Provincial Standards for Registered Assisted Living Supportive Recovery Services

September 2021

BRITISH COLUMBIA

Acknowledgements

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Introduction

The Purpose and Scope of the Standards

The *Provincial Standards for Registered Assisted Living Supportive Recovery Services* (the standards) are applicable to all supportive recovery services registered under the *Community Care and Assisted Living Act* . They have been developed by the Ministry of Health and Ministry of Mental Health and Addictions to strengthen the safety, quality and oversight of registered supportive recovery services in British Columbia.

The standards primarily address the delivery of psychosocial supports for people accessing registered supportive recovery services. They are distinct from clinical standards with respect to the degree of formality, as supportive services do not typically provide clinical care.

In 2019, a new Assisted Living Regulation came into force, providing clearer direction for registered operators of supportive recovery services and greater protection of residents' rights. The standards build from the regulation to establish criteria for the delivery of high-quality care, as supported by research evidence. In meeting the standards, service providers will generally be exceeding the regulatory minimum requirements for care in the Assisted Living Regulation.

The standards have been developed with the following objectives:

- To facilitate the provision of evidence-informed, safe and respectful care across the province;

- To improve linkages between registered supportive recovery services and other substance use services, primary care providers, and organizations that provide psychosocial supports;

- To strengthen staff competencies in the areas of trauma- and resilience-informed practice and Indigenous Cultural Safety and Humility; and

- To improve the information available to people about what they can expect from registered supportive recovery services as well as what is expected of them while they are accessing a service.

The standards supersede the 2011 *Provincial Standards for Adult Residential Substance Use Services* with respect to the provision of registered supportive recovery services. (However, the 2011 standards still apply to licensed residential treatment services.)

Guiding Principles

The *Provincial Standards for Registered Assisted Living Supportive Recovery Services* is underpinned by the principles illustrated in this figure.

These principles closely align with what people with lived experience have said is important to them when participating in substance use services.
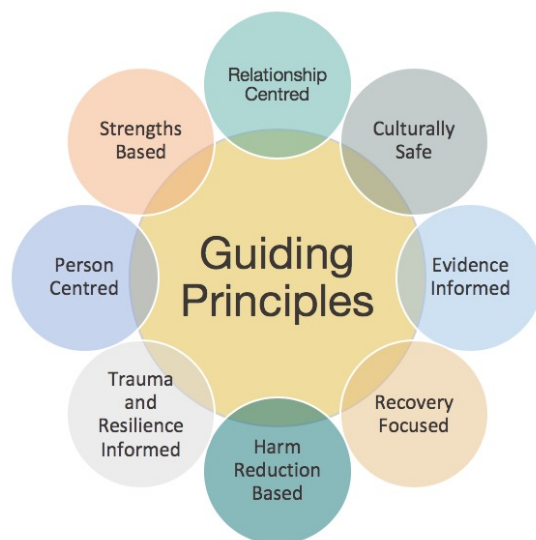
Registered Supportive Recovery Services in British Columbia

Registered supportive recovery services in British Columbia are bed-based or live-in services that provide low to moderate intensity substance use services and supports in a communal and supportive environment. Registered supportive recovery services sit along a continuum of substance use services that includes:

- Community services – such as outreach programs, substance use services offered by primary care providers (including family physicians), community counselling, day treatment, home and community-based withdrawal management, and harm reduction services; and

- Live-in services – such as hospital or facility withdrawal management, residential treatment, supportive recovery, and stabilization programs.

Who may benefit from supportive recovery services

Individuals who may benefit from registered supportive recovery services include those who have a goal to reduce, abstain from, or reduce harms associated with substance use and need a supportive environment away from their usual living situation. Individuals may have completed a more intensive treatment program and require a period of continued daily structure and support before living independently, or they may require a period of daily structure and support to become ready to enter a more intensive treatment program or permanent housing.

Goals of supportive recovery services

Live-in supportive recovery services registered as assisted living under the *Community Care and Assisted Living Act* have the goal of providing a safe, communal environment where individuals have the opportunity and the support to focus on their recovery journey.

Goals and objectives of supportive recovery services include:

- Supporting individuals to reduce, abstain from, or reduce harms associated with substance use;

- Helping individuals to stabilize and prepare for the next steps of their recovery journey; and

- Helping individuals to build the skills and confidence to achieve their recovery goals, including, for example:
    - Improving physical, mental, emotional and/or spiritual wellness;
    - Increasing resilience through the development of relapse prevention and coping skills;
    - Connecting to housing and psychosocial supports;
    - Reconnecting with loved ones and community, and building healthy relationships; and
    - Pursuing employment and/or educational opportunities.

Defining features of supportive recovery services

Broadly speaking, supportive recovery services offer:

- A communal living environment (with communal living spaces and some shared bedrooms);

- Scheduled programs focused on recovery and wellness, delivered by appropriately trained staff, and connection to offsite professional services (such as therapy and medical care). Some services may also provide one-on-one counselling;

- Social or recreational opportunities;

- Hospitality services (access to meals, housekeeping, laundry);

- 24-hour emergency response; and

- Length of stay of 60 – 120 days (though can be longer).

How the Standards Were Developed

Development of the *Provincial Standards for Registered Assisted Living Supportive Recovery Services* was supported by a project team drawn from the Ministry of Health and the Ministry of Mental Health and Addictions, and guided by a steering committee of representatives from government, health authorities, the First Nations Health Authority, the Ministry of Municipal Affairs and Housing, BC Housing and the BC Centre on Substance Use. Research, engagement with community partners, and writing were conducted by a network of Indigenous and non-Indigenous consultants.

The approach to developing the standards was evidence-informed and highly collaborative. A review of relevant research literature was undertaken, and in-person consultations were conducted with registered supportive recovery operators, Indigenous service providers, people with lived experience, families, and health authority leaders. In addition, the drafting process was informed by contributions from an expert advisory panel.

The Structure of the Standards

There is a total of twelve standards. Each standard includes an overarching statement, an expression of intent and required elements. Notes and examples provide further context and practice guidance on how to implement the required elements. Links to relevant resources are also provided.

There is a standard devoted specifically to Indigenous Cultural Safety (ICS) and Humility; however, ICS principles and practices are also woven into all the standards.

The voices of Indigenous and non-Indigenous service providers and people with lived experience are included throughout.

A companion document has been created that offers service providers tools and Indigenous Cultural Safety resources to help with implementing the standards.

> In the *Provincial Standards for Registered Assisted Living Supportive Recovery Services*, the terms 'Indigenous' and 'Indigenous peoples' refer to First Nations, Métis and Inuit peoples, each of whom have unique rights, interests, and circumstances.

The Evidence that Informs the Standards

Key findings from the research literature and from the consultations with registered supportive recovery operators, Indigenous service providers, people with lived experience, family representatives, and health authority leaders offer important guidance for the design and delivery of supportive recovery services. These findings have informed the development of the *Provincial Standards for Registered Assisted Living Supportive Recovery Services* and are reflected in the Required Elements and practice notes throughout.

Best Practices for Supportive Recovery – What the Research Says

❖ The philosophy, approach and goals of each supportive recovery service should be transparent and clearly communicated in, for example, a mission statement, guiding principles or code of ethics.

❖ Service operators and staff should have access to appropriate training to perform the duties as outlined in their job descriptions effectively, form positive relationships with people from diverse populations, and create a safe, healthy living environment for residents. Training in Indigenous Cultural Safety and Humility and trauma- and resilience-informed practice is particularly important.

❖ Residents should participate in ongoing assessment and personal service planning to ensure that the supportive recovery service is meeting their medical, psychosocial, spiritual and recovery needs and preferences.

❖ Person-centred approaches should be prioritized. Where possible and appropriate, this includes encouraging residents to take on active roles and responsibilities in maintaining a safe and stable living environment for themselves, other residents, and service staff.

❖ Involvement of the person's support circle in their recovery plan should be supported and facilitated where possible and appropriate. A person's choice to involve or not to involve their family and loved ones should be respected.

❖ Initiatives and partnerships that foster positive relationships between service providers, residents, and the surrounding neighbourhood and local community should be encouraged.

❖ Residents should be offered a range of individual and group-based social support services to develop the skills, relationships, and resources needed for long-term recovery. Peer-led programs and services should be incorporated.

❖ Specific populations should be offered access to tailored programs and services that meet their needs.

❖ Residents should be supported in accessing clinical, psychosocial, and substance use treatment services of their choice in the community.

❖ Strong linkages with local and regional services in the health and social care and criminal justice sectors (including mental health and other substance use services) should be established to help ensure integrated care.

Safe and Effective Supportive Recovery Services – Key Messages from the Consultations

❖ **Relationships –** Human connection, positive relationships, and a sense of belonging are key to health and wellness. Supportive recovery services should strive to foster trusting relationships between residents and staff, help residents to be in healthy relationships with themselves and others, and (re)build family and social connections.

❖ **Person-centred care –** Every person's situation is different; everyone is an individual. Treatment and supports cannot be the same for all people – the cookie cutter approach does not work. Supportive recovery services should take a person-centred and -informed approach to providing care that offers flexibility and space for individual choice. Individualized personal service planning is crucial.

❖ **Indigenous Cultural Safety and Humility –** Services should support Indigenous resilience and connection to culture, and must be free of discrimination and racism. Indigenous peoples should be offered access to cultural practices, facilitated through consultation and partnerships with the local Indigenous community.

❖ **Trauma- and resilience-informed practice –** Supportive recovery services must be provided in a way that supports the physical and emotional safety of all staff and residents, and avoids re-traumatization. Staff should take a collaborative approach to working with residents, ensuring that residents have choice and control over their care.

❖ **Recovery-focused –** Services should be recovery-focused, rooted in an understanding that recovery is a life-long journey that takes time, looks different for each person, and may have many starts and stops along the way. There should be a focus on rebuilding lives – education, work, life-skills, self-esteem, self-care, and engagement with community.

❖ **Informed decision-making –** People need to be able to make an informed decision about accessing a supportive recovery service. They need to know what they can expect of the service – what programming is offered, what the rules are, what a typical day might look like. Clear and accurate communication from service providers is vital.

❖ **Capable staff –** Staff should be appropriately trained and qualified, and have access to professional development. Services that provide care to Indigenous peoples should hire Indigenous frontline staff and build connections with Elders and Knowledge Keepers. Peers play a crucial role in supporting people to achieve their recovery goals and should be involved in programming and activities.

❖ **Safety –** The safety of residents is paramount. Supportive recovery services must promote and protect each person's health and safety during their stay, and programming should address how to support and ensure the person's safety and wellbeing in life. Development of safety plans, relapse planning and management, and continuation of prescribed medications are all important.

❖ **Transitions –** Transitions into and out of supportive recovery must be safe and supported. Preparations for returning to the community should start early and be done gradually, with residents and staff working together to identify next steps and put in place community connections and supports. Transition plans must address both planned and unplanned departures.

Standard 1: Informed Decision Making and Admissions

Statement

The service provider works with the person, their health and social care team, and involved family members to explore whether the supportive recovery service can safely meet the person's needs, preferences and cultural practices, and, if so, admits the person to the service as quickly as possible.

Intent

To ensure that the person has all the information they need to make an informed decision about whether the service is a good fit for them, and that the admission process is as low barrier as possible.

> For individuals coming into supportive recovery from the correctional system, the admissions process may look slightly different. However, prospective residents should still be active participants in the decision-making process even in these circumstances. Therefore, this standard can still be met for this population.

Required Elements

As the service provider, you must:

1.1	Provide clear, accurate information about your service on the service website and/or in printed brochures or handouts.
1.2	Involve the person as an active participant in making the decision about whether your service is a good fit for them, remembering that they have the right to self-determination and control over their care.
1.3	Be mindful of the person's emotional, mental, physical, spiritual and cultural wellness, and make sure that conversations about the service and the information you are providing match their capacity to fully understand.
1.4	Provide the person with accurate, easy-to-understand and non-stigmatizing information about what your service offers and the model of care that is followed.
1.5	Make sure that your service is low barrier. Ask only for the minimum amount of information necessary to feel reasonably confident that your service will be a good fit for the person and that they will be able to participate safely.
1.6	Welcome and facilitate the involvement of the person's family members and support circle in the decision-making process, if this is what the person wants.
1.7	Include the person's primary care provider and/or other clinician(s) in the decision-making process, if this is what the person wants.
1.8	Provide the person with information about alternative services and supports if it is decided that your supportive recovery service cannot safely meet their needs.

Guidance on Implementing the Required Elements

1.1	**Public information about your service**
	Publicly available information about your service should include a mission statement and/or guiding principles that clearly outline your service model or approach.
	If there are eligibility criteria, these must be evidence informed. They should also be worded inclusively (i.e., stating who *is* welcome rather than who is *not* welcome).
	This information helps community organizations and care providers know what your service offers and make appropriate referrals.
1.2	You can help ensure that people feel respected, comfortable and safe enough to actively participate in the decision-making process by applying the principles of trauma- and resilience-informed practice, gender-inclusive practice, and Indigenous Cultural Safety. See *Resources* on p.10.
1.3	In some cases, people may not be able to take part in a lengthy decision-making process. Some people may be in a vulnerable situation (e.g., experiencing homelessness, or feeling afraid of being judged or rejected) and may therefore be eager to access your service even if it is not the best match for their needs and preferences.
	Every interaction with people interested in your service must be welcoming, respectful, non-judgmental, and free of stigma, racism and discrimination. Each person should be encouraged to ask questions and supported to make fully informed decisions at a pace that feels safe to them.
1.4	**Information provided to prospective residents**
	You should be able to provide the following information about your service to prospective residents:
	• The approach to care and/or specific areas of expertise (e.g., 12-step, faith-based, Indigenous-led, family-centred, LGBT2Q+ focused, etc.);
	• The evidence that underpins your approach to service delivery;
	• Service costs, funding options, and refund policy;
	• The referral and intake process;
	• Typical length of stay;
	• Residents' rights and responsibilities;
	• Medication management and support, including for individuals on opioid agonist treatment;
	• The kinds of personal goals the service can help with (e.g., re-connecting with family, developing life skills, reducing harms, long-term abstinence, etc.);
	• The range of programming that is offered (in-house and in the community, mandatory and optional);
	• The availability of/access to cultural practices, land-based healing and Traditional Medicines;
	• Information about the facility and communal living (including accessibility, use of common and private spaces, rules that residents must abide by and any consequences of not doing so, etc.);
	• What a typical day at the service looks like (e.g., structured vs. unstructured time, ability to continue working, chores, etc.) and the amount of flexibility offered; and
	• What transition out of the service may look like.

	Check in with the person to make sure they understand the information provided to them, especially in cases where there may be literacy or language barriers.
1.5	Low barrier services are easily accessible with few administrative barriers. This means that the process of deciding if your service is a good fit should be as simple and straightforward as possible. **Information collected from prospective residents** It is recommended that you collect the following information about the prospective resident: • Accurate identification of the person; • Personal goals (in broad terms); • Recent substance use history and previous treatment experiences; • Physical and mental health history; • Current legal obligations they may have (e.g., court dates, probation, parole or bail, etc.); • Current medication use; • Connection to a primary care provider and/or other clinician(s); • Current psychosocial supports; and • Capacity and willingness to live in a communal environment safely. Remember that the information gathered about a person at this stage is just the first step in an ongoing process of assessing their needs and reviewing how well your service can meet those needs. See Assisted Living Regulation, section 29.
1.6	**Involving the person's support circle** Involvement of a trusted family member, friend, Elder or peer may help the person to feel safe and able to voice their real needs and preferences. This involvement could be in-person or via the telephone or a web-based videoconference tool. Involving the person's support circle from the beginning will also help to ensure that they can be an active part of the person's journey through supportive recovery and in the longer-term. If the person is not accompanied by someone from their support circle, ask if they would like to include a family member, friend, Elder or peer in the decision-making process. Remember that 'family' must be defined by the prospective resident.
1.7	**Medical oversight** Medical oversight of the person's journey into, through and out of supportive recovery is provided by their primary care provider and/or other clinicians involved in their care. To support this, ask each prospective resident about which health and social care providers they are already connected with and how they would like them to be involved. Not everybody will have a primary care provider, and there are many reasons why this might be the case: in some communities there may be a doctor shortage; some people may be wary of the health-care system and prefer not to be connected; and others may not know how to get connected. You must be able to provide basic information about how the person may connect with a primary care provider in the community (e.g., by contacting HealthLink BC, by asking if a walk-in clinic doctor is accepting patients, etc.).

	People who self-identify as First Nations, Métis or Inuit may prefer to be connected with Elders, Knowledge Keepers and/or traditional healers. It is important to ask each person whether this is their preference.
	See *Standard 7, practice note 7.3* for further information about working with the person's primary care provider.
1.8	If it is decided that your service cannot safely meet the person's needs, you must clearly explain why this is the case.
	You should be aware of and build connections with other substance use services and supports in the local community or region.
	At minimum, you must provide the person with the names and contact information of other services and programs, including other supportive recovery services and cultural supports, that may be available and better suited for their needs.

Terms

Determining 'good fit' is a shared process that requires input from the service provider and the prospective resident. However, the emphasis should be on whether the service is a good fit for the person, and not whether the person is a good fit for the service.

Low barrier describes a service or a provider that makes the process of getting help as accessible and user friendly as possible. Barriers such as paperwork and eligibility requirements are minimized, as are physical- and staff-related characteristics that can stand in the way of people getting their needs met.

Post-Acute Withdrawal Syndrome

Symptoms of Post-Acute Withdrawal Syndrome (PAWS) are common to many people recovering from problematic substance use and may compromise their capacity to make an informed decision. If you are concerned about the person's well-being or their ability to make an informed decision, you should talk to their care team and seek clinical advice. See Dr. Steven Melemis (2019) *Addictions and Recovery – Post-Acute Withdrawal (PAWS)* for further information.

Mission Statement and Guiding Principles

Examples of commitments often found in mission statements or guiding principles for supportive recovery services:
- Foster personal growth and development;
- Create a positive, healthy, safe and supportive living environment;
- Promote and respect residents' rights;
- Support people on their personal journey to reach their full potential;
- Foster personal development, dignity, autonomy, self-worth and independence;
- View recovery as a multidimensional concept incorporating biological, psychological, sociocultural and spiritual factors;
- Recognize that there are multiple pathways to recovery;
- Demonstrate flexibility and adaptability, and tailor services to best meet the circumstances, needs, and preferences of each individual;
- Place an emphasis on the experiential knowledge held by people in recovery; and
- Focus on connections and reciprocity between residents as the driving force of recovery.

Lived Experience Insights

"The decision to change likely comes at the end of a long period of wishing, wanting and hoping for change and not quite being ready to take the step – so it's a momentous decision and service responses need to be positive and timely."

"The door must be open the minute someone wants to walk through."

"It's a difficult balance – ensuring that someone makes the right decision about which supportive recovery service, without them feeling overwhelmed with information and questions."

"Information should help the individual determine 'Do I fit in here?' So that it's a positive choice. Then the individual can opt out if the answer is 'no' – rather than being 'rejected' by the service."

Resources

BC Centre of Excellence for Women's Health. (2013). *Trauma-Informed Practice Guide.*

Northern Health, Indigenous Health. (2017). *Cultural Safety: Respect and Dignity in Relationships*.

R. Schmidt, et al. BC Centre of Excellence for Women's Health. (2018). *New Terrain: Tools to Integrate Trauma and Gender Informed Responses into Substance Use Practice and Policy*.

Standard 2: Supporting People Who Are Waiting to Access Your Service

Statement

When a person must wait or needs to prepare to enter the service, the service provider maintains contact with them.

Intent

To ensure that people who are waiting or preparing to enter a service stay connected to the service, engaged in their recovery, and informed about next steps.

Required Elements

As the service provider, you must:

2.1	Regularly communicate with the person to update them on their expected date of entry to your service and to start building a connection with them.
2.2	With the person's consent, connect with their care team and support circle in preparation for providing collaborative care once the person enters your service.
2.3	Provide information about services in the community that can help the person stay safe, including harm reduction services, outreach services, peer support groups, access to cultural practices, and other substance use and psychosocial services.
2.4	Closer to the date of entry, confirm that the information gathered during the initial decision-making process is still accurate and up to date.

Guidance on Implementing the Required Elements

2.1	**Communicating with someone who is waiting to access your service** There are a variety of reasons why a person may not be able to enter a supportive recovery service immediately. For example: there may be a waitlist; they may be incarcerated; they may be completing another stage of recovery or stabilizing on opioid agonist therapy; they may have cultural commitments (e.g., Ramadan, Big House ceremonies, Lunar New Year, Diwali, Christmas, Kwanzaa). While they are waiting, the person may be able to start preparing for supportive recovery. Preparing for supportive recovery will look different for each individual and service, but may include connecting with a substance use clinician and/or out-patient service, getting ready for communal living, and making arrangements for personal, family and/or work obligations, etc. You should be able to offer guidance on what a person can do during this time to help make their experience in supportive recovery successful. Research suggests that personal connection is important for good outcomes. If someone is waiting to access supportive recovery, making a connection with a staff member will increase their chances of engaging with the service once they enter. Regular communication involves doing a brief, weekly check-in by phone or text (with the person's consent).

2.2 When a person is waiting or preparing to access your service, taking the time to begin building a relationship with their care team and support circle is critical. This includes connecting with the person's primary care physician, if they have one.

Research shows that collaborative care is key to good outcomes for people who are seeking to change their substance use.

Enhanced practice may include:

- Actively supporting a person to connect with appropriate substance use and other psychosocial supports in the community;

- Building relationships with referral agencies, services, and/or clinicians in the community to support care co-ordination; and

- Working to reconnect a person with their Band or Indigenous community and/or to link with Elders or cultural organizations.

Terms

Harm reduction is a public health approach that aims to reduce the social, physical, emotional and/or spiritual harms related to substance use. Harm reduction strategies and services treat people with respect and aim to meet them wherever they are at in their substance use or recovery journey. Services and supports may include: safer substance use supplies and/or take-home naloxone; outreach; referrals to health and social care services; and helping people to develop healthy relationships.

Lived Experience Insights

"If someone is waiting for a supportive recovery bed, it's important that they are not simply some anonymous person on a list, waiting in a vacuum."

"When someone reaches out for help, that's the opportunity."

"Waiting to get into a service can be a really anxious time for family members, especially if the person is living at home."

Standard 3: Staffing

Statement

The service provider maintains an appropriate complement of staff with the necessary training, qualifications and experience to meet residents' needs and to ensure the safety of everybody at the service.

Intent

To ensure that staff members have the skills and competencies to perform the duties outlined in their job descriptions, and to create a positive and safe living environment for residents, and a safe working environment for staff.

In these standards, staff generally includes the paid employees at a service as well as any volunteers. Paid employees and volunteers may also be peers and/or people with lived experience.

Required Elements

As the service provider, you must:

3.1	Be able to demonstrate that you have a clear, systematic process in place to determine the appropriate complement of staff for your service.
3.2	Make sure that there is at least one staff member or designated senior resident on duty and on site at all times.
3.3	Have a plan in place to recruit and retain staff from the communities and populations that access your service.
3.4	Make sure that all paid staff members have, and can show that they have, the qualifications required for the services and programming that they have been hired to provide.
3.5	Provide all paid staff members with professional development opportunities necessary to maintain the key competencies for their roles and to support the delivery of evidence-informed care.
3.6	Make sure that all staff are trained in and can apply the principles of trauma- and resilience-informed practice, and Indigenous Cultural Safety and Humility.
3.7	Conduct an annual review of each paid staff member's performance.
3.8	Provide any volunteers you may have with support and supervision for the work that they are doing.
3.9	Develop and put into action policies and practices to ensure the safety of staff, and to support their mental and emotional wellbeing.

Guidance on Implementing the Required Elements

Note: Division 2 of the Assisted Living Regulation addresses minimum requirements regarding employees, including: employee numbers; employee plans; character and skills; criminal record checks; training; review; and supervision.

3.1	**Determining complement of staff** You must be able to show that you have followed a process to determine the right number of staff with the skills to provide safe, high quality care at your service. This process, which must be documented, should take into account: • Number of residents; • Resident demographics (e.g. age, gender identity, sexual orientation, cultural background, etc.); • Complexity of residents' needs; and • Number and type of services and programming offered. Carefully considering these things will help you come to a decision about the right number of staff for your service, and what they need to have with respect to: • Formal education and qualifications; • Lived experience, frontline service delivery experience, cultural knowledge, and knowledge of colonization in Canada; and • Demographic characteristics (these should broadly reflect the population(s) you serve).
3.2	At all times, there must be a staff member or senior resident (e.g. in the designated role of house monitor) on site. A senior resident performing the role of house monitor must have: • A list of responsibilities; • Appropriate competencies; • Oversight and direction from staff; and • Ability to access promptly a paid member of staff in an emergency. A member of staff who meets the Assisted Living Regulation requirement with respect to First Aid certification must be accessible at all times. See section 27 of the regulation.
3.3	**Staff demographics** The complement of staff at your service should broadly reflect the communities and population(s) served (e.g., women, LGBTQ2+, young adults, Indigenous peoples, culturally and linguistically diverse groups). If this is not already the case, you must be able to show that you have a clear plan in place to move in this direction. In the meantime, population-specific services in the community (e.g. friendship centres, young adult-serving agencies, and cultural centres, etc.) may be useful sources of individualized programming, collaboration, and support for residents. In rural and remote areas, it may not be possible to assemble a team of staff that reflects the population(s) being served. If this is the case, you must be able to demonstrate how you plan to meet the specific needs of residents (e.g., through staff training/capacity building, connections with appropriate services or individuals in the community, etc.).

	Staff qualifications and competencies
	The Assisted Living Regulation, section 21 mandates that there is a written job description for each employee and volunteer position, which sets out duties and responsibilities, training, experience, skills, and other qualifications.
	All staff must be trained in how to administer naloxone in the case of an opioid overdose. See *Standard 10, Required Element 10.6* for more details.
	Staff members must be able to prove their formal qualifications through written documentation.
	Section 23 of the Assisted Living Regulation sets out minimum requirements for employee training in the following areas:
3.4	a) Counselling;
	b) Crisis intervention and conflict resolution;
	c) Psychosocial interventions for substance use disorders; and
	d) Trauma-informed practice.
	Best practice, as supported by the available literature, also includes training in the following areas:
	• General education on substance use and evidence-informed treatment options;
	• Understanding and addressing stigma and discrimination;
	• Indigenous Cultural Safety and Humility;
	• Anti-racism and anti-oppressive approaches;
	• Gender-transformative and inclusive care;
	• Mental health, suicide risk assessment and crisis management; and
	• Communication and conflict resolution.
	Published research and evidence from service users show that having staff with lived experience at the service leads to better outcomes for residents.
	Ongoing professional development for staff
	The Canadian Centre on Substance Use and Addiction (2014) *Competencies for Canada's Substance Abuse Workforce* provides guidance on which competencies apply to which employee roles and how employees may demonstrate each competency.
3.5	Ongoing professional development is vital to ensuring that staff members maintain the skills and knowledge required to provide evidence-informed care.
	Staff must be supported to participate in external professional development opportunities, such as courses, webinars, online training, conferences, etc.
	Ongoing learning opportunities in-house may include, for example, weekly debriefs, lunch and learn events, staff-led workshops, etc. They should allow for sharing and reflection, and support staff to put new learning into practice.
	Trauma- and resilience-informed practice
	There is a strong association between violence, trauma and substance use. Therefore, it is crucial that members of staff can apply the principles of trauma- and resilience-informed practice.
3.6	Trauma- and resilience-informed practice is not about treating an individual's trauma. Rather, it is about being able to recognize when a person's actions are a trauma-response, and knowing how to keep someone safe when they are disclosing trauma or feeling the effects of trauma.

	Indigenous Cultural Safety and Humility
	Staff must be supported to participate in Indigenous Cultural Safety (ICS) training. This training should be mandatory, ongoing, and led by Indigenous facilitators, or a combination of Indigenous and non-Indigenous facilitators. Online ICS training is a useful starting point, but is not a substitute for ongoing, cumulative, in-person training.
	See *Standard 4: Indigenous Cultural Safety* for more details on providing safe and effective services for people who identify as First Nations, Métis or Inuit.
3.7	See section 24(1) of the Assisted Living Regulation.
3.8	Any volunteers at your service should be encouraged to participate in in-house learning opportunities. See *practice note 3.5* for examples of these.
3.9	**Staff self-care**
	Members of staff should be actively encouraged and supported to practice regular self-care. This may include, for example, daily debriefs, weekly staff check-ins, regular self-care training and reminders, and ensuring that staff are not over-burdened in their duties and responsibilities.
	Note that members of staff may have their own trauma and/or may be affected by secondary trauma.
	The Mental Health Commission of Canada has developed a set of voluntary guidelines, tools and resources to guide organizations in promoting mental health and preventing psychological harm at work. See *Resources* on the following page.

Enhanced practice may include:

- Hiring Indigenous staff in equal proportion to Indigenous residents. (If roughly 40% of residents are Indigenous, then 40% of staff should be Indigenous.)

- Having one or more staff members with the training and skills to support residents who have concurrent mental health and substance use issues.

- Having a mentoring program for former residents to prepare them for taking on a volunteer or paid role.

The Supportive Recovery Workforce

Staffing models will vary depending on the intensity of support and supervision provided by the service. However, most supportive recovery services have, at minimum, a service operator and a house manager.

Many services encourage long-term or former residents to take on volunteer or paid roles at the service, such as resident/peer support worker, house monitor and senior resident.

Lived Experience Insights

"Showing that you are supporting the Indigenous community by hiring Indigenous staff is an important first step to creating a safe environment."

"There are lots of non-Indigenous people who do the 'tick box' cultural safety training. They watch a two-three-hour training video and then say, 'I'm trained,' but that's not going to get them that far…"

"It's important to have people with lived experience on staff – they bring understanding and can make an authentic connection with residents."

"It's not helpful when staff bring their own baggage – they need to suspend judgement."

Resources

Mental Health Commission of Canada. (2013). *National Standard of Canada for Psychological Health and Safety in the Workplace*.

Provincial Health Services Authority. *San'yas: Indigenous Cultural Safety Training Program*.

Standard 4: Indigenous Cultural Safety and Humility

Statement

All members of staff at the service actively exercise the principles and practices of Indigenous Cultural Safety and Humility and ensure that these principles and practices are embedded in all aspects of service provision.

Intent

To ensure that all people who identify as Indigenous are respected and safe at the supportive recovery service, are in an environment that is free of racism, discrimination and stigma, and can access programming that supports cultural practices and connection to community.

Required Elements

As the service provider, you must:

4.1	Have a plan in place to recruit and retain Indigenous staff to provide appropriate care to Indigenous peoples accessing your service.
4.2	Develop, and put into action, policies that support the practice of Indigenous Cultural Safety and Humility at your service. This work must be guided by Indigenous staff or Indigenous community members, and all staff members must be familiar with the policies.
4.3	Make sure that all members of staff take ongoing, Indigenous-led Cultural Safety training, and that their learning is applied to policies and practice at your service.
4.4	Offer Indigenous peoples at your service the option to connect and engage with Elders and/or Knowledge Keepers. Build relationships with local Indigenous societies, organizations, groups, and individual service providers to enable this.
4.5	Make sure that Indigenous peoples are offered access to cultural practices, either at your service or in the community.
4.6	Create a physical environment that is welcoming and that contributes to cultural safety for Indigenous peoples accessing services.

Guidance on Implementing the Required Elements

4.1	**Recruiting and retaining Indigenous staff** Hiring Indigenous frontline staff is a vital part of providing culturally safe care for Indigenous peoples. Indigenous staff members should be represented at all levels, including management and governance (e.g., board membership). Note that frontline experience, lived experience and cultural knowledge are as important as academic qualifications and should be valued appropriately when recruiting First Nations, Métis or Inuit staff. Ideally, the proportion of Indigenous staff at your service should roughly match the proportion of Indigenous residents. If this is not already the case, you must be able to show that you have a clear recruitment plan in place to move in this direction. In the meantime, you should support people to connect with Indigenous community organizations (e.g., Indigenous-led health and healing services, friendship centres, etc.).

	See *practice note 4.5* on ensuring that people who identify as First Nations, Métis or Inuit are offered access to cultural practices.
4.2	**Policies that support the practice of Indigenous Cultural Safety and Humility** You must have a policy that addresses staff access to ongoing Indigenous Cultural Safety training. Other policies that may support the practice of Indigenous Cultural Safety and Humility include, for example: • Support for family involvement (e.g. in decision-making, personal goal setting, etc.); • Offering access to cultural practices and facilitating those practices with sacred spaces; and • Offering access to Traditional Medicines. These policies should be developed with Indigenous leadership and community involvement. It must be clear to all residents and staff that your service does not tolerate any anti-Indigenous racism. See *Standard 10, Required Element 10.1* and its p*ractice note* for more details on preventing and dealing with racism and discrimination.
4.3	**Indigenous Cultural Safety training** Indigenous Cultural Safety (ICS) training should be delivered by Indigenous facilitators, or a combination of Indigenous and non-Indigenous facilitators. Wherever possible, Indigenous facilitators should be local to the area. See companion document (Implementation Resources) for information about ICS training and other ICS resources. Online ICS training is a useful starting point. However, it is not a substitute for ongoing, in-person training. Individual staff members are also responsible for their own ongoing work in the practice of Cultural Safety and Humility. While having all non-Indigenous staff trained in ICS is crucial to embedding culturally safe practice, the preferred approach is always to hire Indigenous staff.
4.4	**Engaging with Elders and Knowledge Keepers** Elders and Knowledge Keepers can be important sources of spiritual and emotional support for Indigenous peoples participating in supportive recovery services. Elders and Knowledge Keepers should always be compensated for their work. This is a way of recognizing the value of the wisdom and teachings that they share, and accords with traditional protocols around honouring the role of Elders and Knowledge Keepers in the community. If an Elder or Knowledge Keeper is going to be providing ongoing services, you should consider developing an agreement about fees-for-service, if the Elder or Knowledge Keeper chooses. You must make sure that Elders and Knowledge Keepers are compensated equally to other staff for their expertise and experience. For one-time events, an honorarium (accompanied by a gift) may be more appropriate, and travel expenses should also be covered.
4.5	**Connection to culture** For some First Nations, Métis or Inuit peoples, connection to culture is critical for long-term health and wellness. To make it possible for Indigenous peoples at your service to participate in cultural programming, you must build and maintain strong positive relationships with the local host Nation, and/or local Indigenous groups and organizations in the community. The First Nations Health Authority and the Province have online directories of Indigenous organizations and agencies. See *Resources* on p.21.

Cultural practices may include:

- Traditional language, art, storytelling, music, and song;
- Sweat lodges, smudging, and other ceremonial practices;
- Participation in local community events;
- Land-based healing activities;
- Access to Traditional Medicines; and
- Access to Elders and/or Knowledge Keepers.

It is important to recognize that culture and ceremony are practised differently across different First Nations, Métis and Inuit communities. Make sure you are aware of the culture that is practised in your local community/area, and that residents are informed.

As much as possible, people at your service who identify as Indigenous should be supported to practise their own cultural traditions and healing practices.

	Creating a culturally safe environment
	You should consult with the local host Nation and/or Indigenous partners on how you can work together in partnership to create a space that feels welcoming and to incorporate access to cultural practices in a respectful way.
4.6	You are encouraged to conduct an "equity walk through" of your site from an Indigenous perspective. This will prompt staff to consider the extent to which the space feels welcoming and culturally and emotionally safe for people and their families. See *Resources* on p.21.
	There should be accommodation for cultural practices that involve the burning of traditional medicines in your facility and/or in designated outdoor spaces.

Principles to Support Relationship Building with Indigenous Communities

Each First Nations, Métis and Inuit community will have a unique culture and protocols, so it is best for you to reach out directly and learn from those in your region.

The following principles may help in the relationship-building process:

- Respect the importance of building genuine relationships. Ask to meet in person and take the time to build the relationship before you make any request for input or support.
- Familiarize yourself with the purpose and practice of offering tobacco and/or a gift when seeking advice or knowledge.
- Compensate Elders and Knowledge Keepers for their time and the value of their services.
- Take the time to learn about the history of Indigenous peoples in Canada.
- Be familiar with the *Truth and Reconciliation Commission of Canada: Calls to Action* (2012).
- Learn about the land you are on and the community you would like to work with.
- Recognize that cultural practices may differ from what you are used to – be respectful and open to learning. (Adapted from AUMA, 2019.)

Recruiting Indigenous Staff

Organizations will be at different stages in the process of hiring Indigenous staff. For some, it may be necessary to develop a longer-term recruitment plan to move in this direction. However, all organizations must have a plan in place that they are actively making progress on.

Terms

Land-based healing is important to many Indigenous peoples. The First Nations Health Authority states that the "reconnection to land and the reclamation of our sacred places is foundational to our Indigenous identity and cultures. Through land-based healing and wellness we can revive our spirit, relearn our traditional practices, and revitalize our sacred connection to all our relations." ([FNHA](), 2020.)

Lived Experience Insights

"Cultural safety needs to be a requirement of the supportive recovery service, and it needs to be embedded in everyday practice."

"It's important from a cultural safety perspective that the supportive recovery service is part of the community. Staff and residents should participate in local community events."

"Operators need to build a strong rapport and relationships [with the Indigenous community]. But this is only possible if their heart is in the right place and they are really willing to learn about our culture."

"When cultural programming is offered to people, it wakes something up in them. It helps them to find a better footing in life."

"The most crucial thing is the ability to connect with culture."

Resources

Equip Health Care. (2017). *Equity Walk Through.*

First Nations Health Authority. (n.d.). *First Nations in BC Knowledge Network: BC Directories.*

First Nations Health Authority. (2016). *Policy Statement on Cultural Safety and Humility: "It Starts with Me."*

First Nations Mental Wellness Continuum Framework. Thunderbird Partnership Foundation. (2018). *Land for Healing: Developing a First Nations Land-based Service Delivery Model.*

Interior Health. (2020). *Aboriginal Cultural Safety Resources.*

Northern Health. (2016). *Local Cultural Resources.*

Province of British Columbia. (2019). *Guide to Indigenous Organizations and Services.*

Provincial Health Services Authority. (n.d.). *San'yas: Indigenous Cultural Safety Training Program.*

Vancouver Coastal Health. (2015). *Aboriginal Cultural Practices.*

Standard 5: Helping New Residents Settle In

Statement

During their first days at the service, the person is given the support they need to settle in, be safe and feel comfortable.

Intent

To ensure that the person's immediate needs are met and that the first few days contribute to their positive engagement with the service.

Required Elements

As the service provider, you must:

5.1	Give the person a warm welcome and ask what they need to feel safe and comfortable.
5.2	Review the service's rules and policies with the person and clearly explain their rights and responsibilities.
5.3	Talk to the person about how other members of their health and social care team may be involved in their care during their stay. Explain the circumstances in which you will consult with the person's primary care provider in the interests of the person's health and safety, and obtain their written consent to do so.
5.4	Involve the person in creating a short-term service plan that addresses their immediate needs and safety. This plan must deal with continuation of prescribed medications and what to do in the case of an unplanned departure from your service.
5.5	Regularly touch base with the person during their first few days to make sure they are safe, and to listen and respond to any questions or concerns they may have.

Guidance on Implementing the Required Elements

The first two to three days at a live-in service can be the most challenging for residents. As the service provider, you must make sure that people receive the support they need during this period. For some, this may mean having more contact with staff and other residents at the service, while for others it may mean having more time alone.

5.1	**Welcome and orientation** Depending on the person's wishes and capacity, the initial welcome and orientation to the service may include: • A tour of the facility; • Introductions to staff and other residents; and • An overview of programming and daily schedules. The timing and pace of the orientation must be guided by the person's capacity to participate and what they need to feel comfortable. Ask them what they want to see and know, and respect that. As appropriate and available, support from a senior resident, peer worker or Elder at the service could be provided. Ask the person if this is something they would like.

	Reviewing service rules and policies
	As stated in the Assisted Living Regulation, section 30, rules and policies to review with the person in the first few days include:
	• Shared common areas;
	• Visits and other forms of contact with family and friends;
	• Complaints process (including who to contact if they have a complaint or concern);
	• Circumstances in which residents may be asked to leave the service;
	• Management of medication; and
	• Tobacco and cannabis use, including vaping.
5.2	Give the person a paper copy of the service rules and policies. It may be helpful to make the information available in other formats as well (e.g., videos, posters, etc.).
	Wherever possible, when the person's first language is not English, you should provide information in the appropriate language.
	Explaining rights and responsibilities
	When explaining the person's rights and responsibilities, take time to make sure that they fully understand and to answer any questions that they may have.
	Residency agreement
	Note: Section 31 of the Assisted Living Regulation describes the residency agreement that the registered operator must make with each person.
	Involvement of the person's health and social care team
	It is important that you talk to the person about what communication and collaboration with other health and social care providers they are connected with (e.g., primary health-care provider, traditional healer, substance use counsellor, etc.) may look like. This includes, for example:
	• The circumstances in which a provider may be contacted;
	• Information that may be shared with other providers; and
5.3	• The active involvement of other providers in the person's care during their stay at your service.
	You must make it clear to the person that you will exercise the right to contact a medical professional, with or without the person's consent, in circumstances where their immediate health is at risk.
	In all cases, the person must be informed about decisions to contact another health-care provider.

5.4	The Assisted Living Regulation, section 32 mandates the creation of a short-term service plan to ensure the person's safety prior to the development of a more comprehensive personal service plan. This short-term plan should be in writing with a copy provided to the resident.

When the person is taking prescribed medications, it is imperative that they are supported to continue accessing these medications.

Unplanned departure

The short-term service plan must include information on what will be done to help the person to stay safe and connected to care in the case of an unplanned departure. This information, which may be called an "emergency transition plan," should address:

- Emergency contact information;
- Contact information for a primary care provider or other clinician;
- Contact information for a friend or family member who is willing and able to provide a safe place to stay (if different from the emergency contact);
- Program and contact information for community-based services;
- Harm reduction education/information and supplies;
- Access to a naloxone kit and training on how to use it; and
- What will happen to any personal property left behind.

You must explain to the person that if they make an unplanned departure, their emergency contact will be informed in the interests of the person's safety.

You must also explain to the person your refund policy in cases of early/unplanned departure.

The short-term service plan is kept in the person's file and a copy is also given to them.

See Assisted Living Regulation, section 46 for details on what you must do in the case of an unplanned departure. |
| 5.5 | Even when someone prefers to be left alone at the beginning of their stay, it is still important to do brief, regular check-ins to make sure that they are safe and well. These check-ins should be documented. |

Lived Experience Insights

"For the first few days, it's small steps – to build confidence, engagement. 'What do you want to accomplish next week? Not next year.'"

"Offering some good food and a movie may be the key to helping someone feel welcome and engaged in the service."

"There has to be a 'go-to person' – a senior peer – for the new resident. Someone who can offer that point of connection and be their guide for the first week. Kind of like a buddy system."

Resources

Toward the Heart. (2020). *Take Home Naloxone Program.*

Standard 6: Personal Service Planning

Note: The term 'personal service plan' is used in the Assisted Living Regulation to describe the written plan for the programming and supports that residents will participate in/have access to while they are at the supportive recovery service. Some service providers may be more familiar with the term 'individualized care plan.'

Statement

The person takes part in creating a personal service plan that clearly describes their goals and the programming and activities they will engage in to make progress towards these goals. The personal service plan is a living document that is continually reviewed and updated as people heal and change.

Intent

To ensure that personal service planning is a collaborative process that accurately reflects the person's goals and the steps that will be taken to achieve them, and to ensure that these decisions are clearly documented and regularly reviewed.

Required Elements

As the service provider, you must:

6.1	Support the person to actively participate in creating their personal service plan, together with service staff, other members of their health and social care team and, if the person wishes, members of their family or support circle.
6.2	Make sure that the plan covers personal goals, programming and activities, communication with other health and social care providers, transition planning, and connections to community-based services and supports. The plan must also deal with medication needs and align with the person's clinical treatment plan, if they have one.
6.3	Ensure the person retains a copy of their personal service plan.
6.4	With the person's consent, share the plan with their primary care provider or other clinician(s) involved in their care.
6.5	Review the plan with the person regularly and update it to reflect their changing situation, preferences and goals.

Guidance on Implementing the Required Elements

Sections 33 – 35 and Schedule D of the Assisted Living Regulation deal with the personal service plan and describe general requirements for meeting the resident's needs and achieving their personal goals. This standard sets out further requirements for how to go about creating the plan as well as the range of personal goals that the plan might include.

Standard 9: Programming and Supports addresses the specific programming and activities that are appropriate for people accessing supportive recovery services.

Approach to developing the personal service plan

Section 33(2)(a) of the Assisted Living Regulation states that a personal service plan must be developed within seven days of the person's arrival at the service. A key consideration, however, is the readiness and capacity of the person to be actively engaged in the development of the plan.

The pace at which the plan is created should be sensitive to and appropriate for the person's capacity to participate. The process should begin with identifying short-term goals, as it may be some time before the person is ready to think about longer-term goals.

6.1

Ask the person who they would like to be involved in creating the plan, and support this involvement. The person's 'care team' refers to health and social care professionals with whom they are connected, such as their primary care provider, substance use counsellor, traditional healer, etc.

If an Indigenous person wants to connect with an Elder to develop a cultural or spiritual plan, but prefers to keep this private, respect their wish for privacy.

Encourage and support the person to share their personal service plan with other members of their care team or members of their family/support circle.

You must have the person's consent before sharing their personal health information.

Setting personal goals

It is vital that the person has choice and personal agency over setting their goals and deciding what programming and activities they will take part in.

Personal goals may or may not be directly related to the person's substance use. For example, goals may include:

- Reducing or abstaining from substance use;
- Reducing the harms associated with substance use;
- Connecting to clinical services;
- Improving health and wellness;
- Having a safe and stable place to live;
- Participating in education, employment and/or volunteer activities;
- Improving income and financial management skills;
- Strengthening relationships with family and friends; and
- Building social and/or cultural support networks.

6.2

The personal service plan must also document decisions made about communicating and collaborating with other health and social care providers. See *Standard 5, Required Element 5.3*.

It is crucial that there is clarity across all members of the person's health and social care team about what the person's recovery goals are, and that everyone is working in alignment to support those goals.

Focus on cultural and community connections

The personal service plan must include a focus on increasing the person's social and cultural connectedness and (re)integration into the community. Opportunities to take part in community events and access community-based services, while at your service and as part of transition planning, must be included in the plan.

	Transition planning
	Transition planning must address both planned and unplanned departure from your service. See *Standard 5, practice note 5.4* for information on unplanned departure and *Standard 11: Transition Planning and Ongoing Connections* for information on planned departure.
	Managing medications
	The personal service plan must describe the supports that the person requires to manage any prescribed medications they are taking. See Schedule D(2)(3) of the Assisted Living Regulation and *Standard 7: Medical Needs and Prescribed Medications* for more details.
	As per section 33(5) of the Assisted Living Regulation, the personal service plan must be signed by the resident (or their personal representative) and the registered operator.
6.3	The information in the personal service plan is the residents. They should take a copy with them when they leave your service, so that it can be used to inform ongoing care planning with their care team and members of their family/support circle.
6.4	Sharing the plan supports medical oversight by the person's primary care physician or other clinicians involved in their care.
	See *Standard 1, practice note 1.7* for more details on the role of the person's primary care physician.
6.5	**Reviewing and updating the personal service plan**
	Section 35(1)(a) of the Assisted Living Regulation requires that the personal service plan is reviewed and updated at least every 30 days. However, depending on each person's situation and the length of the supportive recovery program, it may be necessary to review and update their plan more frequently.
	Progress made by the person towards their personal goals should be measured regularly during one-on-one or group sessions and recorded in their plan. Anyone reading the plan should be able to easily identify the goals that have been met or modified during the person's stay at your service.
	Respecting and encouraging progress towards goals that the person has set for themselves, rather than imposing goals on them, is vital to positive outcomes.

Lived Experience Insights

"I want to be asked what do I want and what do I need. I want to make sure that their plan is my plan."

"The service plan should be a plan for how the person – with support – is going to rebuild their life. It shouldn't be program-centred – 'this supportive recovery service offers this' – but goal centred – 'what do you need to do, have or learn to rebuild your life?'"

"If complete sobriety is what they want, then we are going to work towards complete sobriety. Do they need to rest for a month? Then we might skip the psychoanalysis and help them with sleep and exercise."

"You need to be realistic about where the individual is at with respect to their ability to take part in the service planning process – some may be ready to do this from day one, others may need time. Staff need to assess this and move at the appropriate pace. It's important not to overwhelm the person."

Standard 7: Medical Needs and Prescribed Medications

Statement

As needed, the service provider supports the person to access medical care, including prescribed medications.

Intent

To ensure that the person receives help in accessing any medical care they may need, and that they are able to take prescribed medications that support their health, wellbeing, and goals for recovery.

Required Elements

As the service provider, you must:

7.1	Make sure that the person's medical and medication needs can be safely supported during their stay at your service.
7.2	Actively support the person to access medical services of their choice in the community, including primary care, clinical substance use treatment and pharmacy services. This includes support to access the medications that they are prescribed.
7.3	Work with the person's primary care provider (or other clinicians involved in their care) to make sure that their medical needs are met. You must have the person's consent to contact any clinician, except in circumstances where their immediate health is at risk and they are incapable of providing consent.
7.4	Have clear written policies and procedures in place for the safe management, storage, distribution and administration of all medications.
7.5	Make sure that the personal service plan clearly describes any help the person needs to access medical care, and to obtain and take their medications safely.

Guidance on Implementing the Required Elements

This standard places an obligation on service providers to help residents identify and access the medical services that they may need. It is not expected that these medical services are provided in-house.

Some medical services may not be available in every community. However, service providers are responsible for making a concerted effort to connect residents with the treatment and supports they need, when these are available.

7.1	**Supporting the person's medical and medication needs safely**
	As part of the process to decide if your service is a good fit for the person (see *Standard 1:Informed Decision Making and Admissions*), you will have discussed their current/ongoing medical and medication needs, and determined that your service can safely meet these needs.
	If the person's medical or medication needs change at any point, either prior to the person's arrival or during their stay, you may need to reassess the capacity of your service to meet their needs safely.
	Note: Safety is the paramount consideration here. You should not deny a person access to your service based on ideological objections to the prescription medications they are taking.

Practical considerations of whether it is possible to safely support people with their medical and medication needs include (but are not necessarily limited to):

- The complexity of the person's needs, including the level of medical and medication support they will require;
- Your complement of staff and the level of care staff members are trained and qualified to provide;
- Proximity of your service to the person's preferred pharmacy (for pick up or delivery of medications); and
- Availability of primary care and/or specialized substance use and mental health services in your area.

If, during the person's stay, it is determined that their needs can no longer be met safely and that they require a higher level of care, their transition plan for an early (or unplanned) departure is followed. See *Standard 5, Required Element 5.4* and its *practice note*, and Assisted Living Regulation, section 46.

Medication management policy

The Assisted Living Regulation, section 37, requires that you have a written policy describing the type and level of medication management that you can provide at your service.

Standard 7 acknowledges the right of people to access supportive recovery services while taking prescribed medications for substance use disorders (such as opioid agonist treatment) and mental health disorders (such as anti-depressants).

To meet the standard, your medication management policy must not discriminate against people who are taking prescribed medications.

All decisions about what medications you can manage at your service must be based on practical and logistical considerations only (see examples of these above).

7.2	**Helping the person to access medical services** Residents must be able to exercise choice over which medical services they connect with, including (as appropriate to their needs) their preferred pharmacy. Active support to help a person connect with medical services may include, for example: - Providing information about relevant services; - Assisting with making appointments and completing paperwork; - Helping with directions and/or transportation; - Accompanying the person to an appointment; and - Being flexible with scheduled programming or chores to accommodate appointments. All conversations or discussions about medications for substance use disorders (e.g. during group work or individual counselling) must be neutral and non-stigmatizing. Indigenous people at your service may prefer the help of an Indigenous staff member or community member to access the medical care they need.
7.3	**Working with the person's primary care provider** It is important to communicate and collaborate with the person's primary care provider (or other clinicians involved in their care) to help ensure that: - They have access to appropriate medical services in the community; and - There is a level of medical oversight during their stay.

	If there are concerns that a person's prescribed medications might negatively impact their ability to participate in your supportive recovery service, you should seek advice from the person's primary care provider and work together to find a solution/appropriate way forward.
	See *Standard 1*, *practice note 1.7* for further details on general medical oversight.
	See *Standard 5, Required Element 5.3* and its *practice note* for details on contacting a person's primary care provider, with or without consent, when their immediate health is at risk.
	If a person decides to go against medical advice (including not following their prescribed medication regime), every effort should be made to work with the person's primary care provider to find a safe solution.
7.4	Medications must be managed in accordance with applicable legislation and regulations. See Assisted Living Regulation, sections 63 – 67, for detailed requirements on managing, safekeeping, distributing and administering medication. Note that medications may only be administered by the resident themselves or someone who is authorized to do so under the *Health Professions Act*.
	Medication management policies and procedures must reference how to respond to a medication error, and must follow legislation with respect to reporting serious incidents.
7.5	See Assisted Living Regulation, Schedule D (2)(3).
	For Indigenous peoples accessing your service, the personal service plan may identify Indigenous employees, volunteers or community-based individuals who can help them access culturally appropriate and safe medical services, traditional medicines, and/or traditional healers.
	If a person wishes to make a change to their prescribed medications, they should be encouraged to contact their prescribing clinician.

The Risks of Stopping Opioid Agonist Therapy Abruptly

If a person stops opioid agonist therapy (OAT) too quickly or against the advice of their prescribing clinician, their risk of harm is dramatically increased. Because opioid tolerance declines rapidly, just one relapse can result in an overdose death. This risk is especially heightened in B.C. due to the toxic illegal drug supply. For this reason, the decision to taper off OAT should only be made by the individual and their prescribing clinician.

Responding to an Overdose

The "SAVE ME" approach is a proven response to an overdose:

S – stimulation: Can you wake them up? If not, call 911.

A – airway: Make sure there is nothing in their mouth that stops them from breathing.

V – ventilate: Breathe for them. (Plug nose, tilt head back, and give 1 breath every 5 seconds.)

E – evaluate: Are they any better? Are you trained to give naloxone?

M – muscular injection: Inject 1cc of naloxone into a muscle.

E – evaluate & support: Is the person breathing on their own? If they are not awake in 5 minutes, another 1cc dose is needed. Tell the person not to use any more drugs right now – wait at least 2 hours.

(Toward the Heart, n.d., *Overdose Survival Guide*.)

Lived Experience Insights

"Supportive recovery services need to be connected to the wider system of substance use services and supports – so that there is more wraparound care and seamless transitions for people."

"Opioid agonist therapy is a prescribed medication, like insulin or an asthma inhaler. Therefore, it's not in conflict with services that describe themselves as 'abstinence-based.'"

Standard 8: Evidence-Informed Practice

Statement

The service provider uses promising practices and evidence-informed programming to work with each person on the goals set out in their personal service plan.

Intent

To ensure that all supports and programming offered at the service are informed by the best available evidence about what works in the field of supportive recovery for substance use.

Required Elements

As the service provider, you must:

8.1	Be able to demonstrate that you are following evidence-informed practice with regard to your service model, the programming you offer, and the qualifications and competencies of your staff. This includes staying up to date on current evidence and adapting your service as necessary.
8.2	Take a trauma-, gender-, and sex-informed approach to the delivery of all programming and supports.
8.3	Make sure that any Indigenous cultural programming has been developed in consultation with Indigenous organizations, service providers and/or Elders.
8.4	Be able to support people who have concurrent mental health issues with in-house programming and/or by connecting them with services in the community.

Guidance on Implementing the Required Elements

	As a service provider, you need to be aware that evidence on effective practices is constantly changing and emerging. It is important that you and your staff stay informed about current evidence on what works for people in supportive recovery and put these learnings into practice, so that your service continues to be relevant, safe and effective.
	Organizations that publish reliable evidence about substance use treatment and supports are listed in the *Resources* below.
	Demonstrating that your practice is evidence-informed
	Some examples of how you might demonstrate that you are following evidence-informed practice include:
8.1	• Being able to clearly describe the rationale that underpins your model of care and programming;
	• Being able to show that staff members have the necessary qualifications and/or experience for the programming they provide;
	• Making research literature available to staff;
	• Holding regular education and information-sharing sessions for staff (such as 'lunch and learn' sessions);
	• Taking part in knowledge exchange activities with other service providers; and
	• Taking part in educational events, such as webinars, online courses and conferences.

	See *Standard 9: Programming and Supports* for details of the types of evidence-informed programming and supports that are appropriate for supportive recovery services to offer.
8.2	There is growing evidence of the effectiveness of trauma-, gender-, and sex- (TGS) informed approaches in all areas of the substance use field. The Centre of Excellence for Women's Health has produced a practical guide to integrating TGS approaches into service delivery. See *Resources* below.
8.3	See *Standard 4: Indigenous Cultural Safety and Humility* for requirements and guidance on building relationships with Indigenous service providers and communities, and collaborating with them to develop cultural programming.
8.4	**Supporting people with concurrent mental health challenges** Many people who access substance use services also have mental health challenges. Effective care means making sure that people with concurrent mental health and substance use issues can easily access services that meet all their needs. As part of the process of deciding whether your service is a good fit for the person, you will have discussed any mental health needs that the person has and determined that your service is able to meet them safely. See *Standard 1: Informed Decision Making and Admissions.* You can support people with concurrent disorders by: • Hosting formal and/or informal peer support groups for concurrent disorders; • Offering workshops on mental health and wellness promotion; • Having information and resources on mental health available in common areas; • Providing help to find out about and access services in the community (e.g., scheduling appointments, giving directions to services, filling out required paperwork, etc.); • Assisting with transportation and/or going with people to appointments. See *Resources* below for useful materials on mental health.

Terms

Evidence-informed practice draws on information from research and academic studies, and brings it together with the expertise of practitioners and the experiences of people accessing services. Traditional First Nations, Métis and Inuit knowledge and practices are also a key component of evidence-informed practice.

An **intervention** is a 'promising practice' when there is sufficient evidence to show that it is effective at achieving a specific aim or outcome, in line with the goals and objectives of the activity or program.

Lived Experience Insights

"What works is a complex mix of individualized goals and programming that's evidence-informed."

"Land-based treatment, for example. There are no clinical research studies on this, but Indigenous providers know that it works."

"Local consultation needs to be done. There are leaders in the field who are ready to be part of that. Connect with Elders. Engage them!"

Resources

BC Centre of Excellence for Women's Health. (2013). *Trauma-Informed Practice Guide.*

Canadian Mental Health Association. BC Division. (2020). *Mental Health Information*.

HealthLink BC. (2020). *Mental Health*.

Here to Help and Canadian Mental Health Association BC. (2013). *Tips for Improving Mental Health*.

Northern Health, Indigenous Health. (2017). *Cultural Safety: Respect and Dignity in Relationships*.

R. Schmidt, et al. Centre of Excellence for Women's Health. (2018). *New Terrain: Tools to Integrate Trauma and Gender Informed Responses into Substance Use Practice and Policy*.

Organizations that publish reliable research on effective substance use treatment and supports include:

- BC Centre on Substance Use;
- BC Mental Health and Substance;
- BC Partners for Mental Health and Substance Use Information, *Here to Help*;
- Canadian Centre on Substance Use and Addiction;
- Canadian Institute for Substance Use Research; and
- Centre for Addiction and Mental Health.

Standard 9: Programming and Supports

Statement

The service provider offers and facilitates access to a range of programming and supports that help the person to achieve their personal goals.

Intent

To ensure that the person can take part in a variety of programs and activities in-house and in-community that meet their preferences and help them to make progress towards the goals identified in their personal service plan.

Required Elements

As the service provider, you must:

9.1	Offer and facilitate access to a range of individual and group-based programming that helps the person develop the skills, relationships and resources necessary to support them on their recovery journey. This programming must be evidence informed.
9.2	Provide the person with opportunities and support to rebuild, strengthen and/or create positive social relationships.
9.3	Make sure that programming provided in-house is flexible enough to meet the person's needs, circumstances and preferences.
9.4	Connect the person to community-based services relevant to their goals and preferences, as a part of their programming and to support their (re)integration into community.
9.5	Build and maintain linkages and relationships with the community-based organizations that provide programming and supports that are, or may be, relevant to the people who access your service.

Guidance on Implementing the Required Elements

9.1	Core evidence-informed programming for supportive recovery includes (but is not limited to):
	
	• **Formal or structured peer support** – such as peer-led self-help or mutual support groups (e.g., SMART Recovery, LifeRing, Women in Sobriety, Harm Reduction Works, and 12-step programs), mentorship programs, and having dedicated peer support workers on staff;
	
	• **Recovery-oriented (non-clinical) programming** – that helps people to build the internal and external resources necessary to start and maintain their recovery journey and improve their quality of life. This may include (according to individual need):
	    o Supportive counselling (including motivational interviewing);
	    o Psychoeducation and skills training (e.g., anger management, coping skills, communication, problem-solving, building self-esteem, developing respect for self and others, etc.);
	    o Stress management and self-management skills to address mild depression or anxiety;

	o Building healthy relationships (with self, family, friends, community); o Daily living/life skills (including roles and responsibilities for communal living); o Opportunities for leadership and peer support; o Vocational and employment training (e.g., resumé writing, job readiness skills, interview preparation); o Cultural programming; o Recreational and leisure activities; o Community engagement and re-integration; o Relapse prevention education and active practice of relapse prevention skills; o Overdose prevention recognition and response; and o Access to some specialized services in the community (e.g., MI, CBT, DBT, trauma-informed specialists, etc.). Your service is not expected to provide all the above programming in-house; rather, people's needs can be met through a combination of in-house and community-based supports. As the service provider, you must help each person to access clinical, psychosocial and substance use treatment supports of their choice in the community. See *Required Element 9.4*.
9.2	**Building positive social relationships** Positive social relationships are key to health and wellness. Some residents may wish to strengthen existing connections with friends and family who are supportive of their recovery goals. Other residents may choose to create relationships with a new circle of people who can support them in their healing journey. Connection to community may be particularly important for people who identify as First Nations, Métis or Inuit. For those who have been disconnected from their community for a long time, it may be helpful to support them to learn about where they come from and to find positive connections. Programming should include: • Exploration of the impact of the person's substance use on family, friends and community members; and • Concrete actions that may help the person to rebuild positive connections (e.g., writing gratitude letters to friends and family members, setting up visits, etc.).
9.3	Evidence shows that a 'one size fits all' approach to substance use treatment and supportive recovery services is not effective. Therefore, it is vital that your service provides programming in a way that is flexible and responsive to the diverse range of people you serve. The types of programming that each person participates in should align with the personal goals that they have set for themselves. Cultural practices should be among the essential supports offered to people who identify as Indigenous. See *Standard 4: Indigenous Cultural Safety and Humility.*
9.4	**Building connections to community** Connecting people to community-based services not only enables them to get the full range of supports they need; it is also essential for helping them to build their own network of relationships in the community. Such relationships can strengthen people's sense of belonging and contribute to their capacity for independent living.

	In addition to formal connections to community through programming, it is important to give people opportunities to engage with the local neighbourhood in informal ways (e.g., taking part in community events, volunteering, helping a neighbour, etc.)
9.5	To help connect people with services in the community, it is essential that you are aware of, and work to establish strong linkages with, health and social care agencies in your area. Community-based organizations with which you are linked may also be able to help with the design and delivery of in-house programming at your service.

Lived Experience Insights

"People need to be in the 'real world' throughout the supportive recovery experience. This is why it's so important for the supportive recovery service to develop and model strong community linkages and become a strength in the community."

"Taking part in activities with others and feeling like you're in community – that's the heart of a program."

"Human connection is crucial for healing and recovery. It's important to identify allies in the community and connect people to them."

"Learning to be in healthy relationship with self and others is an important part of the work of supportive recovery. Setting healthy boundaries – to ensure the safety of self and others. This is crucial for when the person leaves the service."

"Learning fundamental life skills is key. These tend to be neglected, or forgotten, or never developed during the period of someone's substance use."

"It's critical for people to be prepared for the next stage in their progression to wellness."

Standard 10: Keeping Residents Safe

Statement

The supportive recovery service is a safe environment for all residents.

Intent

To ensure that all residents are free from harm and feel safe and respected in the supportive recovery community.

Required Elements

The Assisted Living Regulation sets out extensive provisions to support the health and safety of residents. The following required elements align with these provisions and set out additional expectations for supportive recovery services.

As the service provider, you must:

10.1	Strive to create and maintain an environment that is free of racism, sexism, discrimination, harassment and violence.
10.2	Recognize and respect the individual rights of each person accessing your service.
10.3	Explain to each person what their rights and responsibilities are with regard to maintaining a safe and stable living environment.
10.4	Have a transparent complaints process in place that ensures both confidentiality and accountability, and make certain that the process is clearly communicated to all residents.
10.5	Respond to and report any incidents that threaten the health and safety of residents and/or staff.
10.6	Make sure that all members of staff have the knowledge and skills to recognize and respond effectively to relapse and overdose. Naloxone training is mandatory for all staff.
10.7	Touch base with each person regularly and stay alert to any adverse changes in their behaviour or physical condition.

Guidance on Implementing the Required Elements

10.1	**Preventing and dealing with discrimination** It must be clear to all residents, staff and visitors that your service does not tolerate: • Discrimination based on race, ethnicity, sex, gender identity, culture, sexual orientation, age, religion, nationality, marital status, political beliefs, mental or physical disability, medical condition or any other personal characteristic, condition or status; and • Physical or sexual violence, threats of violence, sexual harassment or bullying. Any incident of racism or discrimination and/or violence must be taken seriously and dealt with by a senior member of staff. Ideally, the staff member dealing with the incident will have specific training on and/or experience with working through such issues. There must be processes in place for residents and staff to safely debrief any incidents of discrimination and actual or threatened violence. Such incidents must also be documented.

See also *Standard 4: Indigenous Cultural Safety and Humility.*

10.2	**Individual rights** All people accessing your service have the right to: • Be treated with dignity and respect; • Receive services regardless of race, ethnicity, national origin, sex, gender identity, age, religion, disability, sexual orientation, or financial circumstances; • Actively contribute to personal service plans; • Expect privacy and confidential handling of personal information; • Have freedom from harm and abuse; • Receive services in a safe and clean environment; • Access medical care in the community; • Ask questions and get help with rights; and • Have complaints resolved promptly and fairly.
10.3	**Rights and responsibilities for safe communal living** A statement of residents' rights and responsibilities with respect to the communal living environment should be developed and made available to all residents, involved family members and staff. In addition, you must take the time to go through these rights and responsibilities clearly and carefully with each resident (and involved family members) at the beginning of their stay, taking into account any language barriers, and answering any questions that they may have to support their understanding. All residents must treat staff members, visitors and other residents with respect. This includes being polite, honouring people's diversity and preferences, preserving people's dignity and respecting different cultures and gender identities. It may be helpful to give individuals concrete examples of what respectful behaviour does and does not entail. Core programming should address the skills needed to contribute to a safe and respectful living environment (including, for example, managing feelings and dealing appropriately with conflict). See *Standard 9: Programming and Supports.*
10.4	**Complaints process** As per Assisted Living Regulation, section 43, you must have a policy in place that describes how residents (or their personal representatives) may make a complaint about your service, and how concerns will be resolved. Section 31(3)(b) and section 43(2) of the Assisted Living Regulation also require you to display the contact information for the Assisted Living Registry in a prominent place, so that residents know whom to contact if they have a specific complaint about your service. Wherever possible, there should be an option for residents to make a complaint to a neutral party. Complaints must be dealt with promptly and compassionately, and people must be fully informed about the outcomes. There must be no negative repercussions for any resident who makes a complaint about the service. Anyone who has made a complaint must continue to receive the same level of service as every other resident.

If a person has made a complaint about another resident, you should provide any additional supports or protections that may be necessary to keep the complainant safe.

10.5	**Responding to and reporting incidents** The nature of any incident should be carefully considered to determine if additional people or authorities should be involved to address the issue appropriately. Incidents of racism and physical or sexual violence may require intervention from law enforcement. Dealing with a complaint of racism against an Indigenous resident may require support from an Elder or other community member to ensure that the process followed is culturally safe. Under the Assisted Living Regulation, a serious incident report must be sent to the Assisted Living Registry if there is any physical or sexual violence against a resident. This is in addition to notifying the police and other relevant authorities/agencies. See section 51 and Schedule E for further details about reportable incidents and reporting requirements.
10.6	**Responding to relapse** Relapse is possible no matter how long an individual has been working to change their substance use and it is most helpfully seen as a normal part of the recovery journey. Relapse should not automatically result in a person being made to leave your service. Instead, staff should take a nonjudgmental and compassionate approach to help sustain the person's engagement with their recovery. This could include, for example: • Checking-in more frequently with the person and working with them to identify and address any unmet needs that may be contributing to relapse; • Increasing the level or intensity of in-house and/or community-based programming that the person is taking part in; • With the person's permission, engaging family members, friends and/or care team members to provide extra support; and • Connecting the person with a community-based clinician that can prescribe appropriate pharmacotherapy (such as opioid agonist therapy or relapse prevention medications). Response to relapse should also include an analysis of the safety of and potential harms to other residents. It may be necessary to provide support and resources to other residents who have been affected by the person's substance use. In some cases, it may be determined that your service is no longer the right fit for the person. If it is necessary for the person to leave your service, this must be handled sensitively and with full regard for the person's health and safety. You must make every effort to work with the person to find an alternative live-in service that will better meet their needs, and support their transition to that service. It is crucial that the person has safe accommodation to go to when they leave your service. See also *Standard 5, Required Element 5.4.* **Responding to an overdose** All staff members must be able to recognize the signs of an overdose and respond appropriately. Signs of overdose and the appropriate response may be different depending on the substance used.

	The BC Centre for Disease Control's *Toward the Heart* website provides current information about naloxone training as well as reliable online resources. Fraser Health has a useful guide to recognizing and responding to a stimulant overdose and a depressant (opioid) overdose. See *Resources* below.
	The Assisted Living Regulation, section 28 deals with opioid overdose. As per this section of the regulation, all staff and residents must have ready access to naloxone and related supplies and know how to administer it safely.
10.7	**Touching base regularly with people** At some point throughout each day, staff must have had at least two face-to-face interactions with each person. These interactions may take place, for example, during group sessions, mealtimes, roll call, etc. When a person is expected at a group session, meeting or meal, etc. and does not show up, a check-in should be conducted promptly. At the beginning of a person's stay, it may be necessary to conduct more formal and more frequent check-ins to ensure their safety. See *Standard 5, Required Element 5.5*. See the *Assisted Living in B.C.: Handbook for Operators* (2019), p. 26 for suggestions on what types of changes to be aware of.

Lived Experience Insights

"Operators and staff need to think about the safety of everyone in the community they're creating."

"There is an issue of balance - someone cannot bring substances into the house, as it puts everyone at risk. But there is a way of dealing with it that helps ensure the person is safe. Find the person somewhere else to go that is safe and leave the door open for them to return."

"Staff need to be able to say to someone in recovery, 'You're going to make mistakes, and that's okay.'"

Resources

BC Centre for Disease Control. (2020). *Toward the Heart*.

Fraser Health. (2018). *Overdose Prevention and Response*.

Standard 11: Transition Planning and Ongoing Connections

Statement

The person takes part in creating a plan for their transition to another living situation and is connected to the community-based services identified in the plan.

Intent

To ensure that the person experiences a seamless and safe transition from the supportive recovery service to their next living situation and is supported to continue building on the progress they have made.

Required Elements

As the service provider, you must:

11.1	Support the person to create a written transition plan (as part of their personal service plan). This should be done in collaboration with service staff, other members of the person's health and social care team and, if the person wishes, members of their family or support circle.
11.2	Begin working with the person on their transition plan as early in their stay as possible.
11.3	Make sure that the transition plan addresses both planned and unplanned (emergency) departure from your service and that what is needed to put these plans into action is available and at hand.
11.4	Work with the person to identify, and document in the transition plan, the community-based housing, health and social services they may require or wish to connect with to support their safety and ongoing recovery.
11.5	Actively support the person to connect with the services identified in their transition plan.
11.6	Give the person a copy of their transition plan and, with their consent, share the plan with their primary care provider or other clinician(s) involved in their care.

Guidance on Implementing the Required Elements

11.1	**Collaborative transition planning** Wherever possible, at least one community-based service provider should be involved in the transition planning process. Ideally, this will be someone that the person is already connected with, such as a referral agent, substance use counsellor, primary care provider or Elder. It is important to include the person's family and/or support circle in developing the transition plan, as these individuals may provide ongoing help and care to the person. By being involved in the transition planning, family and friends will better know what to expect when the person returns to the community or the family home and will have sufficient time to organize any supports they may require. Family involvement could take place in person, over the telephone, or by videoconference. See Assisted Living Regulation, section 45(3) for requirements regarding planned end of residency.
11.2	Preparation for a person's transition to another living situation should begin as soon as the person is ready to participate in this kind of planning.

All programming and activities at your service should be focused on helping the person to (re)integrate into the community. Any positive community connections that the person already has should be maintained throughout their stay, and additional connections developed.

11.3	**Key information/contacts** In preparation for a planned departure, the transition plan must identify: • The person's intended departure date; • The family/support circle and care team members who will be notified that the person is leaving; • The staff member responsible for notifying appropriate family/support circle and health and social care team members; and • The support people/service providers that will be present to help the person settle into their accommodation. If the person's planned date of departure changes, the new date must be recorded in their transition plan. **Putting the plan into practice** It is important to think through and cover off the logistical elements of putting the transition plan into practice. These include, for example, preparing the person's home for their safe return (cleaning and a safety inspection may be required) and arranging transportation. **Marking the person's return to the community** Ask the person how they would like to mark their return home/to the community. Some people may want to celebrate in some way with family and friends; others may prefer time to themselves. For more information on creating an emergency transition plan, see *Standard 5, Required Element 5.4* and its *practice note*. See also Assisted Living Regulation, section 46 for details on what you must do in the case of an unplanned departure.
11.4	To help ensure the person's immediate safety upon leaving your service, **the transition plan must address**: • Access to safe and secure housing; • Connection to a primary care physician (or other clinician or traditional healer); • Ongoing substance use treatment and supports; • Access to mental health services; • Overdose prevention recognition and response; • What to do in the case of a relapse; • Ongoing access to prescription medications; and • Safety from violence and abuse. **The transition plan may also address** the following, as appropriate to each person's situation and goals: • Personal and social supports (including connections to community groups); • Cultural organizations and connections to Elders; • Education and/or vocational training; • Employment; • Life skills training and support; • Spiritual or faith organizations;

	• Recreational interests (e.g., arts, sports, social activities); and
	• Parenting skills and supports.
11.5	**Actively supporting the person to connect with community services** may include:
	• Providing information about relevant services;
	• Helping the person to establish a connection with a service (e.g., by making a phone call, sending an email, or setting up a meeting);
	• Helping complete necessary paperwork, such as application forms; and
	• Going with the person to visit the service and meet staff.
	Your ability to help residents connect with community-based services will be strengthened if you have already developed linkages with these services, as required by *Standard 9, Element 9.5*.
11.6	The written transition plan may be a section within the personal service plan or a separate written document. In either case, the resident must be given a copy.
	Sharing the transition plan with the person's primary care physician or other clinicians helps to ensure medical oversight and continuity of care.
	You must make sure that the person takes their transition plan with them when they leave the service.

Lived Experience Insights

"If the service doesn't help the person to leave in a safe, supported way, then they're being set up to fail. The service may as well say, 'See you again in a few weeks.'"

"Transition planning should start when the person walks in the door."

"Communication with family members or another primary contact is so important, especially when the person leaves the service."

"People who return to the community without a transition plan are especially vulnerable to relapse or overdose. So there needs to be significant effort put into the transition plan from the beginning to reduce these risks."

"We need to ensure a smooth transition back into their regular life."

Standard 12: Evaluating Your Service and Continuous Quality Improvement

Statement

The service provider evaluates their service to identify what is working well and to help improve the quality and relevance of programming and supports.

Intent

To ensure that the service provider seeks and uses input from individuals and organizations connected with their service in order to evaluate and enhance the effectiveness of the care provided.

> Health-authority contracted and funded services must also participate in all monitoring, evaluation and quality assurance activities required by the health authority as per their contract to provide services.

Required Elements

As the service provider, you must:

12.1	On an ongoing basis, collect and record key outputs and outcomes data that will support you to evaluate your service. These data should include: a. The number of people accessing your service, their demographic information, and their level of participation; b. Informal and formal feedback from residents on their satisfaction with the service, and the extent to which they feel it is meeting their needs and supporting their recovery journey; c. Informal and formal feedback from staff about what is working well at the service and what areas could be improved; and d. Informal and formal feedback from other professionals and agencies that are linked to your service.
12.2	Every one to three years, plan and implement a more formal evaluation of your service that looks systematically at what the service is doing and what it is achieving.
12.3	Use the evaluation findings to improve your service and the programming and supports you offer.

Guidance on Implementing the Required Elements

When providing feedback on your service, residents must be assured that all information will be confidential, will be used to improve the service, and will not be used in any way against them.

To ensure confidentiality and protect residents' privacy, all data collected for the purposes of evaluating your service must be anonymized, i.e. there must be no personal identifiers (such as name, date of birth, address, etc.) attached to the data.

Outputs data

a. It is important to have a clear picture of who is accessing your service and the extent to which your service is meeting the needs of the resident population.

   Number of people accessing your service: This information should be tracked for a specific period of time (e.g., over the course of a year or over the course of a specific funding period).

   Demographic information: This includes, for example, age, gender identity, sexual orientation, cultural background, etc. You can use this information to make sure that your complement of staff, and the programming being provided, are appropriate for the population(s) you serve.

   Level of participation: This may include, for example: the number of people participating in specific programming and activities; the proportion of people who stay for the full duration of their planned time; and the proportion of people who choose to leave or are asked to leave your service early. Low levels of participation in programming and high numbers of early/unplanned departures from your service may indicate that the needs of the resident population are not being met.

12.1

Outcomes data

b. You may choose to collect feedback from residents in written or oral form through, for example, surveys, interviews, and/or informal conversations.

   Upon leaving the service, each resident should be invited to fill out a satisfaction survey and/or take part in an exit interview. Feedback from residents should measure their impressions of the quality of your service, and how well the service has met their needs and supported them to make progress towards their personal goals. People who identify as Indigenous should also be invited to comment on the extent to which they felt culturally safe and supported in the ways they needed.

c. Feedback from staff can be collected informally and on an ongoing basis via, for example, daily staff huddles, weekly debriefs, regular staff meetings, etc. Formal feedback on how the service is doing may also be collected as part of each employee's annual performance review (as per section 24(1)(a) of the Assisted Living Regulation).

d. At least annually, invite the health-care professionals and community-based agencies that you are connected with to share their impressions of your service. This could be done formally via a survey, or informally via a telephone conversation.

To support a **formal evaluation** of your service, you should create a written evaluation guide that includes the following components:

- An overarching plan that describes:
    - The purpose of the evaluation;
    - What will be evaluated; and
    - How the findings will be used; and
- A more detailed framework that sets out:
    - The objectives of your service that you will evaluate;
    - The evaluation questions you will ask;
    - The indicators you will use to measure success; and
    - The kind(s) of data you will collect.

Example of an evaluation framework

Objectives or Intended Outcomes	Evaluation Questions	Indicators	Data Source
To support residents to increase their social connectedness	Did residents take part in community events?	Number of individuals who participated in one or more events outside of the service	Personal service plan review
	Do residents feel more connected to family and friends?	Increased feelings of connectedness to one or more friends or family members	Exit interview
To support residents to access the medical care they need in the community	Were residents able to continue accessing prescribed medications?	Number of residents who did not experience a disruption in their medication regime	Personal service plan review
…	…	…	…

If evaluation is new to you, there are many resources available to help you get started. You can access a wide variety of free evaluation information online, as well as downloadable tools and resources. Some of these are listed in the *Resources* below. If you have specific resources allocated for evaluation, you could consider working with a local, experienced evaluator.

Using your evaluation findings

As a service provider, it is critical that you are monitoring the ongoing effectiveness of your service and actively addressing any issues that may be having a negative impact on your resident population.

You can use the findings from your formal evaluations to:

- Understand and improve your service;
- Describe what your service is doing and achieving;
- Be accountable to your residents and your funders; and
- Support fundraising efforts.

12.2

12.3

Key Evaluation Terms

Evaluation is the systematic collection of information about a program that enables stakeholders to better understand the program, improve its effectiveness and/or make decisions about future programming.

Activities are the actions that are needed to implement a program – what you do with program resources in order to achieve program outcomes and, ultimately, your goal(s). Common activities are providing services, developing products, engaging in advocacy and building infrastructure.

Outputs are the measurable, tangible, and direct products or results of program activities. They lead to desired outcomes – benefits for participants, families, communities, or organizations – but are not themselves the changes you expect the program will produce. They help you assess how well you are implementing the program.

- Examples include: number of people served; hours of service provided; number of group sessions/workshops delivered; number of partnerships formed; and hours of staff training completed.

Outcomes express the results that a program intends to achieve if implemented as planned. Outcomes are the changes that occur or the difference that is made for individuals, groups, families, organizations, systems, or communities during or after the program. They answer the questions: "What difference does the program make?" "What does success look like?" They reflect the core achievements you hope for your program.

Outcomes can be about changes in *learning*, changes in *action*, or changes in *condition*:

- *Changes in learning* – new knowledge; increased skills; changed attitudes, opinion or values; changed motivations or aspirations.

- *Changes in action* – modified behaviour or practice; changed decisions; changed policies.

- *Changes in condition* – human (e.g., from vulnerability to resilience; from homelessness to secure housing); economic (e.g., from unemployed to employed), civic (e.g. from disenfranchised to empowered); environmental (e.g., from polluted to clean).

Adapted from *Innovation Network.*

Resources

Evaluation-related websites:
- Better Evaluation.
- Innovation Network.

Evaluation tools and resources:
- Colorado Nonprofit Association. (2011). *Evaluation Toolkit.*
- Community Toolbox. (n.d.). *A Framework for Program Evaluation.*
- Imagine Canada. (2006). *Project Evaluation Guide for Nonprofit Organizations*.
- Innovation Network (n.d.). *Evaluation Plan Workbook.*
- National Collaborating Centre for Aboriginal Health. (n.d.). *Indigenous Approaches to Program Evaluation.*
- National Council of Nonprofits (US). (n.d.). *Evaluation and Measurement of Outcomes.*

Glossary of Key Terms

Cultural Humility – Cultural humility is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust. It involves humbly acknowledging oneself as a learner when it comes to understanding another's experience, taking an ethical stance that steers clear of arrogance, and being open to interrogating one's moral sensibilities. (See First Nations Health Authority.)

Elder – Is someone who has earned the trust and respect of an Indigenous community by contributing to its growth and by building respectful relationships with the land and the people. Elders are humble. They guide the next generations as they lead by example. Elders provide teachings through oral history and ways of being, and by sharing wisdom and insights. A person may not proclaim themselves an Elder. Rather, 'Elder' is a title of respect that is bestowed by the community.

Evidence-informed – Evidence-informed practice (EIP) is a model that involves the mindful and judicious use of certain types of information when making decisions about policy and practice. EIP takes into consideration: the best available research evidence; the knowledge and expertise of practitioners; and the needs, values, and preferences of people accessing services. Traditional First Nations, Métis and Inuit knowledge and wisdom may also be integrated into evidence-informed practice.

Family – While the term 'family' traditionally refers to persons related by blood, marriage or adoption, it is important that each person participating in health-care services define 'family' for themselves. The term is generally used in this document to mean 'family of choice,' i.e. encompassing the circle of supportive and trusted people that that an individual has assembled around them, which may include, augment and/or replace their family of origin. This document also uses the term 'support circle' to describe this group of people.

Gender- and sex-informed practice – Involves developing substance use services that are effective and appropriate for everyone. Gender-informed approaches consider how social factors such as gender relations, roles, norms, gender identity and gendered policies affect individual experiences of substance use, the effectiveness of treatment, and a person's ability to access care and treatment. Sex-informed approaches consider how biological characteristics such as anatomy, physiology, genes, hormones and neurobiology affect the ways that bodies respond to various substances and influence treatment outcomes. (See Centre of Excellence for Women's Health, 2018.)

Harm reduction – Is a public health approach that aims to reduce the social, physical, emotional and/or spiritual harms related to substance use. Harm reduction strategies and services treat people with respect and aim to meet them wherever they are at in their substance use or recovery journey. Services and supports may include: safer substance use supplies and/or take-home naloxone; outreach; referrals to health and social care services; and helping people to develop healthy relationships. (See BC Centre for Disease Control, *Harm Reduction Services*, 2020.)

Indigenous Cultural Safety – Is a theory, a process and an outcome. Most importantly, it is an outcome that is based upon respectful engagement with Indigenous peoples that recognizes and strives to address power imbalances inherent in health and social care systems. Culturally safe services are free of racism and discrimination, and provide appropriate care in an equitable and safe way. Acknowledging and addressing Indigenous-specific racism is a key part of creating safe environments for Indigenous peoples to work and to receive services.

Indigenous Peoples – Refers to the original inhabitants of the land, which, in Canada, includes First Nations, Métis and Inuit peoples. The first letters are capitalized to recognize nationhood, and the term is plural to recognize the multiplicity of Indigenous nations that exist across the country. The term 'Aboriginal' is sometimes used interchangeably with 'Indigenous.' However, 'Indigenous' is increasingly recognized as the preferred term due, in part, to its association with the *United Nations Declaration on the Rights of Indigenous Peoples.* In this document, the terms 'Indigenous peoples' and 'First Nations, Métis and Inuit peoples' are both used.

Knowledge Keeper – Is a title bestowed on some individuals and is distinct from the title of 'Elder.' Knowledge Keepers are recognized for their specific gifts, the traditional knowledge they hold, the wisdom they carry, and the lived experiences they bring forward that can help to provide guidance. Like living libraries, Knowledge Keepers hold spiritual, cultural and ceremonial knowledge. They pass on valuable teachings and oral histories from generation to generation.

Recovery – Recovery from problematic substance use is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. While in recovery, people often experience improved health, social connections, functioning and sense of purpose, as well as enhanced quality of life. (See SAMHSA, n.d., and CCSA, 2017.)

Trauma- and resilience-informed practice – Takes into account an understanding of trauma in all aspects of service delivery and places priority on the individual's safety, choice and control. Services create a treatment culture of nonviolence, learning and collaboration, in which people are assisted to identify their strengths and to (further) develop resilience. Using a trauma- and resilience-informed approach does not necessarily require disclosure of trauma. Rather, services are provided in ways that recognize the need for physical and emotional safety. A central tenet of trauma- and resilience-informed practice is that people can recover, and the approach is grounded in hope and the honouring of each individual's resilience. (See *Trauma-Informed Practice Guide*, 2013.)

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