Provincial Standards for Registered Assisted Living Supportive Recovery Services

IMPLEMENTATION RESOURCES

September 2021

BRITISH COLUMBIA

Table of Contents

About this Document

This is a companion document to the *Provincial Standards for Registered Assisted Supportive Recovery Services* (2020). It contains a variety of tools and resources to help supportive recovery operators to implement the *Provincial Standards* at their service.

The document is organized as follows:

- **Part 1** – provides an "organizational self-assessment tool" designed to help service operators and staff to reflect on and gauge how their service is doing with respect to meeting the *Provincial Standards*.
- **Part 2** – provides sample forms to support implementation of the required elements in *Standard 1: Informed Decision Making and Admissions*, and *Standard 6: Personal Service Planning*.
- **Part 3** – offers a curated list of Indigenous Cultural Safety and Humility training and education resources, as well as definitions of key terms.

Important Note to Service Operators About the Sample Forms

Service operators are <u>not required</u> to use the sample forms provided in Part 2 of this document in order to comply with the *Provincial Standards*.

Service operators are encouraged to review the sample forms with consideration of the new *Provincial Standards* and the processes and systems they may already have in place at their service.

Sample forms can be:

- Used by service operators "as is";
- Adapted to fit their resident population, service needs and circumstances; or
- Used to inform or adjust processes and systems that are already in place.

Service operators are encouraged to add or remove elements in the sample forms as appropriate and relevant to their service.

PART 1

Organizational Self-Assessment Tool

Organizational Self-Assessment Tool

This organizational self-assessment tool supports service operators and staff to reflect on and gauge how their service is doing with respect to meeting the *Provincial Standards for Registered Assisted Living Supportive Recovery Services* (2020).

It is intended to guide discussion and consensus building among staff members at all levels of the organization (including people with lived experience, peers, and/or volunteers) about where the service is at, where it needs to go, and what steps can to be taken towards increasing compliance with the *Provincial Standards*.

Use of this tool is optional. Implementing the tool requires some dedicated time and effort (see *How to Use the Tool* below) but operators should find that the information it generates is worth the investment.

As well as providing an internal measure of an organization's compliance with the *Provincial Standards*, the tool generates information that can be shared with health authority funders – for example, as part of an external evaluation process – to highlight the strengths of the service being provided and to demonstrate that evidence-informed practices are being used. Finally, the process of using the tool should help to build / further strengthen relationships between staff and ensure that everyone is working towards shared goals and outcomes, to the benefit of all residents.

How to Use the Tool

A three-step process is recommended:

- **Step 1 – Individual staff members complete the organizational self-assessment template:**
    - For each of the required elements in a standard, check the *Not meeting*, *Partially meeting*, or *Meeting* box. The *Comments* space can be used to make brief notes to support your selection.

  Check *Meeting* if all aspects of a required element are being done consistently and completely.

  Check *Partially meeting* if aspects of the required element are being done sometimes but not always and/or not as completely as they could be.

    - Based on your assessment of how well the service is meeting the required elements, give an overall rating for the standard as a whole. This rating may be anywhere along the spectrum *1 Just started – 2 On the road – 3 Nearly there – 4 We're there*. Use the spaces underneath the rating scale to briefly describe why you gave that rating and record ideas for actions that the service can take in order to make progress.
    - You should allow about 1.5 to 2 hours to complete the template with sufficient thought and detail.
- **Step 2 – Staff members meet as a group to share and discuss their individual assessments:**
    - Staff members take part in a facilitated process to share and discuss their overall ratings for each standard. The goal is to come to a consensus rating for each of the standards and to agree on actions that should be taken next.
    - If possible, a neutral facilitator (i.e. from outside of the organization) should be engaged to help ensure that everyone's opinions are given equal consideration. If this is not possible, consider using:

        - A staff member/volunteer who has some experience in group facilitation; or
        - A member of the organization's leadership with accountability for acting on the decisions made.
    - Assign someone to record the findings of the discussion (i.e. the consensus ratings and agreed action items).
    - It is recommended to put action items into a timeline and to assign responsibility for implementing them.
    - The amount of time needed for Step 2 will depend on the degree of agreement/ disagreement between the ratings given by staff members, and the number of people participating. At minimum, it is recommended to allow about 4 hours. If necessary, Step 2 can take place across a number of shorter meetings (for example, three or four weekly staff meetings).
- **Step 3 – Senior staff/leadership write up the findings (including the actions and timeline for implementing them) and share with all staff members.**

The tool can be completed at regular intervals (e.g., every six or 12 months) as a means of evaluating progress towards meeting the provincial standards and flagging any issues that need to be addressed.

Organizational Self-Assessment Template

Date of Assessment _____

Standard 1: Introducing Your Service and Supporting Informed Decision Making

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.

Required Elements

1.1 We provide clear, accurate information about our service on the service website and/or in printed brochures or handouts.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

1.2 We involve the person as an active participant in making the decision about whether our service is a good fit for them, remembering that they have the right to self-determination and control over their care.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

1.3 We are mindful of the person's emotional, mental, physical, spiritual and cultural wellness, and make sure that conversations about the service and the information we are providing match their capacity to fully understand.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

1.4 We provide the person with accurate, easy-to-understand and non-stigmatizing information about what our service offers and the model of care that is followed.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

1.5 We make sure that our service is low barrier. We ask only for the minimum amount of information necessary to feel reasonably confident that our service will be a good fit for the person and that they will be able to participate safely.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

1.6 We welcome and facilitate the involvement of the person's family members or support circle in the decision-making process, if this is what the person wants.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

1.7 We include the person's primary care provider and/or other clinician(s) in the decision-making process, if this is what the person wants.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

1.8 We provide the person with information about alternative services and supports, if it is decided that our supportive recovery service cannot safely meet their needs.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

Overall Rating for Standard 1

– – – – – 1 – – – – –	– – – – – 2 – – – – –	– – – – – 3 – – – – –	– – – – – 4 – – – – –
Just started	**On the road**	**Nearly there**	**We're there**

Why I gave this rating:

What we can/need to do next to make progress:

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

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

Required Elements

2.1 We regularly communicate with the person to update them on their expected date of entry to our service and to start building a connection with them.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

2.2 With the person's consent, we connect with their care team and support circle in preparation for providing collaborative care once the person enters our service.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

2.3 We 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.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

2.4 Closer to the date of entry, we confirm that the information gathered during the initial decision-making process is still accurate and up to date.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

Overall Rating for Standard 2

––––– 1 –––––	––––– 2 –––––	––––– 3 –––––	––––– 4 –––––
Just started	**On the road**	**Nearly there**	**We're there**

Why I gave this rating:

What we can/need to do next to make progress:

Standard 3: Staffing

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.

Required Elements

3.1 There is a clear, systematic process in place to determine the appropriate complement of staff for our service.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

3.2 There is at least one staff member or designated senior resident on duty and on site at all times.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

3.3 There is a plan in place to recruit and retain staff from the communities and populations that access our service.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

3.4 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.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

3.5 All paid staff members are provided with professional development opportunities necessary to maintain the key competencies for their roles and to support the delivery of evidence-informed care.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

3.6 All staff are trained in and can apply the principles of trauma- and resilience-informed practice, and Indigenous Cultural Safety and Humility.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

3.7 An annual review is conducted of each paid staff member's performance.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

3.8 Volunteers are provided with support and supervision for the work that they are doing.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

3.9 Policies and practices have been developed and put into action to ensure the safety of staff, and to support their mental and emotional well-being.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

Overall Rating for Standard 3

– – – – – 1 – – – – –	– – – – – 2 – – – – –	– – – – – 3 – – – – –	– – – – – 4 – – – – –
Just started	**On the road**	**Nearly there**	**We're there**

Why I gave this rating:

What we can/need to do next to make progress:

Standard 4: Indigenous Cultural Safety and Humility

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.

Required Elements

4.1 There is a plan in place to recruit and retain Indigenous staff to provide appropriate care to Indigenous peoples accessing our service.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

4.2 Policies that support the practice of Indigenous Cultural Safety and Humility have been developed and put into action at our service. This work has been guided by Indigenous staff or Indigenous community members, and all staff members are familiar with the policies.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

4.3 All members of staff take ongoing, Indigenous-led Cultural Safety training and their learning is applied to policies and practice at our service.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

4.4 We offer Indigenous peoples at our service the option to connect and engage with Elders and/or Knowledge Keepers. We build relationships with local Indigenous societies, organizations, groups, and individual service providers to enable this.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

4.5 We make sure that Indigenous peoples are offered access to cultural practices, either at our service or in the community.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

4.6 We have created a physical environment that is welcoming and that contributes to cultural safety for Indigenous peoples accessing services.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

Overall Rating for Standard 4

– – – – – 1 – – – – –	– – – – – 2 – – – – –	– – – – – 3 – – – – –	– – – – – 4 – – – – –
Just started	**On the road**	**Nearly there**	**We're there**

Why I gave this rating:

What we can/need to do next to make progress:

Standard 5: Helping New Residents Settle In

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

Required Elements

5.1 We give the person a warm welcome and ask what they need to feel safe and comfortable.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

5.2 We review the service's rules and policies with the person and clearly explain their rights and responsibilities.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

5.3 We talk to the person about how other members of their health and social care team may be involved in their care during their stay. We explain the circumstances in which we 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.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

5.4 We involve the person in creating a short-term service plan that addresses their immediate needs and safety. This plan deals with continuation of prescribed medications and what to do in the case of an unplanned departure from our service.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

5.5 We 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.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

Overall Rating for Standard 5

– – – – – 1 – – – – –	– – – – – 2 – – – – –	– – – – – 3 – – – – –	– – – – – 4 – – – – –
Just started	**On the road**	**Nearly there**	**We're there**

Why I gave this rating:

What we can/need to do next to make progress:

Standard 6: Personal Service Planning

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.

Required Elements

6.1 We 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.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

6.2 We 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 also deals with medication needs and aligns with the person's clinical treatment plan, if they have one.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

6.3 We ensure that the person retains a copy of their personal service plan.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

6.4 With the person's consent, we share the plan with their primary care provider or other clinician(s) involved in their care.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

6.5 We review the plan with the person regularly and update it to reflect their changing situation, preferences and goals.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

Overall Rating for Standard 6

– – – – – 1 – – – – –	– – – – – 2 – – – – –	– – – – – 3 – – – – –	– – – – – 4 – – – – –
Just started	**On the road**	**Nearly there**	**We're there**

Why I gave this rating:

What we can/need to do next to make progress:

Standard 7: Medical Needs and Prescribed Medications

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

Required Elements

7.1 We make sure that the person's medical and medication needs can be safely supported during their stay at our service.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

7.2 We 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.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

7.3 We work with the person's primary care provider (or other clinicians involved in their care) to make sure that their medical needs are met. We make sure we 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.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

7.4 There are clear written policies and procedures in place for the safe management, storage, distribution and administration of all medications.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

7.5 We make sure that the personal service plan clearly describes any help the person needs to access medical care, and to obtain and take their medication safely.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

Overall Rating for Standard 7

– – – – – 1 – – – – –	– – – – – 2 – – – – –	– – – – – 3 – – – – –	– – – – – 4 – – – – –
Just started	**On the road**	**Nearly there**	**We're there**

Why I gave this rating:

What we can/need to do next to make progress:

Standard 8: Evidence-Informed Practice

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.

Required Elements

8.1 We can demonstrate that we are following evidence-informed practice with regard to our service model, the programming we offer, and the qualifications and competencies of staff. We stay up to date on current evidence and adapt our service as necessary.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

8.2 We take a trauma-, gender-, and sex-informed approach to the delivery of all programming and supports.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

8.3 We make sure that any Indigenous cultural programming has been developed in consultation with Indigenous organizations, service providers and/or Elders.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

8.4 We can support people who have concurrent mental health issues with in-house programming and/or by connecting them with services in the community.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

Overall Rating for Standard 8

– – – – – 1 – – – – –	– – – – – 2 – – – – –	– – – – – 3 – – – – –	– – – – – 4 – – – – –
Just started	**On the road**	**Nearly there**	**We're there**

Why I gave this rating:

What we can/need to do next to make progress:

Standard 9: Programming and Supports

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

Required Elements

9.1 We 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 is evidence informed.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

9.2 We provide the person with opportunities and support to rebuild, strengthen and/or create positive social relationships.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

9.3 We make sure that programming provided in-house is flexible enough to meet the person's needs, circumstances and preferences.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

9.4 We 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.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

9.5 We 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 our service.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

Overall Rating for Standard 9

– – – – – 1 – – – – –	– – – – – 2 – – – – –	– – – – – 3 – – – – –	– – – – – 4 – – – – –
Just started	**On the road**	**Nearly there**	**We're there**

Why I gave this rating:

What we can/need to do next to make progress:

Standard 10: Keeping Residents Safe

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

Required Elements

10.1 We strive to create and maintain an environment that is free of racism, sexism, discrimination, harassment and violence.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

10.2 We recognize and respect the individual rights of each person accessing our service.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

10.3 We explain to each person what their rights and responsibilities are with regard to maintaining a safe and stable living environment.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

10.4 There is a transparent complaints process in place that ensures both confidentiality and accountability, and this process is clearly communicated to all residents.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

10.5 We respond to and report any incidents that threaten the health and safety of residents and/or staff.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

10.6 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.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

10.7 We touch base with each person regularly and stay alert to any adverse changes in their behaviour or physical condition.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

Overall Rating for Standard 10

– – – – – 1 – – – – –	– – – – – 2 – – – – –	– – – – – 3 – – – – –	– – – – – 4 – – – – –
Just started	**On the road**	**Nearly there**	**We're there**

Why I gave this rating:

What we can/need to do next to make progress:

Standard 11: Transition Planning and Ongoing Connections

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.

Required Elements

11.1 We support the person to create a written transition plan (as part of their personal service plan). This is 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.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

11.2 We begin working with the person on their transition plan as early in their stay as possible.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

11.3 We make sure that the transition plan addresses both planned and unplanned (emergency) departure from our service and that what is needed to put these plans into action is available and at hand.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

11.4 We 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.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

11.5 We actively support the person to connect with the services identified in their transition plan.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

11.6 We 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.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

Overall Rating for Standard 11

– – – – – 1 – – – – –	– – – – – 2 – – – – –	– – – – – 3 – – – – –	– – – – – 4 – – – – –
Just started	**On the road**	**Nearly there**	**We're there**

Why I gave this rating:

What we can/need to do next to make progress:

Standard 12: Evaluating Your Service and Continuous Quality Improvement

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

Required Elements

12.1 On an ongoing basis, we collect and record key outputs and outcomes data that support us to evaluate our service.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

12.2 Every one to three years, we plan and implement a more formal evaluation of our service that looks systematically at what our service is doing and what it is achieving.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

12.3 We use the evaluation findings to improve our service and the programming and supports we offer.

Not meeting ☐ Partially meeting ☐ Meeting ☐

Comments:

Overall Rating for Standard 12

– – – – – 1 – – – – –	– – – – – 2 – – – – –	– – – – – 3 – – – – –	– – – – – 4 – – – – –
Just started	**On the road**	**Nearly there**	**We're there**

Why I gave this rating:

What we can/need to do next to make progress:

PART 2

Sample Forms

Standard 1: Informed Decision Making and Admissions

The information and tools provided here are intended to support service operators to meet the required elements of *Standard 1: Informed Decision Making and Admissions*. Prior to entering a supportive recovery service, the service provider works with each prospective resident, their health and social care team, and involved family members to explore whether the supportive recovery service can safely meet their needs, preferences, and cultural practices.

Gathering Information

As outlined in the *Provincial Standards for Registered Assisted Living Supportive Recovery Services* (the provincial standards) the following information should be collected to ensure that the supportive recovery service can meet a prospective resident's needs:

- 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.

Depending on your service and the systems you have in place, you may collect this information at different times during the decision-making and admission process (for example, before or after a person enters the program) or in different ways (for example: the potential resident, family member, or referral partner submits an application form; staff have one or more conversations with potential clients, their family members, or service providers). Most often, a combination of methods that work best for each service, its staff, and potential residents would be used to collect information at different stages of the decision-making and admission process.

Regardless of the approach used, gathering certain information from a prospective resident during decision-making and admission ensures that the service is a good fit (from both the perspective of the resident and the service provider) and has the appropriate resources, programs, and supports in place to safely meet the resident's needs and goals.

To support service operators in this work, this section includes:

- **A general framework** for connecting with prospective residents, which highlights important topics to cover to support shared and informed decision-making and to align with the provincial standards; and
- **Example forms** that can be used to structure conversations with potential residents for each topic area described in the framework.

General Framework for Informed Decision Making with Potential Residents

During initial conversations with prospective residents, it is important for both parties to ask questions and gather information to determine if the service is a good fit and can meet that person's needs.

Below are some general topic areas to consider during the decision-making process that align with *Standard 1: Informed Decision Making and Admissions.*

Information	Rationale and Considerations
Contact Information	Collecting contact information (address, phone number, email) would be considered routine for follow-up communication and planning purposes. It is important to: • Confirm consent to collect personal information (if applicable); • Confirm the prospective resident's preferences for communication and privacy; • Establish if there are any language, literacy or communication barriers; and • Request an alternate/emergency contact if the prospective resident is hard-to-reach. To confirm a person's identity and to set up linkages with health care and social service systems (if applicable), you might also collect data such as: • BC Services Card Number; and • Person's date of birth.
Substance Use / Addictions	Asking a prospective resident about their reasons for seeking recovery support would be considered routine during the decision-making process to best understand their current challenges and what kind of care and supports they may need. This may include asking about: • Main substance(s) used, current and/or past substance use patterns; • Problems/health issues related to substance use; and/or • Behavioural addictions (if service has supports available).
Personal Information	To learn more about a prospective resident and their core needs, challenges, and goals, asking questions about the following items during screening can be helpful: • Cultural identity/ ethnicity • Gender • Housing • Employment/income • Relationships • Family/parenting
Specific Needs	To determine if your service can provide or connect clients with tailored, individualized programming, you might ask a prospective resident about their need for or interest in: • Culturally specific care and practices • Indigenous wellness services • Family/parenting services • Sex/gender-specific care • LGBTQ+-inclusive services • Trauma care and services • Other specialized or tailored recovery support programs offered by your service or in community
Personal Goals	To determine if a prospective resident's recovery goals align with your program's model of care and supports available, you might ask them general questions about: • Personal motivations, goals, and areas they want to work on; • Expectations from the program; and • Previous experiences in treatment and supportive recovery services.

Information	Rationale and Considerations
Personal Safety	To ensure that your service has adequate staff and supports in place to protect a prospective resident's health and safety, it is important to ask about personal safety issues. For example: • Suicidal thoughts, suicide attempts, or self-harm behaviours • Intimate partner violence and if person is at risk or in danger • Recent hospitalization(s) • History of overdose(s) • Seizures (related and unrelated to alcohol/drug use) • Other safety issues specific to your resident population, service, or community
Health and Mental Health Needs	To determine if the prospective resident's medical and mental health needs can be met safely at your service, ask questions about the following: • Medical conditions and how they are managed; • Mental health needs and how they are managed; • Communicable infectious diseases (TB, hepatitis, HIV, MRSA); and • Prescription medications (ensure that access will not be interrupted).
Note: Understanding a prospective resident's medical and mental health needs is important, as more complex needs may require a higher level of care than can be met in a supportive recovery service. Staff should be familiar with and able to refer to other recovery-oriented services with capacity to care for complex needs if required.	
Criminal Justice System Involvement	Some prospective residents may have legal obligations, requirements, or past convictions that you may need to become aware of. This may include asking questions about: • Pending court dates; • Parole or probation requirements; and • Past incarceration and convictions.
Note: Asking individuals about criminal justice involvement is important, as many supportive recovery services do not accept people with certain charges or convictions (sex offences, violent crimes) as they are not resourced to provide the level of care or supervision needed to guarantee safety of that person, other residents and staff.	
Community Supports	Understanding a prospective resident's current support system and how this can be accommodated by and complement your service is important. Examples of community supports include (but are not limited to): • Primary care clinician/clinic • Addiction medicine clinician/clinic • Specialist clinician/clinic • Psychiatrist/Mental Health Worker • Counsellor • Mental health and substance use services/clinic • Social worker/case manager • Legal advocate/lawyer • Probation/parole officer
Note: Building relationships and working collaboratively with other members of a person's extended care team can improve the quality and continuity of care that they receive and strengthen their overall recovery.	

Information	Rationale and Considerations
Service Information	To make sure your service is a good fit for a prospective resident, confirm that they are aware of and/or comfortable with the living conditions and service structure: • Living in a communal environment; • Daily tasks of living, personal hygiene and housekeeping/chores; • Sharing a bedroom with another person (if applicable); • Faith-based programming (if applicable); and • Specific rules and policies of your service, including consequences for breaking rules.

The following sample forms can be used to document the elements listed in the general framework (above) and in *Standard 1: Informed Decision Making and Admissions* of the provincial standards.

Protection of Personal Information

Before collecting any personal information from a prospective resident, explain why you will be asking certain questions and ensure that they understand and consent to the collection of this information (if applicable). Emphasize that the person can choose not to answer certain questions if they are not comfortable sharing that information. Any personal information collected from an individual must be securely stored with access limited to staff directly involved in the decision-making process and admissions process.

For prospective residents who decide to enter your service, any personal information that is collected or documented during the decision-making process should be stored securely in their client file and in accordance with the *Assisted Living Regulation, Section 75* "Protection of Confidentiality" and the *BC Freedom of Information and Protection of Privacy Act*.

For prospective residents who decide not to enter your service, any personal information that is collected or documented during the decision-making process must be destroyed or safely disposed of in accordance with the *BC Freedom of Information and Protection of Privacy Act* and related organizational policies for retention and disposal of personal information.

Personal Information includes, but is not limited to:

- Name, age, sex, weight, height
- Home address and phone number
- Race, ethnic origin, sexual orientation
- Medical information
- Health care history, including physical or mental disability
- Income, purchases and spending habits
- Marital or family status
- Religion
- Education
- Financial information
- Criminal information
- Employment information

☐ **Individual named below has consented to collection of personal information in this form.**

APPLICANT / CLIENT CONTACT INFORMATION		
Full Name	**Address**	
Phone ☐ OK to leave msg	**Alt. Phone** ☐ OK to leave msg	**Email** (if available)
Services Card No.	**Date of Birth (mm/dd/yyyy)**	

EMERGENCY CONTACT	
Name	**Relationship**
Phone	**Alt. Phone**
Can we contact this person with important updates if unable to reach client? ☐ YES ☐ NO	

SUBSTANCE USE / ADDICTION INFORMATION	
Substance(s) used /primary reason for seeking help	

PERSONAL INFORMATION	
Gender	☐ Male ☐ Female ☐ Nonbinary ☐ Prefer not to answer ☐ Prefer to self-describe _____ Additional Notes:

PERSONAL INFORMATION	
Cultural/ Ethnic Identity	☐ Prefer not to answer Response: _____ Additional Notes:
Housing Status	☐ No fixed address ☐ Temporary Housing Name of Program: _____ ☐ Permanent Housing Additional Notes:
Employment Status	☐ Full-time employment ☐ Unemployed ☐ Part-time employment ☐ Not part of labour force Additional Notes:
Relationship Status	☐ Single ☐ Separated/Divorced ☐ Married/Common Law ☐ Widowed ☐ In a Relationship ☐ Other: _____ Additional Notes:
Family/Parental Status	☐ Client does not have dependents or children ☐ Client is a parent/guardian of dependents or children No. of Dependents: _____ Additional Notes:
Would client benefit from (continued or new) access to Culturally Specific Care or Practices? If **YES**, please describe needs:	

PERSONAL INFORMATION
Would client benefit from (continued or new) access to other tailored services? If **YES**, please describe needs:

PERSONAL GOALS
What are client's general motivations, goals and areas they want to work on?
What are client's expectations for this service?
Does client have any previous experience with this service or similar supportive recovery services?

PERSONAL SAFETY	
Suicidal thoughts or suicide attempts ☐ YES ☐ NO	If YES, is client currently experiencing thoughts of harming themself? Notes:

PERSONAL SAFETY	
Self-harm behaviour(s) ☐ YES ☐ NO	If YES, when was the last time this happened? Notes:
Intimate partner violence ☐ YES ☐ NO	If YES, is applicant currently at risk or in danger? Notes:
Recent hospitalization (within past 30 days) ☐ YES ☐ NO	If YES, please describe the reason for hospitalization. Notes:
History of overdose(s) ☐ YES ☐ NO	If YES, when did overdose occur? Notes:
History of seizure(s) ☐ YES ☐ NO	If YES, when was the last time client had a seizure? Was the seizure related to substance use or withdrawal? Notes:
Other personal safety concerns (please describe and add notes):	

HEALTH AND MENTAL HEALTH INFORMATION	
Medical Conditions (list below)	**How is condition managed?**
Mental Health Issues (list below)	**How is condition managed?**

Communicable Diseases	☐ **Tuberculosis (TB)** ☐ **MRSA** ☐ **Hepatitis** ☐ **Other:** _____ Notes:

PRESCRIPTION MEDICATIONS			
Medication	**Condition**	**Access to Prescription/Prescriber During Stay**	
		☐ YES ☐ NO	Notes:
		☐ YES ☐ NO	Notes:
		☐ YES ☐ NO	Notes:

		☐ YES ☐ NO	Notes:
		☐ YES ☐ NO	Notes:

CRIMINAL JUSTICE SYSTEM INVOLVEMENT	
Pending Criminal Charges ☐ YES ☐ NO	Comments:
Pending Court Date(s) ☐ YES ☐ NO	Comments:
On Probation or Parole ☐ YES ☐ NO	Comments:
Previous Incarceration ☐ YES ☐ NO	Comments:

COMMUNITY SUPPORTS	
Service Provider/Program (examples provided)	**Name and Contact Information (if known)**
Primary Care Physician/Clinic	
Psychiatrist/Mental Health Supports	
Counsellor	
Social Worker	

COMMUNITY SUPPORTS	
Probation or Parole Officer	
Lawyer	
Other: _____	
Other: _____	
Other: _____	

Information About Your Service – Sample Checklist

The following items have been discussed with the prospective resident:

☐	General model of care and recovery support used in your service
☐	Personal goals and how the service can support residents to achieve them
☐	Information about the facility and communal living – Accessibility – Sleeping/rooming arrangements – Use of common and private spaces – Rules that residents must follow and any consequences of not doing so – Daily tasks and expectations (chores, housekeeping, maintenance)
☐	What a typical day at the service looks like and the amount of flexibility offered
☐	Core programming and supports offered on-site or in the community – Mandatory and optional programming – Culture-based programs and supports – Specialized and tailored programming designed for specific client populations
☐	Inclusion of family and friends in service – Availability of family-based supports/programming – Visitor policy
☐	Availability and access to Indigenous wellness practices and traditional medicines
☐	Medication management and support
☐	Typical length of stay and transition planning
☐	Residents' rights and responsibilities
☐	Service costs, funding options, and refund policy
☐	Any additional resident fees (adjunct services, aftercare programs)
☐	Other:
☐	Other:

Standard 6: Personal Service Planning

The information and sample forms provided here are intended to support service operators to meet the required elements of *Standard 6: Personal Service Planning*. Each resident should take 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.

As outlined in the provincial standards, a personal service plan should include the following:

REQUIRED COMPONENT	LINK TO FORMS
Personal goals	Go to Sample Form
Consent for release of information	Go to Sample Form
Emergency departure plan	Go to Sample Form
Transition plan	Go to Sample Form
Record of programming and activities	Go to Sample Form
Record of communications with resident's care team (other health and social care providers)	Go to Sample Form
Medications list	Go to Sample Form
Clinical service plan	Go to Sample Form

Sample forms for documenting the elements listed above are provided below.

Setting & Tracking Personal Goals – A Guide for Residents

This guide is meant to help you map out your personal goals during your stay in [*service/facility name*].

Your personal goals plan will be developed with help from service staff and your extended care and support team. You may also wish to seek input from your family, friends and/or other important people in your life. Your plan should be considered a living document that can change over time as you progress in your recovery.

You will regularly meet with service staff to review progress towards achieving your personal goals and to update your plan as needed. You should keep a copy of your plan to track your progress on your recovery journey, and another copy should be kept by service staff for their records.

Before You Start

Before you map out your personal goals, start by asking yourself a few questions:

- What are my reasons or motivations for making changes in my life?
- What are the strengths I have that will help me achieve my personal goals?
- What are some things about myself I want to work on to help achieve my goals?
- What are some skills I want to learn?
- What kinds of supports do I need?
- What programs and services are available to me at the supportive recovery service and in the community?
- Do I feel safe and ready to make changes?
- Who can I ask for help, advice or support if I need it?

Reach out to supportive recovery staff if you have questions or need more information on programs and supports that are available to you. They can help with developing a plan that works for you.

Make a List of your Goals

Start by writing down a list of your goals. You can write the list on a sheet of paper or electronically, as long as you have a record that you can go back to and review later. You can also ask someone else to help write or type out your list if this step is challenging for you.

TIP: Try to make goals focused, achievable, and realistic.

Personal Goals Plan – How to Guide for Residents

1	**Prioritize Your Goals.** Using your list of goals, pick out the top two or three that are most important to you and your health and wellness. Double check that they are realistic and achievable, and that there are staff, programs or services available to help you if you need it. *Example goals are provided on the next page of this guide.* Starting with your first goal, complete steps 2 to 5 (below). Then, repeat for each goal you wish to include in your personal service plan.
2	**Create A Step-By-Step Plan.** Write down your goal, and then make a to-do list of small, specific action steps that will move you towards achieving the goal. Each step must be realistic, important to you, and measurable, so that you (and others) will know when each step is completed. An example form for making a step-by-step plan is included on the next page.
3	**Add Time Frames.** Add tentative time frames to each action step. For items with specific dates, such as medical appointments or group meetings, put in the exact dates and times. If some steps are ongoing, add frequencies such as "three times a week," "weekly" or "daily." Other steps may only need an estimated target date for completion.
4	**Identify Supports.** Accessing programs and supports available at the supportive recovery service or in the community can help you make progress towards achieving your goals. Be sure to speak with supportive recovery staff about your needs and include a section for supports and resources in your plan. It is also helpful to identify a support network, which could include supportive recovery staff, housemates, friends, family, health-care professionals, peer support workers, faith leaders, and support group members or sponsors. Talk about your needs with them and discuss how they may be able to assist you with specific parts of your plan. Consider including someone you trust who you can call for help if struggling or in crisis.
5	**Recognize Your Successes.** Think of some ways you can celebrate progress and completion of goals and build this into your plan. Make time for sharing your progress with people in your network who have helped you along the way or add in small rewards to your plan that you can give yourself to stay motivated. A celebration of your successes would be something affordable, accessible, and healthy that can be shared with a group or personally. Examples include trying new hobbies, a recreational or physical activity, visiting friends or family, or watching a movie.
6	**Make A Commitment.** The final step is to make a commitment to your personal goals. Make a private commitment as well as to service staff, peers, and members of your support network, who can help keep you accountable to the goals you have set for yourself.
7	**Update Your Plan.** Over time and as you complete your goals, you should revisit your original list with service staff and add new goals.

Recovery Goals – Examples

Listed below are some example goals that may be helpful as you develop your own personal goals and plan. This list is intended to be a guide only; you are encouraged to set goals that are meaningful and personal to you and for your recovery journey.

Domain	Example Goals
Health	Manage health conditions, take medications, recover from injury or surgery
Mental health	Manage stress, depression, anxiety or other mental health issues
Substance use	Reduce or stop use of drugs and alcohol, quit smoking or gambling, maintain recovery
Spiritual goals	Connect with faith-based groups, join mindfulness or meditation group, explore land-based healing approaches
Cultural goals	Connect with and learn about culture, access traditional healing and medicines, engage with Elders and Knowledge Keepers
Self-learning	Read self-help books, attend on-line or in-person support groups, take classes
Wellness Goals	Eat a healthier diet, improve health and fitness, start an exercise plan, get more rest
Relationships	Build connections and social networks, become a better parent, friend, co-worker, spouse, or partner
Personal growth	Read more, learn a new skill or hobby, create new routines, work on self-care strategies
Basic needs	Find a safe and stable place to live, obtain reliable transportation, get personal identification (ID) card
Employment	Find a new job, change occupations, take on-the-job training courses, advance in career
Money	Open a bank account, get out of debt, create a personal budget, seek financial assistance
Education	Get a high school diploma, attend college or university, learn a skilled trade
Legal issues	Resolve civil or criminal charges, settle child custody issues, file for bankruptcy
Community service	Volunteer, help others in need, support worthy causes, join mentorship program
Quality of life	Find greater peace of mind, happiness, sense of purpose or direction
Creative	Explore self-expression through music, art, journaling, writing, dance, or other creative outlets

Personal Goals Plan – Sample Form

This sample form can be used to map out a plan and track your progress over time towards achieving your goals during your stay at [*service/facility name*].

Your plan should be developed and updated over time in collaboration with program staff, and you should both keep a copy of this plan in your files. One form should be filled out for each goal that you set.

Name:	Date:
Goal:	
Step-by-Step Plan	Time Frame
1.	
Progress & Notes:	
2.	
Progress & Notes:	
3.	
Progress & Notes:	
4.	
Progress & Notes:	
Supports for Achieving My Goal	
Programs and Services:	
Support Network:	

Consent for Release of Information – Sample Form

This form should be completed and signed by the resident (client) in collaboration with service staff.

Please fill out this form to provide your consent to share your personal information with the following individual(s).

Service Provider *(examples below)*	Name	Telephone / Email	Any limitations to the information you consent to share?
Family Physician			
Pharmacist			
Psychiatrist			
Counsellor			
Probation or Parole Officer			
Lawyer			
Other*			

* Other roles might include housing worker, MCFD social worker, victim services worker, EAP claims representative, insurance representative, mental health worker, clinical therapist and/or trauma counsellor.

Client Authorization

I, _____ (print name), consent to the release and exchange of my personal information as specified above for the purpose of collaboration and coordination of my care. This authorization will be valid for the duration of my stay at [service name] and at no other time.

PRINT NAME: SIGNATURE:

DATE:

WITNESS

PRINT NAME: SIGNATURE:

RELATIONSHIP: DATE:

Please note: Any personal information you provide to staff during your stay will be collected, used and shared in accordance with the *BC Freedom of Information and Protection of Privacy Act*.

Emergency Departure Plan – Sample Form

This form should be completed and signed by the resident in collaboration with service staff.

Clients's Name:	Date:

The following plan will be put into place if I leave early from [*service/facility name*], whether this is my choice (against staff advice) or if I am asked to leave (for example, for violating house rules).

Should I leave the residence prior to program completion, I agree to:

☐ Receive information on community supports and resources and safe transition planning from service staff;

AND

☐ Return to my home or the home of the individual(s) named below for immediate shelter and support with my transition;

AND/OR

☐ Contact the agency or support worker named below for immediate shelter and support with my transition.

Emergency Contact List

1	Name:	Relationship:
	Phone:	Alt. Phone:
2	Name:	Relationship:
	Phone:	Alt. Phone:
3	Organization/Agency:	Contact Name:
	Phone:	Alt. Phone:

Additional Details

Please provide additional details of your emergency departure plan:

Client Authorization

I, _____ (print name), understand that if I leave the service earlier than originally planned, my emergency contact(s) will be notified immediately by service staff.

PRINT NAME: _____ SIGNATURE: _____

DATE: _____

Community Transition Plan – Sample Form

The community transition plan should be developed collaboratively by the resident and service staff. This form can be completed together in regular check-in meetings leading up to the resident's planned departure and kept in the resident's file.

Client's Name:	Date:
Please list your personal strengths and skills that will support your ongoing recovery as you transition to living independently in the community.	
Please list the personal goals you have achieved during your stay at [service/facility]. What are your continued or new personal goals as you transition back to living in community?	
Please describe what you have learned and the personal growth that you have experienced during your stay at [service/facility].	
What are some challenges you might experience with your ongoing recovery once you are away from the supportive recovery environment?	

Please describe the strategies you could use to deal with challenges. Include resources and supports you can reach out to for help if needed.
Please provide information on where you will live after you leave the supportive recovery service.
Please provide details on your plan for accessing recovery support services in the community (e.g. aftercare program, counselling, 12-step meetings, other peer support groups, etc.).
Please provide details on your plan for accessing other health and wellness supports in the community (e.g. medical care, mental health supports, culture-based services, community services, social and recreational activities, spiritual or faith-based groups, etc.)

Please provide details on your plans for securing employment, income and/or other financial supports after you leave the service.	
Please list the people you will contact if you need support with your recovery.	
Name:	Phone:
Name:	Phone:
Name:	Phone:
Additional Notes:	

Community Transition Plan – Sample Checklist for Service Providers

This checklist can be completed by service operators as a record of the steps conducted to prepare for a resident's planned departure and safe transition back to the community. This record can be kept in the resident's file and updated during regular check-in meetings leading up to their departure date.

Client's Name:	Date:
☐	**Housing**: Client has a stable and secure place to live in community.
Notes:	
☐	**Income**: Client has a secure source of income (employment, social assistance, other support).
Notes:	
☐	**Safety**: Client has been given information about crisis support and emergency services (crisis lines, emergency/transitional housing, partner and family violence services, food banks).
Notes:	
☐	**Harm Reduction**: Client has been offered a take-home naloxone kit (or advised where to get one) and given information about harm reduction supports available in the community.
Notes:	
☐	**Recovery Support**: Client has a plan in place for accessing recovery-oriented supports in the community (peer support groups, community-based services, treatment and recovery services).
Notes:	
☐	**Aftercare Services:** Client plans to participate in aftercare services provided by the service.
Notes:	

☐	**Support Network**: Client has identified people they can contact if they experience challenges and need help.
Notes:	
☐	**Transition Plan:** Client has completed a community transition plan with support from service staff, including a plan for accessing the following services in community: ☐ Medical care ☐ Mental Health Supports ☐ Social support services ☐ Culture-based services ☐ Other: _____
Notes:	

Resident's Record – Sample Form for Participation in Programs and Supports

Service providers should document all programs and supports the resident participates in during their stay. Include participation in onsite and offsite programs and supports. Indicate if participation is mandatory or optional, and expectations of residents (if known).

Client's Name:			Date:	
Name of Program or Support		**Start Date**	**Attendance Schedule**	**End Date**
1	*Example: 12-Step Support Group*	*Jan 1*	*1 meeting per week for duration of stay (onsite or in community)*	*N/A*
	☐ Mandatory ☐ Optional	Progress & Notes: *Client attends onsite AA meeting every Weds evening. Attendance good and client speaks and participates regularly. States overall satisfaction as "good."*		
2				
	☐ Mandatory ☐ Optional	Progress & Notes:		
3				
	☐ Mandatory ☐ Optional	Progress & Notes:		
4				
	☐ Mandatory ☐ Optional	Progress & Notes:		
5				
	☐ Mandatory ☐ Optional	Progress & Notes:		

6				
	☐ Mandatory ☐ Optional	Progress & Notes:		
7				
	☐ Mandatory ☐ Optional	Progress & Notes:		
Add additional rows as needed				

Resident's Record – Sample Care Team Communications Log

Use the table below to document communication with members of a resident's care team during their stay. Include information on items for staff to monitor or follow-up on (if applicable). Ensure that you have written consent from the resident for release of personal information for each service provider listed.

This document contains personal information and should be stored securely and in accordance with the *Assisted Living Regulation* Section 75 "Protection of Confidentiality."

Client's Name:		Date:	
Date	**Service Provider/ Organization/Agency**	**Summary of Discussion**	**Follow-up Details**
Add additional rows as needed			

Resident's Record – Sample Prescription and OTC Medications List

List all prescription and over-the-counter (OTC) medications the resident is taking in the table below and update as needed to ensure information is accurate. Include additional information about the resident's clinical services plan (specialist appointments, medical procedures, surgery) in the section provided on the next page.

This document contains personal information and should be stored securely and in accordance with the *Assisted Living Regulation* Section 75 "Protection of Confidentiality."

Client's Name:		Date:		
Medication	**Dosage**	**Condition Being Treated**	**Start Date**	**End Date**
If client is prescribed opioid agonist treatment (OAT)				
Are they prescribed carry doses?		☐ Yes ☐ No Notes (safe storage, carry schedule, medication management):		
Are they prescribed delivery doses?		☐ Yes ☐ No Notes (delivery schedule, medication management):		
OAT Prescriber Name: _____ Phone: _____		Pharmacy Name: _____ Phone: _____		

Resident's Record – Sample Clinical Services Plan

Record any additional information about the resident's ongoing medical or mental health care below that service staff should be aware of and update regularly and as needed. This record should be completed and filed with the **Resident's Record – Prescription and OTC Medications List** on the previous page.

This document contains personal information and should be stored securely and in accordance with the *Assisted Living Regulation* Section 75 "Protection of Confidentiality."

Client's Name:	Date:
Record information about the client's clinical services plan (e.g., specialist consults, assessment/ diagnostic procedures, medical procedures, surgery, preventative care, sexual health, dental care, vision care, physiotherapy, etc.).	

PART 3

Indigenous Cultural Safety Training & Education Resources

Indigenous Cultural Safety and Humility – Training and Education Resources

These resources were curated by Indigovation Consulting Inc. (indigovation@gmail.com). They are intended to support service providers to strengthen their knowledge and understanding of Indigenous Cultural Safety (ICS) and Humility, and to help them put these learnings into practice. Resources include: training courses; literature (books and articles); toolkits and workbooks; and links to relevant podcasts, radio shows, and TV programs. A list of key terms and definitions is also provided.

ICS Training Courses

San'yas Indigenous Cultural Safety – Provincial Health Services Authority in B.C.

The San'yas ICS Training is free for any individual who is: an employee of a B.C. health authority; an employee of the B.C. Ministry of Health; or a First Nations, Métis or Inuit person living in British Columbia.

Individuals who do not identify as First Nations, Métis or Inuit, or who do not hold any of the positions listed above, may also request participation in the training by emailing: ics@phsa.ca.

The training is scaffolded, and there are five core programs. It is recommended that participants begin with the *Core ICS Mental Health* course before moving on to some of the more advanced offerings (such as *From Bystander to Ally* or *Unpacking the Colonial Relationship*).

Online ICS Modules – University of Victoria

The University of Victoria offers three online ICS modules that are available to the public for free:

- Module 1: Introduces the relationship between colonial history and health;
- Module 2: Explores power and privilege, and the intersections of peoples' experiences in relation to marginalization, oppression, and dominance; and
- Module 3: Explores the intersections of Indigenous peoples' experiences in relation to health, health care and healing.

Reaching out…

Service providers may also wish to reach out to Indigenous Cultural Safety facilitators in their regional health authority to supplement online training opportunities. ICS facilitators can help to tailor training programs to the service provider's organization/team, which can enhance the learning experience.

It is also recommended that service providers connect with local First Nations, Métis or Inuit communities to build relationships and identify opportunities for partnerships.

Online Workbooks and Toolkits

- dRworks. (2016). Dismantling Racism – Workbook.
- dRworks. (2020). Dismantling Racism Works – Web Workbook.
- Layla F. Saad. (2020). Me and White Supremacy (Workbook).
- Montreal Urban Aboriginal Community Strategy Network. (n.d.). Indigenous Ally Toolkit.

Webinars

- Harley Eagle hosts a range of webinar sessions from the UBC Learning Circle (2018), including:
  - Cultural Safety and Addressing Systemic Racism with Harley Eagle;
  - Cultural Safety and Leadership; and
  - Embracing the Critical Consciousness Theory in an Indigenous Context.
- National Indigenous Cultural Safety Webinar Series. (2020). Provincial Health Services Authority.

Lectures

- Chimamanda Ngozi Adichie. (2009). The Danger of a Single Story. TED Talk.
- Daniel Hill and Jeffrey Marcus. (2018). White Awake: An Honest Look at What it Means to be White. Courageous Conversations: Understanding Privilege & Becoming a Better Ally.
- Robin DiAngelo. (2016). White Fragility. Western Washington University; and (2017). Critical Race and Social Justice Education. The College of Saint Benedict.

ICS Reading List

Books

- Chelsea Vowel. (2018). *Indigenous Writes: A Guide to First Nations, Métis and Inuit Issues in Canada.* (Brantford: W. Ross MacDonald School Resource Services Library).
- Eduardo Bonilla-Silva. (2018). *Racism without Racists: Color-Blind Racism and the Persistence of Racial Inequality in America.* (Lanham: Rowman & Littlefield).
- Frances Henry. (2013). *The Colour of Democracy: Racism in Canadian Society.* (Vancouver: Langara College).
- Larry Brendtro, Martin Brokenleg, and Steve Van Bockern. (2012). *Reclaiming Youth at Risk: Our Hope for the Future.* (Hoopla Digital).
- Lee Maracle. (2017). *My Conversations with Canadians.* (Toronto: BookThug).
- Richard Wagamese. (2018). *Indian Horse.* (Toronto: CNIB).
- Robin DiAngelo. (2020). *White Fragility: Why It's So Hard for White People to Talk about Racism.* (Massachusetts: Beacon Press).
- Tema Jon Okun. (2010). *The Emperor Has No Clothes: Teaching about Race and Racism to People Who Don't Want to Know.* (University of North Carolina: NC DOCKS).

Articles

- Bonita Lawrence and Enakshi Dua. (2005). Decolonizing Antiracism.
- Crossroads. (n.d.). Racial Identity Caucusing: A Strategy for Building Anti-Racist Collectives.
- Dina Gilio-Whitaker. (2018). Unpacking the Invisible Knapsack of Settler Privilege and Settler Fragility: Why Settler Privilege is So Hard to Talk About.
- Eve Tuck and K. Wayne Young. (2012). Decolonization is Not a Metaphor.
- Joan Olsson. (1997). Detour-Spotting for White Anti-Racists.
- Kathy Obear. (2019). Dismantling Racism and White Supremacy in Organizations: The Role of White Leaders and Change Agents.
- Kenneth Jones and Tema Okun. (2001). White Supremacy Culture from *Dismantling Racism: A Workbook for Social Change Groups*.
- Linda Diffey and Barry Lavallee. (2014). Is Cultural Safety Enough? Confronting Racism to Address Inequities in Indigenous Health.
- Mackenzie Churchill, et al. (2017). Evidence Brief: Wise Practices for Indigenous-specific Cultural Safety Training Programs.
- Megan-Jane Johnstone and Olga Kanitsaki. (2008). The Neglect of Racism as an Ethical Issue in Health Care.
- Nicola Carpenter. (2018). Resources for White People to Learn and Talk about Race and Racism.
- Peggy McIntosh. (n.d.). White Privilege: Unpacking the Invisible Knapsack.
- Robin DiAngelo. (2011). White Fragility; and (2012). Nothing to Add: A Challenge to White Silence in Racial Discussions.

Additional Online Sources

- Cheryl Ward, Chelsea Branch, Alycia Fridkin. (2016). What is Indigenous Cultural Safety – And Why Should I Care About It? *Here to Help, Visions Journal.*
- Dr. Lynn Gehl, Algonquin Anishinaabe-kwe. (n.d.). Ally Bill of Responsibilities.
- National Collaborating Centre for Indigenous Health. (n.d.). Anti-Indigenous Racism in Canada.
- The College of Family Physicians of Canada. (2016). Health and Health Care Implications of Systemic Racism on Indigenous Peoples in Canada.
- Wellesley Institute. (2015). First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-being of Indigenous Peoples in Canada.

Podcasts and Radio Programs

- *Media Indigena: Indigenous Current Affairs* offers a wide range of ICS-related podcasts, including:
  - Episode 15: Indigenous Peoples and Public Health;
  - Episode 140: Unpacking Colonial Foundations of Philanthropy; and
  - Episode 155: How Do We Solve "The Settler Problem"?
- Tanya Talaga (CBC Massey Lectures). (2019). All Our Relations: Finding the Path Forward.
- White Coat, Black Art (CBC Radio). (2014). First Nations, Second-Class Care.

Videos, Film, and TV

- Colonization Road: The Path of Reconciliation is Long and Winding. (2016). Directed by Michelle St. John; Hosted by Ryan McMahon. CBC Docs. Firsthand.

  Examines the impacts of pathways established in Ontario by early European settlers to break ground in First Nations communities and settlements.

- Eighth Fire (Four-Part Series). (2012). Hosted by Wab Kinew. CBC.

  Takes a provocative look at Indigenous/settler relationships in Canada.

- Jordan River Anderson: The Messenger. (2019). Directed by Alanis Obomsawin. National Film Board of Canada.

  The story of Jordan River Anderson – after whom Jordan's Principle is named – and how his life initiated a battle for the rights of Indigenous children to receive equitable standards of social, health and educational services. (Note: the director, Alanis Obomsawin, has created a number of other films, and has been recognized for her efforts to bring awareness to Indigenous issues, as well as to Indigenous resistance and strength.)

- Mansbridge One on One: Cindy Blackstock. (2016). CBC News: The National.

  Interview with Cindy Blackstock, ED of the First Nations Child & Family Caring Society, advocating for equal treatment and funding for First Nations children.

- Two Worlds Colliding. (2004). Directed by Tasha Hubbard. National Film Board of Canada.

  Explores anti-Indigenous racism and discrimination that surface during an inquest into the experiences of an Indigenous man who survived being dumped on the outskirts of Saskatoon by police officers late at night in -20 C temperature.

Indigenous Cultural Safety and Humility: Terms and Definitions

The following definitions were compiled by Indigovation Consulting Inc. (indigovation@gmail.com). In some cases, they are taken or adapted from published sources (for which citations are provided).

Names and Identities

Note: In the following definitions the term 'Indian' appears in quotation marks, signifying that it is a term that has been placed upon Indigenous peoples and not a term that Indigenous peoples used to identify themselves.

- **'Indian'** – As defined by the *Indian Act* and/or those individuals who reported that they were members of an Indian Band or a First Nation.
- **Status 'Indian'** – Refers to a person who is recorded as an Indian on the Indian Register pursuant to the *Indian Act*, and to whom the federal government has a fiduciary responsibility. The term 'First Nations' is now preferred. The *Indian Act* has not historically recognized Métis and Inuit peoples.
- **Non-Status 'Indian'** – Refers to a person of First Nations ancestry who is not recorded as an Indian on the Indian Register. Many of these individuals were simply not enrolled with a band at the time registration was occurring or were removed from the register due to enfranchisement provisions in the *Indian Act*.
- **Treaty 'Indian'** – A Status Indian belonging to a band that has signed a treaty with the federal government.
- **Aboriginal** – Refers to persons who identify with at least one Aboriginal group (in Canada, First Nations, Métis or Inuit) and/or those who reported being a Treaty 'Indian' or a Status 'Indian.'
- **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*.
- **Métis** – A person who self-identifies as Métis, who is distinct from other Aboriginal peoples, who is of historic Métis Nation ancestry and who is accepted by the Métis Nation. (Definition adopted by the Métis National Council in 2002.)
- **Band** – Typically, but not always, a single community. Many bands, especially in British Columbia, control multiple parcels of land (reserves). Although bands currently have considerable control over their reserve land, neither the band itself, nor its members, own the land; rather, the land is held in trust for the band by the Crown.

Important consideration…

In North America and worldwide, there are many terms that have been used over time to refer to, or to identify, Indigenous peoples. Currently, Indigenous is the term that appears to have global acceptance. However, it is important to learn and consider the identifier that each Indigenous person or community prefers. For instance, many First Nations groups now identify themselves by the specific nation from which they descend. This names their roots and ensures their nation, and the ancestral land with which they hold a connection, are kept alive.

Cultural Safety Learning Continuum

- **Colour blindness** – The idea that race does not matter and that people should be treated equally regardless of the colour of their skin, in recognition of a common humanity. Although the intention behind colour-blindness is often positive, the result of such a perspective can be detrimental. By denying the significance of race, a colour-blind approach erases the lived experiences of people who must deal with racism and discrimination daily. Colour blindness also fails to acknowledge or address the structural and systemic inequities that racism engenders in our society.

- **Cultural awareness** – Being conscious that people with different cultural backgrounds and upbringings may have different values, beliefs and perspectives. Developing awareness and understanding of these differences is the focus of cultural awareness. However, this approach often centres Western values, beliefs and perspectives as the norm, and all other cultures as different or deviant from the norm.

- **Cultural safety** – A theory, process and outcome. Most importantly, it is an outcome that is based upon respectful engagement with Indigenous peoples and communities 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.

- **Cultural humility** – 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 (First Nations Health Authority).

Many Indigenous Cultural Safety facilitators will use the phrase ***cultural safety and humility***.

Terms Commonly Used in Cultural Safety Dialogue

- **Colonialism** – A process by which a foreign power dominates and exploits Indigenous groups by appropriating Indigenous land and extracting the wealth from it. In Canada, colonialism has three major components: dispossession; dependence; and oppression. Indigenous peoples live with these forces every day of their lives (Henry & Tator, 2002; Manuel, 2018). Patrick Wolfe (1999) emphasizes that settler colonialism is a structure, not an event, and it is ongoing. In the process of settler colonialism, land is remade into property and human relationships to land are restricted to the relationship of the owner to property (Tuck & Yang, 2012).

  The ideology that enables colonization is grounded in the belief that settlers are inherently superior to Indigenous peoples. The morals, values and worldviews that follow from this belief are used to justify and perpetuate ***colonial policies and practices*** such as: land confiscation; (human and natural) resource exploitation; imposition of settler laws and frameworks; racial segregation and two-tiered service provision; and outlawing of traditional forms of governance, cultural practices and self-sustaining livelihoods. ***Colonial dynamics*** uphold and reinforce colonialism through systems and structures that continue to legitimize the state at the expense of Indigenous peoples. These ***colonial patterns*** underpin and enable individual, social, structural, systemic and epistemic violence against Indigenous peoples.

  Canada is founded on colonialism and it is the invisible framework that continues to perpetuate the inequitable status and living conditions of Indigenous peoples in this country today.

- **Colonization** – The process by which a central power establishes and maintains control over other lands and peoples. The word is derived from the Latin *colonus*, meaning farmer. This is a reference to the practice of sending settlers over to a new territory to take over and work the lands in order to establish a claim over that territory. Control of a territory is often centred around eliminating, assimilating and/or oppressing the original inhabitants of a land – as was, and continues to be, the case in Canada.

  Although settlement in Canada began with British and French settlers in the 17th century, colonization continues to be upheld through descendants of the original settlers, as well as through more recent settlers from around the world (often referred to as 'immigrants'), who arrived and settled in Indigenous territories thereafter. Colonization is therefore intimately linked to, and dependent on, the ongoing actions and behaviours of settlers who establish and uphold the domination of a central power.

- **Decolonization** – The process of deconstructing colonial ideologies of the superiority and privilege of Western thought and approaches. On the one hand, it involves dismantling structures that perpetuate the status quo and addressing unbalanced power dynamics; on the other hand, it involves valuing and revitalizing Indigenous knowledge and approaches, and weeding out settler biases or assumptions that have negatively impacted Indigenous ways of being (Open Text BC). Decolonization brings about the repatriation of Indigenous land and life (Tuck & Yang, 2012).

- **Inequity** – A difference that is steeped in injustice or unfairness. It is important to distinguish the term from 'inequality,' which also refers to difference but without a clear connotation of injustice. Inequitable access to health care refers to a difference in access that is unjust – such as being turned away from health services due to racist bias; whereas unequal access to health care may simply refer to reduced access – such as a circumstance involving a shortage of doctors.

- **Race** – A socially-constructed category used to classify humankind according to common ancestry. It is reliant on differentiation by such physical characteristics as colour of skin, hair texture, stature and facial characteristics. The concept of race has no basis in biological reality and, as such, has no meaning independent of its social definitions. But, as a social construction, race significantly affects the lives of racialized people (Henry & Tator, 2002).

- **White** – A political term to describe a system of power and racial hierarchy that became embedded through colonization.

- **Racism** – A system in which one group of people exercises power over another based on skin colour. It is an implicit or explicit set of beliefs, erroneous assumptions and actions based on an ideology of the inherent superiority of one racial group over another, and evident in organizational or institutional structures and programs as well as in individual thought or behaviour patterns (Henry & Tator, 2002).

- **Embodied (internalized) racism** – Involves the physical and mental reactions arising from the stress associated with alienation, discrimination and social violence. Research shows that racism is a chronic stressor on the body and that those who experience ongoing racism (actual or perceived) suffer a reduction in their mental and physical resources due to the continuous activation of their stress response systems. This can lead to poor health outcomes. (See Allan & Smylie, 2015 and Grant, Parry & Guerin, 2013.)

- **Systemic racism** – Racism enshrined in policies and practices, and entrenched in established institutions that results in the exclusion of specific groups of people and the advancement of others. Systemic racism manifests itself in two ways: 1) institutional racism – racial discrimination that derives from individuals carrying out the dictates of others who are prejudiced or of a prejudiced society; and 2) structural racism – inequalities rooted in the system-wide operations of a society that exclude substantial numbers of members of particular groups from meaningful participation in major social institutions. The power of systemic institutional and structural racism is that they are embedded in everyday ideological beliefs and practices.

- **Structural racism** – A term that refers to the deep level of racism in society, manifested in the racial bias embedded in all social, economic, legal, political, and educational systems and structures. It occurs when policy makers do not rectify the structural inequities experienced by and between racialized groups (Reading, 2013). While individual racism is about personal prejudices and how these prejudices can translate into racist interpersonal relations, structural racism is about the underlying social foundations and frameworks that systematically privilege white identities and ideologies, at the expense of racialized identities and ideologies. To understand how structural racism works in Canada, one must understand how colonization and colonial processes in relation to Indigenous peoples have shaped and formed the country.

- **Democratic racism** – An ideology that permits and sustains the ability to justify two conflicting sets of values and attitudes. One set consists of a commitment to a democratic society motivated by the egalitarian ideals of fairness, justice and equality. The other set consists of the ways of thinking and behaving that result in differential or discriminatory treatment of certain groups (Henry, Tator & Smith, 2006).

- **Conflict** – A struggle and/or an attitude of opposition to our self or another person. It.is not in itself unhealthy; in fact, healthy conflict is important for self-awareness, learning, growth and change. The degree of self-awareness we have influences how we find ways to get our needs met.

- **Power** – The capacity or ability to direct or influence the behaviour and beliefs of others over the course of events. Power can be exerted in a positive or a negative manner. How we use our power is critical, and is important to examine. A member of a dominant group, for instance, can acquire social power through embedded social inequities. Such power is systemic and unearned by the individual who holds it.

Terminology Often Used by Indigenous Peoples

- **Lateral Violence** – Occurs in groups being oppressed by a racial and cultural majority when feelings of powerlessness and anger are directed laterally, at one's own people (First Nations Health Authority). Lateral violence can be both destructive and dismissive. It is a cycle of abuse and its roots lie in colonization, oppression, intergenerational trauma and the ongoing experiences of racism and discrimination.

- **Lateral Kindness** – An approach to addressing lateral violence based on Indigenous values, which promote social harmony and healthy relationships (First Nations Health Authority). By practising lateral kindness, Indigenous peoples seek to replace violence with acts of kindness, drawing upon cultural protocols, traditional moral teachings, ceremonies and spiritual practices.

- **Maya'xala (Respect)** – A Kwakwaka'wakw word that loosely translates as respect. Maya'xala is the principle of respecting each other and all that we are surrounded by – the earth, family, community, animals, plants, oceans and land. It is holding each other up and respecting each other's differences.

- **Knowledge Keeper** – A title bestowed on some individuals that 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.

- **Elder** – Someone who has earned the trust and respect of the 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.

- **Vulnerability** – As defined by Brené Brown, vulnerability is not about being weak, rather it is about having courage: the courage to share stories about who we are, from our whole heart. Courage derives from the Latin word *cor,* meaning heart. When Indigenous Cultural Safety facilitators ask people to step into the work of cultural safety, they encourage people to have heartfelt conversations. Vulnerability is having the courage to be imperfect, to be ready to be self-aware and open to learning. It involves being willing to let go of who we think we should be in order to build connections with others. It means having compassion for our self and others.

- **Trauma** – May be defined as experiences that overwhelm an individual's capacity to cope. Trauma early in life, including child abuse, neglect, witnessing violence and disrupted attachment, as well as later traumatic experiences such as violence, accidents, natural disaster, war, sudden unexpected loss and other life events that are out of our control, can be devastating (Trauma-Informed Practice Guide, 2013). It is always important to reflect on what the difference might be between a 'therapeutic understanding' and an 'Indigenous understanding' of what trauma looks like and feels like. A cultural safety lens requires us to consider the historical, cultural, interpersonal and systemic nature of trauma.

- **Resilience** – Refers to our ability to restore balance and come back to centre. It is the nurturing strength within ourselves and our capacity to connect with others for support, as well as to provide support. Resilience involves learning to live our best lives, walking in balance as best we can, remaining grounded in our teachings, and remaining connected to all of this as we face challenges.

- **Trauma- and Resilience-informed Practice** – Considers an understanding of trauma in all aspects of service delivery and places priority on the individual's safety, choice and control. Rather than looking at a person as 'damaged' or saying that something is 'wrong' with someone, a trauma- and resilience-informed approach reframes challenging behaviours as a person's response to painful and distressing life events. Trauma- and resilience-informed practice is not necessarily outcomes based; it is about working through a process to build understanding, and walking alongside someone as they move through their journey.

  From a cultural safety lens, it is crucial to consider the historical, cultural, interpersonal and systemic nature of trauma. It is crucial to understand how the intergenerational experience of colonization may become embodied in a person, and to reflect on what is needed to support the person in moving through the trauma they carry. Integrating traditional cultural ways of being into practice can help to support a person's healing journey.


BRITISH
COLUMBIA