communication planning with the JAG PM and co-leads IOM/HIP Community Integration Committee Meetings.

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The IOM Case Coordinators identify and screen IOM clients who are eligible to enrol in the IOM/HIP pilot project, that is, clients who are homeless or at risk of homelessness. IOM Case Coordinators, in close consultation with the HIP Key Worker and the Community Probation Officer, coordinates the IOM/HIP clients' integrated case plans both while in custody, as well as the transition and community releasing plans. The IOM Case Coordinators also support the client in identifying the area of residence for release to enable planning for access to services that include housing, income assistance, health services and supports, such as the Homeless Outreach Program Worker (HOP).

All clients enrolled in the IOM/HIP pilot project are screened by IOM Case Coordinators for FASD using the Adult FASD Screening Tool. For those clients showing a positive result, client referrals are made to the CLBC Provincial Lead to determine eligibility for the Personal Supports Initiative (PSI) and eligibility for the FASD diagnostic assessment.

The JAG IOM/HIP Project Manager (PM) provides ongoing support to project management oversight and coordination. The JAG PM engages in joint communication planning with the SDSI PM and co-leads IOM/HIP Community Integration Committee Meetings.

BC Housing

BC Housing works collaboratively with community partners to identify and remove barriers to housing for IOM/HIP clients.

BC Housing, through external service contracts, provides the *Homeless Outreach Program (HOP)*. The HOP outreach workers liaise with the IOM Case Coordinators and HIP Key Workers on a case by case basis when developing the integrated case plan for housing and support services, when clients are released from custody into communities served by the IOM/HIP project.

Ministry of Health

The Ministry of Health works collaboratively with the project manager SDSI, as well as other stakeholders identified in the MOU, to where possible, assist in removing barriers to health services for IOM/HIP clients.

Provincial Health Services Authority

PHSA funds and manages FASD diagnostic assessments for eligible clients who do not have a developmental disability and who have significant limitations in adaptive functioning.

Community Living BC

The Personalized Supports Initiative (PSI) is an existing provincial program that augments, rather than replaces existing support. Where necessary, PSI may provide funding for services such as supported living, respite, employment support, skill development, homemaker support, and development of support networks. Clients with mental health and problematic substance use are referred to Mental Health and Addictions services.

To be eligible for PSI, the client must not have a developmental disability, must have significant limitations in adaptive functioning, and a confirmed diagnosis of FASD. PSI Facilitators receive referrals of IOM/HIP clients identified by IOM Case Coordinators through the IOM/HIP FASD Screening Tool as needing a diagnostic assessment for FASD. PSI Facilitators arrange assessments to confirm that the client does not have a developmental disability and has significant limitations in adaptive function. Following those assessments, IOM/HIP clients with significant limitations in adaptive functioning are referred by the PSI facilitator for full diagnostic assessment.

For clients who are found eligible for PSI, PSI Facilitators work with IOM Case Coordinators, Probation Officers and HIP Key Workers, the clients and their family/support network to determine an individual service plan, including specific goals. Existing local supports such as home support, day programs, residential care, mental health and substance use programs, community programs are considered, when appropriate, in the support plan. Where necessary, CLBC may contract with agencies to provide supported living, community inclusion (includes skill development and employment), homemaker support and development of support networks. The plan is reviewed regularly to ensure PSI clients are supported to a level of independence consistent with their goals.

Fraser Health

Fraser Health provides assessments and/or services to eligible adults with acquired brain injury. The assessment and/or services may be provided by Fraser Health staff or a contracted service provider. Upon referral of an IOM/HIP client by the IOM Case Coordinators, Fraser Health's brain injury team will assess the client for eligibility and services. Services may include mental health and primary health services, as well as addictions treatment to eligible IOM/HIP clients.

Vancouver Coastal Health

In Vancouver Coastal Health eligible acquired brain injury (ABI) clients are referred for ABI case management through their local home and community care program. When appropriate, partnerships with the local mental health team and addictions team are also created. With the

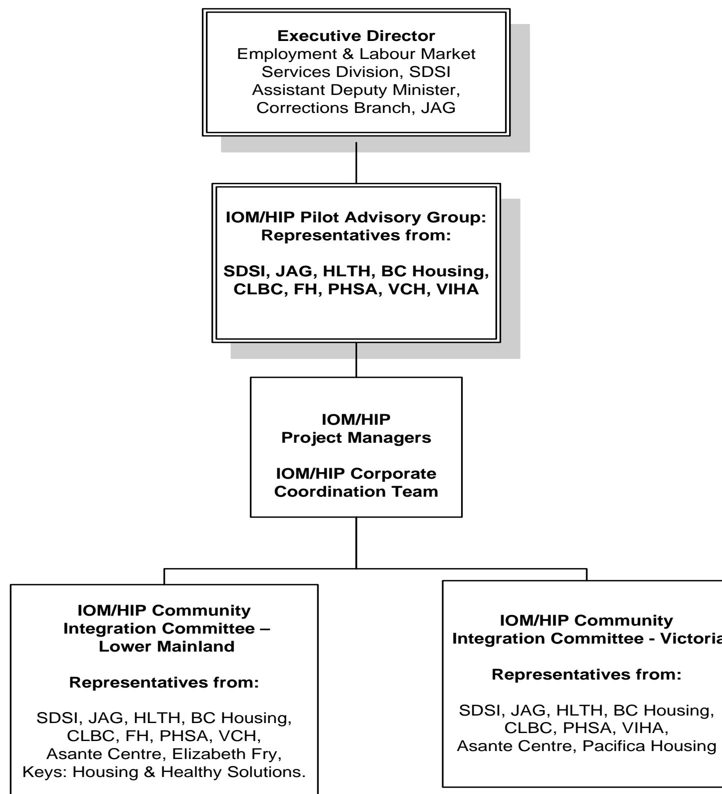
client, the ABI case manager determines a client care plan including specific goals. If specialized ABI supports are required, contracted services are made available through a regional budget. The Regional ABI lead provides contract management and consultation around appropriate use of regional resources and the case manager monitors and adjusts the services and case plan as required. Such services may include life skills support, occupational therapy/rehab assistance, counseling, and housing.

Island Health

Island Health (VIHA) provides mental health services and substance use treatment that may be provided by Island Health staff or a contracted service provider. VIHA also provides assessments and/or services for those eligible IOM/HIP clients with acquired brain injury.

3. IOM/HIP Governance and Accountability

The Lead and Co-Lead Ministries, SDSI and JAG (respectively) provide project management oversight and coordination around communications and service integration with all government and community partners and team members.



The IOM/HIP Advisory Group provides project direction and guidance as well approves project deliverables and timelines.

The IOM/HIP Community Integration Committee (CIC) is comprised of representatives from the partnerships and external service providers. IOM/HIP CIC meetings are held quarterly and are responsible for using an integrated service delivery approach to ensure IOM/HIP clients have improved outcomes such as access to housing, income assistance, health services and supports as necessary. Delivery of integrated services through partnerships has been an important factor in assisting clients to achieve success.

4. IOM/HIP Project Implementation

In April 2011, HIP in partnership with the IOM program piloted IOM/HIP to link IOM clients who are homeless or at-risk of homelessness at Fraser Regional Correctional Centre (FRCC) and Alouette Correctional Centre for Women (ACCW) with the resources and services needed at release for successful transition from custody into the community catchment area of Abbotsford and Mission west to the Coast and north to Lions Bay.

In April 2012, IOM/HIP expanded to the Vancouver Island Regional Correctional Centre (VIRCC) with the catchment area of Greater Victoria being defined as Sidney to Sooke. IOM/HIP has been implemented at VIRCC for one year and for that reason client data is not included in the two-year evaluation report for the IOM/HIP pilot project.

The IOM/HIP pilot project uses a preventative approach to support sentenced adult offenders. In collaboration, HIP Key Workers and IOM Case Coordinators strengthen service integration at transition points by working together to provide integrated case management plans for IOM/HIP clients. Additionally, each partner organization involved in serving IOM/HIP clients agrees to follow and support the client for a minimum period of six months following release.

5. IOM/HIP Project Objectives

The project objectives and strategies are to:

- Provide an integrated service delivery framework implemented through the MOU and Addendum.
- Strengthen service integration at transition points to provide IOM/HIP clients with access to housing, income assistance, assessments and supports; and assisting them to move toward employment, self-sufficiency and well-being.
- Use best practices such as service integration and collaboration with government and community partners to monitor IOM/HIP client progress for a period of six months following their release from custody to increase their connection to the community.

6. IOM/HIP Clients

IOM/HIP eligibility criteria are IOM clients at three BC Correctional facilities, ACCW, FRCC and VIRCC that are at high risk of re-offending, are homeless or at risk of homelessness, and who voluntarily

enrol into the IOM/HIP pilot project. Clients may also have mental health issues, problematic substance use, an acquired brain injury and FASD.

Essential to IOM/HIP is the voluntary nature of client participation; the client is actively engaged in the planning for their release from custody, as well as long term planning for the community. The IOM/HIP intake process ensures that access to the pilot meet clients' needs and readiness, in addition to the following criteria: availability of housing, supports and resources. Further, IOM/HIP clients provide informed, signed consent to authorize the sharing of information between each partner organization to assure optimum collaboration and integration of services.

Section 2 – BC Housing Report

A. Background

The Integrated Offender Management/Homelessness Intervention Project is a two-year pilot project developed to prevent homelessness for people leaving Corrections. The program is a partnership between the Ministries of Social Development and Social Innovation, Justice and Health along with Community Living BC, the Fraser Health, Vancouver Coastal Health, Provincial Health Services, and BC Housing. Each partner's role was established in a Memorandum of Understanding signed in early 2011.

As part of the project, BC Housing worked with non-profit homeless outreach providers to connect those IOM/HIP clients being released from custody and requiring assistance with access to outreach services and rent supplements. Homeless outreach workers would then work with the IOM/HIP clients to help them find and maintain housing.

The two non-profit homeless outreach providers who participated in the pilot project are the *Elizabeth Fry Society of Greater Vancouver* and *KEYS: Housing and Health Solutions Society*.

The details provided within this summary report are from BC Housing's Homeless Services System database.

B. Highlights

- Homeless outreach services helped to connect 57 IOM/HIP clients to housing between April 1, 2011 and March 31, 2013.
- IOM/HIP clients were housed in a combination of subsidized and private rental market housing, as well as recovery/treatment programs.
- Homeless outreach services were able to confirm that 16 IOM/HIP clients were still housed at their six month follow-up.

C. Summary Report

As part of the Integrated Offender Management/Homelessness Intervention Project, homeless outreach workers from Elizabeth Fry and KEYS in Surrey helped to connect 57 IOM/HIP clients recently released from correctional facilities with housing between April 1, 2011 and March 31, 2013.

Average Rent Payment

On average, IOM/HIP clients were being **charged** $503 for rent. Average rent payment by type of housing is as follows:

- $422 for those housed in subsidized housing/SROs
- $654 for people in the private market with a rent subsidy
- $536 for those housed in recovery/treatment programs
- $571 for those housed in secondary suites

By comparison, the average rent for a bachelor unit was $614 and $723 for a 1 bedroom unit in Surrey in Fall 2012[2]

Type of Housing

Over the two-year pilot project, IOM/HIP clients were connected to the following housing options:

- 7% were housed in the private market with a rent subsidy (4 participants)
- 30% were housed in subsidized housing, including social housing, supportive housing, and SROs (17 participants)
- 19% were housed in recovery houses/treatment programs (11 participants)
- 21% were housed in secondary suites (12 participants)
- 23% were housed in other locations, including rooms in a house or apartment, a market unit without subsidy, and friends/relatives (13 participants)

[2] Source (Average rent for Surrey): Canada Mortgage and Housing Corporation, Rental Market Report, Vancouver and Abbotsford CMAs, Fall 2012 (for private row and apartment units).

Table 1: Number of IOM/HIP clients Where Housed for Most Recent Placement, *April 1, 2011 to March 31, 2013*

Where Housed for Most Recent Placement	#	%
Apartment in market housing with rent subsidy	4	7%
Hotel/rooming house (SRO)	12	21%
Recovery/treatment program	11	19%
Secondary suite	12	21%
Social / Supported housing	5	9%
Other	13	23%
Total	**57**	**100%**

Six Month Follow Up

Elizabeth Fry and KEYS were able to complete a six month follow up on 30% of the IOM/HIP project pilot participants (16 participants) who were connected to housing.[3]

- Of those IOM/HIP clients who could be reached at six months, 94% remained housed[4].
- Of those who remained housed at six months, 44% were housed in some kind of subsidized housing, including social/supported housing, SROs (Single Room Occupancy) and market housing with rent subsidies (7 participants)
- 64% housed in recovery/treatment programs were not contacted for their six month follow up (7 out of 11 participants)
- 71% of those who were housed in market housing (including secondary suites and rooms in houses/apartments)[5] were not contacted for their six month follow ups (12 out of 17 participants)

BC Housing is in conversation with both the Elizabeth Fry Society and KEYS to ensure that all possible six month follows up are completed.

There are a number of things that can make it challenging to complete the six month follow up. A complete list has been provided in Appendix B.

[3] It is possible that participants who could not be reached for 6 month follow up were still housed, but perhaps elsewhere or they did not want to be contacted.
[4] Remained housed could include a permanent housing arrangement other than where the program participant was originally placed by the homeless outreach provider.
[5] Excludes participants housed in market housing with a rent subsidy.

Table 2: Housing Status for IOM/HIP clients at Six Month Follow Up After Most Recent Housing Placement, *April 1, 2011 to March 31, 2013*

Housing Status at Six Month Follow Up	#	%
At same address	11	65%
Housed elsewhere	5	29%
No longer housed	1	6%
Sub-total	**17**	**100%**
Could not reach – housing status unknown	12	
Did not conduct 6 month follow up[6]	28	

Source: BC Housing, Homelessness Services System, April 1, 2011-March 31, 2013 - October 10, 2013 snapshot

Data Notes:

1. *IOM/HIP clients may have been housed more than once between April 1, 2011 and March 31, 2013.*
2. *Data represents the most recent housing record within the reporting period.*
3. *HSS data is entered by providers. The accuracy of the data is dependent on provider entry.*
4. *HSS is a live database - shelter providers can go back to clean up previous data at any time. Data clean up may affect the comparability of data between time periods. All data provided in these tables are based on snapshots for a particular year and reflects what was known to be true based on data entry on that particular day.*

[6] Note: 4 of the 28 participants were the number of housing placements which did not have a 6-month follow-up. However, not all housing placements were due for a follow-up and a number of these were also not done because the client declined/refused to have a follow-up, and a few were because the client had moved to another address before 6 months, or had moved to other stable housing within the first three months of being housed. Once participants move to other stable housing, homeless outreach providers are not required to do a six month follow up. Because the snapshot used for this analysis was for the period October 2013, six month follow ups for those housed in the six months leading up to the end of the reporting period (March 31, 2013) were captured if they had been completed.

Section 3 – BC Corrections Data

A. Methodology

1. Overview

This section used data gathered through IOM/HIP client tracking sheets which identified who participated in the IOM/HIP project at Alouette Correctional Centre for Women (ACCW) and at Fraser Regional Correctional Centre (FRCC) between Feb 1st, 2011 and March 31st, 2013.

The report section includes the following information:

- The number of clients eligible versus the number of clients accepted into the project;
- Reasons clients are not accepted or removed from the project;
- Number of clients screened for FASD at intake, number referred to the Asanté Centre, and number of IOM/HIP clients diagnosed with FASD;
- Number of clients referred for an adaptive functioning assessment; and
- Rates of re-contact and rates of return for IOM/HIP clients, including a survival analysis (time between sentence end and a recidivating event).

The initial data extract was prepared in July 2013, using tracking sheets prepared and managed by IOM Case Coordinators at ACCW and FRCC. These client tracking sheets were used to identify clients, their screening and acceptance dates, and their participation in IOM/HIP.

2. Sample Selection

The data for this section was derived from the records of 458 clients (106 ACCW clients and 352 FRCC clients; including 6 repeat cases) that were evaluated for IOM/HIP participation.

3. Client Enrollment

Rates for IOM/HIP eligibility, enrollment and client referrals for clients at ACCW and FRCC are given separately. Reason for client ineligibility and removal from the project are listed, by count and by proportion.

4. Client Recidivism

Re-offence rates (sentenced offences, including and excluding breaches) and the length of time before a re-offence (survival analysis) were calculated for IOM/HIP clients released from custody at ACCW and FRCC from February 1, 2011 to March 31, 2013.

5. Most Serious Offence

An analysis of the seriousness of a reoffending event was determined by comparing the most serious offence (MSO) of each reoffending IOM/HIP client before and after project participation. MSO categories are based on a nationally standardized system and are calculated on all offenses up to two years before the current custody sentence, as compared with the MSO of any recidivating events after custody exit (up to two years after).

B. Results

1. IOM/HIP Enrollment (ACCW)

From February 1, 2011 to March 31, 2013, 106 IOM clients were reviewed for IOM/HIP eligibility, with 25% of these clients subsequently being enrolled to the project (27 of 106; see Table 3). Reasons for non-enrollment include client movements such as releases and transfers, clients declining project participation or already having secured accommodations after release.

Table 3: IOM/HIP enrollment (ACCW)[7]

	Count	Total	%
Ineligible	76	106	72%
Eligible (all)	30	106	28%
Eligible and accepted	27	30	90%
Eligible and not accepted	3	30	10%

[7] Each graph represents total and subtotal data for a given aspect, eg IOM/HIP eligibility and/or acceptance

Of the 76 clients who were ineligible for IOM/HIP assistance, the majority of clients were ineligible due to moving outside the catchment area (74%; see Table 4).

Table 4: Reasons for IOM/HIP ineligibility (ACCW)

	Count	Total	%
Ineligible	76	106	72%
Ineligible; moving outside area	56	76	74%
Ineligible; not homeless	17	76	22%
Ineligible; has existing supports	3	76	4%

Of the 27 clients enrolled into IOM/HIP, 66% were later removed for various reasons; including lack of contact with the HIP key worker and moving outside the catchment area (see Table 5).

Table 5: Reasons for IOM/HIP removal (ACCW)[8]

	Count	Total	%
Accepted to IOM/HIP and currently active	9	27	33%
Accepted to IOM/HIP and later removed	18	27	66%
Removed; has not made contact	5	18	28%
Removed; moved outside area	5	18	28%
Removed; back to custody	1	18	6%
Removed; transferred prior to release	2	18	11%
Removed; opted out / refused	5	18	28%

[8] Each graph represents total and subtotal data for a given aspect, eg IOM/HIP eligibility and/or acceptance

Part of the induction process for IOM/HIP included a FASD screen at intake. Of the 27 clients accepted into the IOM/HIP project, 23 underwent a FASD screening at intake (85%; see Table 6).

Table 6: FASD Screens (ACCW)

	Count	Total	%
Yes - FASD screen completed	23	27	85%
No - FASD screen not completed	4	27	14%

In total, four clients were referred to the Asanté Centre for further FASD testing (4 of 23; 17%). The results of these referrals were problematic, as all four of the referred clients moved before testing was complete. In a single instance, a diagnosis of "Not FASD" was likely, but was not confirmed due to incomplete records (see Table 7).

Table 7: Client referrals to Asanté Centre (ACCW)

	Count	Total	%
Not referred	21	23	91%
No; does not meet criteria	18	23	78%
No; client transferred	2	23	9%
No; not recommended	1	23	4%
Were referred	4	23	17%

2. IOM/HIP Enrollment (FRCC)

In all, 62 of the 352 clients screened were eligible for the project (18%), with 16% of these clients being enrolled. Reasons for non-eligibility are listed in Table 8.

Table 8: IOM/HIP enrollment (FRCC)

	Count	Total	%
Ineligible	286	352	81%
Eligible (all)	62	352	18%
Unknown	4	352	1%
Eligible and accepted	55	352	16%
Eligible and not accepted/unknown	7	352	2%

Seven clients were eligible, but not accepted to IOM/HIP at FRCC, since they were moved back to custody shortly after release, or refused to participate.

There were a number of reasons why clients were deemed ineligible for IOM/HIP (and IOM) assistance, with the highest proportion (41% of all ineligible clients) due to sentencing limitations such as less than six months probation or a non-reporting probation order. The top ten reasons for IOM/HIP ineligibility are listed in Table 9.

Table 9: Reasons for ineligibility (FRCC)

	Count	Total	%
Not eligible; Sentencing limitations	118	290	41%
Not eligible; capped caseload	40	290	14%
Not eligible; client transferred	40	290	14%
Not eligible; refused participation	39	290	13%
Not eligible; moving outside area	16	290	6%
Not eligible; Sex Offender	12	290	4%
Not eligible; Mentally Disordered Offender	11	290	4%
Not eligible; not homeless	9	290	3%
Not eligible; in treatment	2	290	1%
Not eligible; back to custody	2	290	1%
Not eligible; language barrier	1	290	0.5%

Of the 55 clients initially accepted into IOM/HIP, 58% of them were later removed from the project for various reasons, including refusal to participate (see Table 10).

Table 10: Reasons for IOM/HIP removal (FRCC)

	Count	Total	%
Accepted to IOM/HIP and currently active	23	55	42%
Accepted to IOM/HIP and later removed	32	55	58%
Removed; refused further participation	12	32	38%
Removed; moved outside area	4	32	13%
Removed; found housing	3	32	9%
Removed; transferred prior to release	3	32	9%
Removed; removed from project	2	32	6%
Removed; back to custody	2	32	6%
Removed; began work	2	32	6%
Removed; lost contact	1	32	3%
Removed; supports already in place	1	32	3%
Removed; died	1	32	3%
Removed; released	1	32	3%

Part of the induction process for IOM/HIP includes an FASD screen at intake. Of the 55 FRCC clients accepted to IOM/HIP, 87% underwent a FASD screening at intake (see Table 11).

Table 11: FASD screening (FRCC)

	Count	Total	%
Yes - FASD screen completed	48	55	87%
No - FASD screen not completed	6	55	11%
Unknown if FASD screen completed	1	55	2%

29% of clients screened for FASD in custody were later referred to the Asanté Centre and CLBC for an adaptive functioning assessment and a clinical determination of FASD (see Table 12).

Table 12: Asanté Centre Referrals (FRCC)

	Count	Total	%
Yes – referral sent to Asanté	14	48	29%
No - referral not sent to Asanté	34	48	71%
No – client did not meet criteria	29	34	85%
No – client refused to continue	4	34	12%
No – client back to custody	1	34	3%

In total, 14 clients were referred to the Asanté Centre for further FASD testing, with 50% of the assessment completed, and 50% not completed (see Table 13).

Table 13: Adaptive functioning assessment results (FRCC)

	Count	Total	%
Yes – Adaptive functioning assessment completed	7	14	50%
No – Incomplete assessment	7	14	50%
Incomplete – client refused to continue	2	7	29%
Incomplete – transferred	2	7	29%
Incomplete – client back to custody	1	7	14%
Incomplete – client died	1	7	14%
Incomplete – assessment ongoing	1	7	14%

Of the seven clients whose adaptive functioning assessments were completed, three clients were not diagnosed as FASD, two clients had developmental disorders one client was diagnosed with Autism and one client was diagnosed with FASD (see Table 14). The individuals with a diagnosed developmental disability, Autism and FASD are all eligible to access CLBC funded supports

Table 14: Adaptive functioning assessment diagnoses (FRCC)

	Count	Total	%
Completed – Not FASD	3	7	43%
Completed – Developmental disorder	2	7	29%
Completed – Autistic	1	7	14%
Completed – confirmed FASD	1	7	14%

3. FASD and Adaptive Functioning Results (ACCW and FRCC)

In all, 62 of the 352 clients screened were eligible for the project (18%); Table 15 illustrates the overall rates for ACCW and FRCC clients evaluated for IOM/HIP, accepted into the program, and those receiving a completed adaptive functioning assessment and/or clinical FASD diagnosis.

Table 15: IOM/HIP Activity Rates (ACCW and FRCC)

	ACCW			FRCC			Overall		
	Clients	Total	%	Clients	Total	%	Clients	Total	%
Evaluated for IOM/HIP	106	106	100%	352	352	100%	458	458	100%
Accepted	27	106	25%	55	352	16%	82	458	18%
FASD screen	23	27	85%	48	55	87%	71	82	87%
Asanté and CLBC Referrals	4	23	17%	14	48	29%	18	71	25%
Completed Evaluations	0	4	0%	7	14	50%	7	18	39%

4. Acquired Brain Injury Results (ACCW and FRCC)

Records indicate few IOM/HIP clients (less than 5%) self-reported recent ABI incidents (at either ACCW or FRCC). When a client did self-report an ABI, or records indicated recent head trauma, the staff indicated there was no clear referral system in place to support a later clinical assessment. Due to a lack of ABI referrals and records, this aspect of the project could not be evaluated and a review of IOM/HIP ABI support is recommended.

Staff noted that records of self-reported ABI and subsequent clinical referrals were rare with IOM/HIP clients, as very few of these clients have documented proof of ABI (such as a recent CT scan or previous clinical assessment). In cases where additional healthcare referrals were initiated, none could be fulfilled within the 90 days before the client was released from custody.

The Fraser Health Authority ABI Program committed to assessing clients referred by a health practitioner, community or government agency, family member, or by self-referral, however, proof of injury is a requirement for service (CT scan, physician or clinician assessment, etc.).

5. IOM/HIP Recidivism (ACCW and FRCC)

Table 16 provides data on the re-offence rates (IOM/HIP client sentenced offences, including and excluding breaches) and for those who recidivated, the average length of time before a recidivating offence.

IOM/HIP recidivism data is based on a subset of IOM/HIP clients between February 1, 2011 and March 31, 2013 who were *released from IOM/HIP* (thus excluding HIP clients who were later removed from the project for other reasons such as day parole, transfers to other regions), a total of 49 clients from both ACCW and FRCC.

The rate of recidivism (including breaches) after project participation was 47%, while the average time to re-contact was 16 months (approx. 487 days). The rate of recidivism (excluding breaches) for IOM/HIP clients after project participation was 35%, and the average return to custody time was 19.8 months (approximately 604 days).

Table 16: IOM/HIP client recidivism

	Count	Total	%	Time to Re-offence	
Re-offences (including breaches)	23	49	47%	487 days	16mths
Re-offences (excluding breaches)	17	49	35%	604 days	20mths

Due to the variable nature of the IOM/HIP client population, it was not possible to perform a statistical analysis between IOM/HIP and a matched comparison group. It can be said, however, that the 35% IOM/HIP recidivism rate is much lower than the 61% re-offence rate of medium and high risk IOM participants, as found in the Autumn 2013 IOM impact analysis (both rates at two years, excluding breaches).

6. IOM/HIP Most Serious Offences (ACCW and FRCC)

As shown in the previous table (Table 14; IOM/HIP recidivism), 47% of IOM/HIP clients recidivated (23 clients; including breaches) after being released from custody between February 1, 2011 and March 31, 2013. Examples of MSO charges before and after IOM/HIP participation include break and enter (pre IOM/HIP) vs. an MSO of theft under $5,000 (post IOM/HIP), and aggravated assault (pre IOM/HIP) vs. breach of probation as the most serious offence after IOM/HIP participation. Overall, 78% of the recidivating clients had decreased the severity of their most serious offence (MSO) after IOM/HIP participation, with 26% of these re-offences associated with breaches as their return MSO (see Table 17).

Table 17: Changes to Seriousness of Offences (ACCW and FRCC)

	Count	%
Re-offence MSO decreased (all)	18	78%
Re-offence MSO decreased (breaches only)	6	26%
Re-offence MSO increased	3	13%
Re-offence MSO remained the same	2	9%

Section 4 – Overall Conclusions

This evaluation summarizes the IOM/HIP implementation and the pilot project's effectiveness at ACCW and FRCC for the period February 1, 2011 to March 31, 2013. The IOM/HIP pilot project is a partnership of ministries, government organizations, community-based agencies and service providers acting in collaboration to provide supports and resources to high risk IOM clients who were homeless or at risk of homelessness enrolled in the IOM/HIP pilot project. IOM/HIP clients faced many issues which may have included mental health issues and problematic substance use, acquired brain injury, Autism, or Developmental Disabilities and FASD.

BC Housing reports that during the period February 2011 to March 2013, the Homeless Outreach Program (HOP) services, provided by the Elizabeth Fry Society and Keys: Housing and Health Solutions connected 57 IOM/HIP clients to some form of housing. It will be important to work closely with those placed in recovery/treatment programs to ensure they obtain stable housing once they leave the programs. As well, outcomes could be improved if outreach workers check in more regularly with those placed in market housing to ensure the housing is working out and provide immediate assistance if a new housing arrangement is required to help the IOM/HIP client maintain stable housing.

Statistics around client eligibility and enrollment suggests that a limited number of IOM clients (28% ACCW clients; 18% FRCC clients) reviewed for IOM/HIP were eligible and accepted to enroll in the project. The main reasons for client ineligibility were due to clients moving outside the catchment area (74% of ACCW ineligible clients) and sentencing limitations (41% of FRCC ineligible clients), such as less than 90 days remaining in their custody sentence. Partway through the pilot project, it was necessary to cap IOM/HIP client intake at FRCC (intake was limited to a prescribed number per month) due to the size of the sentenced adult population housed at FRCC that qualified for IOM/HIP.

In custody, IOM/HIP screening interviews were initially expected to include a FASD screening process, and healthcare referrals for clients who reported any recent acquired brain injuries (ABI). FASD screening was completed in the majority of cases (85% of IOM/HIP clients at ACCW; 87% at FRCC). Later referrals to the Asanté Centre for clinical assessments were initiated for 17% (ACCW) and 29% (FRCC) of clients after a positive FASD screen in custody. In all, a total of seven clients successfully completed an adaptive functioning assessment from FRCC (one client not FASD, two with developmental disorders, one with autism and one with FASD). None of the ACCW clients completed the process, mainly due to the length of the assessment process and the high proportion of clients moving outside the project catchment area of the lower mainland.

Records indicate few IOM/HIP clients (less than 5%) self-reported recent ABI incidents. When a client did report an ABI, staff noted there was no clear referral system in place to support a clinical assessment, leading to either no referral being made, or incomplete referrals by the time the client was released from custody. Without documented proof of ABI (such as a recent CT scan or previous clinical assessment), the Fraser Health ABI Program was unable to initiate ABI services for IOM/HIP clients. In practice, the requirement to prove injury was a barrier to for IOM/HIP clients to obtain ABI support through Fraser Health.

Records of IOM/HIP recidivism included re-offence rates (IOM/HIP client sentenced offences, including and excluding breaches) and the average length of time before a recidivating offence. An impact analysis of IOM/HIP client recidivism depends on a matched comparison sample, which was not possible, given the variable nature of these clients' needs and profiles, however it is worthwhile noting that the recidivism rate for IOM/HIP clients was 35% compared to 61% re-offence rate of medium and high risk IOM participants, as found in the recent IOM impact analysis (both rates at two years, excluding breaches).

Differences between the seriousness of index and recidivating offences were determined by comparing the most serious offence (MSO) two years before IOM/HIP enrollment and up to two years post-IOM/HIP custody exit. 78% of recidivating clients had less severe MSO rankings, and 13% had increased MSO rankings after IOM/HIP, suggesting a considerable reduction in the seriousness of IOM/HIP client offences and may be promising result for future evaluations.

Appendix I – Literature Review

Literature Review – Accessing Housing and Housing Retention for Offenders

- Offenders who do not have stable housing arranged prior to their release are much more likely to return to prison[9]
- Canada Mortgage and Housing Corporation estimates that 30% of those incarcerated have nowhere to go upon release in Canada[10]
- Current prisoners interviewed in Edmonton were asked about their housing expectations upon leaving corrections facilities – 18% of interviewees expected to be homeless, 38% expected to be unstably housed, and 44% expected to find stable housing[11]
- After being released from transitional or halfway houses, 70% to 90% of offenders were released to long-term housing[12]
- 60% to 80% of offenders achieved their short-term or long-term housing goals

Literature Review - Barriers for Offenders Accessing and Maintaining Housing Once Released from Corrections Facilities[13]

- Offenders may lack stable employment or have low incomes
- Offenders may have been previously homeless
- Even if offenders had housing prior to incarceration, they may have lost that housing while incarcerated (because cannot pay for rent and mortgage payments or relationships with housing partners may have become strained)
- Housing arrangements may be secured with families members or intimate partners before leaving prison, but these living situations are often temporary
- Offenders may have addiction issues and/or mental health issues
- Offenders may be released in communities far from where they consider home
- Offenders may be released without identification papers
- Offenders may have restrictive parole conditions that impact their housing search
- Offenders may experience discrimination when trying to secure housing
- In many provinces, landlords can legally discriminate against those with criminal records
- Many offenders do not have access to support services to help them find and maintain housing
- Many offenders leave correction facilities without relevant discharge planning
- There may be a lack of safe and affordable housing
- Due to barriers, offenders may end up having to live in neighbourhoods with high crime rates, which puts them at risk of reoffending
- Offenders may lack life skills required to remain independently housed

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[9] Source: John Howard Society of Ontario. The Missing Link: Discharge Planning, Incarceration and Homelessness, 2006
[10] Source: Canada Mortgage and Housing Corporation, Housing Options Upon Discharge from Correctional Facilities, 2007
[11] Source: The Mustard Seed Edmonton and the University of Alberta (Jessica Thomson, Kris Knutson, Jonathan Nicolai deKoning, Jana Grekul, and Debbie Fawcett), Housing Needs of Adults Post-Incarceration in Edmonton, 2013
[12] Source: St. Leonard's Society of Canada, Homes for the Hard to House, 2012
[13] Sources: Canada Mortgage and Housing Corporation, Housing Options Upon Discharge from Correctional Facilities, 2007; St. Leonard's Society of Canada, Homes for the Hard to House, 2012; John Howard Society of Ontario. The Missing Link: Discharge Planning, Incarceration and Homelessness, 2006

Appendix II – Challenges with Conducting Follow Ups

HOP providers were asked to identify challenges with conducting follow ups at the Spring 2012 regional meetings. The following challenges were identified:

Clients can be very transient

- Clients move within the community, without necessarily letting providers know
- Clients move out of the community, so providers lose touch with clients

Not all clients want follow ups

- Some clients do not leave forwarding contact information
- Some clients do not want follow ups because they want to move on from the experience of losing their housing

Information sharing with third parties does not always work as a means of conducting follow ups

- Some landlords do not want to be bothered with follow up calls
- Some landlords do not want to share information about their tenants
- Some clients do not want providers contacting their landlords

Providers cannot reach all clients who agreed to follow up

- Phones get disconnected or lost
- Some providers try to set up email addresses in case phones get disconnected or lost or clients move, but not all clients check their email accounts regularly and not all clients have computer skills
- Clients with mental health and addictions issues may not respond to follow up attempts

Appendix III – Qualitative Success Stories

Service providers, IOM Case Coordinators and HIP Key Workers reported on several client successes to illustrate the positive results that have been achieved through client participation in the pilot project. The success stories offer insight into better outcomes for clients when partner organizations collaborate to provide integrated services to this vulnerable population.

 # 1 – Jon was released from custody into the community. Over the next few months he was in and out of detoxification as well as numerous treatment centres and recovery homes. Sometimes he simply walked away, and other times he was asked to leave due to his poor attitude and rule infractions. He had no plans for his future and was drifting between recovery houses and shelters in the Downtown East Side. He was then charged with a new offence and spent a short time in jail. The following month he came to the HIP Key Worker's office and advised her that he was finally going to change and was headed to a treatment facility out of town.

That was almost seven months ago and he is still there. He has been clean and sober for the entire time, has filed his income tax return for the first time in many years, and has applied for and received a full set of identification. Best of all...Jon has been asked to stay on at the recovery house and become a peer counselor.

IOM Case Coordinators at ACCW comment regarding Success Stories #2 to #5: "*Reflecting on the IOM/HIP project and the participants we have provided services to through custody in addition to the community under Probation Supervision and without Supervision there are several women's stories that are inspirational. They demonstrate that when an individual receives appropriate supports and services for the stage of change they are at, and they have a worker they trust to work with them to support them through their ups and downs as they progress toward a better life, that change is possible.*"

#2 – For Jane, it is our opinion that this project literally saved her life. She has an extensive criminal record and a number of health challenges resulting from her lifestyle. She had severe depression issues and has had to deal with significant past trauma. She had made several attempts to change her life and had made some gains but was still not able to manage in the community for an extended period of time. Her inability to make lasting change was also increasing her depression and despair. She began to meet with the HOP Outreach Worker, and gained a renewed sense of hope even prior to leaving custody as she knew she had support and that others had faith in her ability. She stumbled a few times initially but quickly called the HOP Outreach Worker for help and the Outreach Worker was able to respond. Jane has market housing of her own that she has been able to sustain for more than a year. She has maintained her sobriety and is working a couple of days a week at a recovery house. When she has attempted this work in the past, things quickly fell apart for her. Jane has come to the realization that it is important for her to maintain her own residence and has no plans to return to living in the recovery house where she works. This is a positive step for her in terms of thinking through the consequences of her decisions and making ones that are healthier for her. With the help of the HOP Outreach Worker, Jane was able to obtain a puppy for herself and is now attempting to get part-time employment through dog sitting and dog walking. They have made flyers and have distributed them in

the neighbourhood to assist her in this effort. Jane completed her Probation Supervision after a year of being released. She has not been free of the criminal justice system for many, many years and this is a big achievement for her. With the HOP Outreach Worker's assistance, Jane was also able to locate a family doctor whom she sees regularly. She also obtained her PWD status, received her BCID, SIN card, Health Care Card, her annual bus pass and opened a bank account. The HOP Outreach Worker works with her on budgeting issues and Jane attended a financial literacy course.

#3 – We have one young woman, Dawn who's offending and addiction in the community was so out of control her Probation Order banned her from a community and surrounding area where she had resided her entire life. She is in the first few months of her community participation in the IOM/HIP project and she is doing very well. She has been able to obtain a residence in private market housing. She has also gained employment and was provided with work boots. Additionally, she was aided with her Birth Certificate, BCID and Health care card. The HOP Outreach Worker accompanied her to her probation appointments and her substance abuse services program which was mandated by her Probation Officer. This greatly assisted her in coping with the stress induced by her fear of missing these appointments.

#4 – Susan Initially chose to move in with friends upon her release from custody but after a number of discussions became open to finding her own residence. After about 5 months she was able to accomplish this. She has had a few issues with the landlord but was able to resolve them in an appropriate manner. She did finally decide to move from this residence, and was able to secure another rental suite without too much difficulty. Susan also obtained employment and is working as a crew leader. She and the HOP Outreach Worker worked hard on her PWD application and also sought the assistance of the BC Coalition for Persons with Disabilities to complete it. Her application has been submitted and she is waiting for approval. Susan was also aided in obtaining her Birth Certificate, her driver's licence, and SIN card. She was accompanied to a number of probation appointments and was able to develop a positive working relationship with her Probation Officer. Her Probation Officer has assisted her with obtaining counselling and has also been supportive in Susan's desire to have changes made to her Probation Order. The HOP Outreach Worker continues to meet with her on a bi-weekly basis. Susan has a tendency to take on too much at one time and this increases her stress level, which also increases her risk level. She continues to receive support around when to take a break, what she can do for self care, what is important to do and what can wait, and how certain situations can compromise her plans. Susan also received and continues to receive assistance in going to the food bank and financial assistance when she needs additional groceries unavailable through the food bank.

#5 – After Vickie's release from custody, Vickie did not follow her case plan and did not maintain contact with the HOP Outreach Worker. She reconnected with the Outreach Worker after several months because things were not going well for her. The HOP Outreach Worker helped her to get things back on track and she is currently doing very well. She was successful in her application to the court to be able to reside with her boyfriend in a rental apartment. She has been able to meet all of her probation appointments (on time), initially with the help of the HOP Outreach Worker and now on her

own. She continues to meet with her mom on a regular basis. With the help of the HOP Outreach Worker she has been attending a Work BC location. She completed a number of courses on resume writing and interviewing skills. She has completed a First Aid course and a Fork Lifting course. She has sent her resumes out on a weekly basis, and hopefully will begin employment in the next several weeks. Vickie continues to meet with the HOP Outreach Worker on a weekly basis as well as contacting her as necessary to receive support. Additionally she has received financial support to help with her groceries.

Concluding comment from the IOM Case Coordinators at ACCW: *"These clients continue to achieve important successes through their involvement in the IOM/HIP project."*

#6 – Jack is 40 years old. He was given a 23 month sentence for robbery, and has been incarcerated for the past 9 years with only 90 days of "street time" within the 9 year period. The IOM/Case Coordinators completed an intake interview with Jack who was eager to enter IOM and was recognized as a client that also fit the criteria for the IOM/HIP project. We (IOM Case Coordinators) completed the FASD screening tool and Jack screened positive for FASD and has completed his assessment. He suffers from a number of ailments including partial FASD; Psychiatric-Depression; Post Traumatic Stress Disorder; General Anxiety Disorder and Borderline Personality Disorder.

The Asante Center identified specific strategies to assist with each issue identified, and committed to assist Jack as a resource with each identified issue. At a family conference held for Jack each attendee provided input around other resources that may be available to Jack.

Jack was initially part of the *Living Right Unit* at FRCC prior to it being discontinued and is working closely with the Drug and Alcohol Counselor, IOM program and IOM/HIP pilot project. Jack has multiple barriers and because of his anxiety he often gets himself worked up. When this would happen to him on the street he would start to self-medicate and commit criminal acts. Jack advised that he was relieved when he learned that he had FASD. During the family conference at the Asante Centre there was a circle of support surrounding Jack which included both IOM Community and Custody coordinators, HIP Key Worker, Drug and Alcohol Counselor, HOP Outreach Worker, CLBC and representatives from the Asante Centre such as the Pediatrician, Psychologist and Executive Director. Jack's grandmother who is 92 also joined in on a conference call. Jack was amazed by the support and commented that he wished he had this support 10 years ago. Jack has worked very hard on his own initiative and made great strides but he knows that this circle of support will extend into the community and is exactly what he requires to achieve success.

Upon release, Jack has been set up to go to Rivendale which is supportive housing in Mission. He will also attend Alcoholics Anonymous and Narcotics Anonymous meetings held right across the street. The Drug and Alcohol Counsellor will connect him with Fraser House which will provide support for mental health and addictions in Mission. The IOM Case Coordinator has helped Jack to have a Probation Officer in the community who specializes in offenders with mental health issues. The Asante Centre will apply to CLBC on Jack's behalf with the goal of getting him further support when he is in the community. The HIP Key Worker has set up an early Income Assistance appointment for Jack so that his rent will be paid and he can go straight to Rivendale when he is released on a Sunday. The HOP Outreach Worker will pick Jack up from FRCC and take him to Rivendale, the HOP Outreach Worker will continue to work

closely with Jack. Jack has been reminded that the IOM/HIP Team remains a source of support after he is released.

Jack's story is incomplete however it indicates that clients who are given the opportunity and resources feel hopeful that replaces the hopeless cycle that they have been living in most of their lives.