

Person Centered Planning Final Report by Centerpoint Facilitation Inc.

July 2007 – March 2009

The course of this project has truly been one of innovation and flexibility. Over the previous 21 months, the team of Centerpoint Facilitation has developed a strong understanding of the people of Grande Prairie that require assistance due to homelessness or the threat of homelessness.

The initial proposal described how we saw person centered planning working with people who are homeless or at risk and as the months have progressed, we have been able to adapt to meet people's needs, to meet some of the gaps in our community and still work within the values of being person centered. The following information provides a summary (spanning the 21 months of service) of what we have tried, what we have learned, what we are pleased about and what we are concerned about when it comes to assisting those experiencing homelessness. Also, it includes steps we will take in the ongoing months to improve the program so it continues to benefit our community and those individuals experiencing difficulties finding or maintaining a home.

One of our standing value statements is that "we are rooted in flexibility". We are deeply grounded in the philosophy of person centeredness however how we deliver services to people has to be extremely flexible to meet each unique need.

PLANNING

Initially Centerpoint planners were excited to work with people on 'planning' their way out of homelessness and taking the time to put it all on paper. It quickly became apparent that the people coming to us were coming in crisis and weren't looking to set out a life plan immediately, they needed a home. Centerpoint planners very quickly changed their approach to focus on person centered thinking vs. person centered planning. They used a person centered approach to assist people to deal with the crisis situation in front of them which was to find and secure housing and provided the opportunity to do more in-depth planning after the crisis time was over.



We assist people to identify what the barriers are that are stopping them from accessing housing and then help them set up some action plans of how to rid of the barriers. Centerpoint planners have become experts in knowing what, how and who to access in the community for resources and supports. They contact these resources with the individual and then accompany them as they go to their appointments to ensure that they are assisted. This could be Income Supports, the Food Bank, AISH, doctors, etc.

Individuals that come to us, often come with no support in their lives, whether it is paid or unpaid so 'walking with them' as they acquire what they need is very important.

Time spent with each individual varies greatly. Sometimes we may only meet with an individual one or two times and make a couple of phone calls, while other times we may spend a number of hours each week with one person until they are settled into a new home and then this decreases. It was originally anticipated that we would spend 12 hours with each person; however, with many we have spent far more or less than this amount.

We are very pleased that we are able to provide a service to individuals faced with homelessness or the risk of becoming homeless that addresses the crisis, and also can provide longer term support for those interested. The person is held in high regard from the moment they enter our office. We know that they have the capability to do great things and respect that they have asked for assistance as they do this. One of the first impressions people leave with after their first visit is a renewed sense of confidence and faith in their abilities to move forward.

We have always attempted to have two planners in the office for security purposes however the risk has increased and it is now policy to have two planners in the office at all times when meeting with people

As people are successful in finding or maintaining their home we often lose contact with them. This happens as people left the shelters or their temporary home to move into a new home and their phone number changed or, if they had no phone number to start with. So, often we were uncertain at 3 or 6 months if someone was still maintaining their home. Over the next year, Centerpoint planners will work more closely on a plan to ensure follow-up with individuals, so we are able to determine their success. This follow-up will require more time of each planner, with each individual, so will increase the time spent with each individual.

LOCATION

Initially we thought that we would be able to use home offices for our base and then meet with people to help them plan. Again it became very quickly apparent that a space in which people could drop in was a necessity. We have found that we need to be available when the 'mood strikes someone' to get housing. If we had them make an appointment, we would lose their interest.



The Community Village is an excellent space for our work. This works for most people needing to access services, because it is easy to reach using public transportation or by walking. One of the functions of the Community Village is to house resources together so people could easily access them and this works very well for us. When we need to move offices, having a downtown location will be a priority.



What we are concerned about regarding our location is that we are on the second floor of a building and are not accessible to individuals with physical disabilities. As we grew we needed more office space for staff work spaces and meeting space to ensure confidentiality. Initially we started this project with 3 staff working in a 158 sq. ft. space, which was tight but adequate. As the project progressed and two more part-time positions were hired, we now have to accommodate 5 staff working in the same space. We have also had to rent additional “meeting space” in order to meet

with clients. We also would like to set-up a landline, so there is one central, listed phone number for individuals to reach us at.

TRAINING

We have offered 2 workshops on Person Centered Thinking in the community.

Planners have received HSA Person Centred Thinking and Person Centred Team Development training.

We have obtained the trauma and grief recovery certification program through Dr. Jane Simmington, which is an invaluable asset to compliment our person centered approach. We can help people to discover & envision what direction they want their lives to go however they could fall back into homelessness if the trauma and root cause of what made them homeless in the first place is not addressed. This not only helps the adult from becoming homeless again but also their children from being part of the cycle.

LOCAL AND INTERNATIONAL PARTNERSHIPS

Centerpoint Facilitation has built very strong partnerships with many local community agencies. A strong belief of person centered thinking is that the person remains at the center of their decision making. Therefore planners assist the person to determine what resources they would like to pursue and then help them to connect with those resources. This ideal plus that of a holistic approach to one’s life necessitates strong partnerships and the success that people have had with the connection with Centerpoint hinges on the organization’s relationship with other agencies.

We are exploring a working partnership with professionals who are experienced in trauma and grief to partner with us to more holistically address people's needs.

Katherine Fleming, Chief Executive Officer of Centerpoint Facilitation, is an HSA Canada associate. HSA Canada is a member of HSA International. We are the leads in person centered approaches with those persons experiencing homelessness for HSA International as well as the Learning Community for Person Centred Practices.

TEAM DEVELOPMENT

The Centerpoint team continues to use person centered team approaches to strengthen their work together and to strengthen approaches used with their clients.

STATISTICAL INFORMATION

Centerpoint worked with a total of 377 individuals through the course of the project. Of the 377 individuals, 185 (54%) were successful in finding or maintaining a home. We continue to work with 33 individuals, as the program continues on. We have no contact with 159 individuals (134 we are unable to contact, 8 have decided they do not need the service, 11 have moved, 4 have transferred to other programs and 1 is deceased). While we have met 377 individuals, we have indirectly supported 256 dependants. Of the 256 dependants, 151 (62%) have been in situations where they have found a new home or maintained the home they were in. We continue to work with families with 10 dependants.

Below is a list of organizations who have referred people to Centerpoint.

Agency	# Referred	Agency	# Referred
Income Supports	76	Mat Program	3
Odyssey House	69	Wapiti Dorm	3
Friends	27	MLA	3
Hospital Social Workers	21	Grande Spirit Foundation	3
Family	16	gpChase Line	3
Self	16	Senior's Outreach	3
FCSS	11	Employer	2
Unknown	10	Access Program at Hospital	2
Salvation Army	9	Lawyer	2
HIV North	7	Psychologist	2
The Community Village	7	Native Counseling	1
Advertising	6	Canadian Paraplegic Association	1
Pregnant and Parenting Teens	6	Doctor	1
AADAC	5	Federal Probation Officer	1
Friendship Centre	4	Alberta Mental Health	1
Regional Council of Lesser Slave Lake	4	Home Care	1
GALAP	4	R. Work Group	1
Immigrant Settlement Services	4	ASLS	1
Oxford	4	Youth Connections	1
TOTAL	341		

Planner's Memorable Moments

I met Eva only days before Christmas 2008. She has already been staying at Odyssey House for a month prior to me meeting her. She had spent the previous 6 years living on the streets and in shelters between Grande Prairie, Fairview and Edmonton. She had decided to come to Grande Prairie to get away from an abusive partner and set-up a home here. Eva was determined to find somewhere to live where she could get healthy so she could meet her grandchildren. She had recently been diagnosed with HIV and Hepatitis C and was not healthy.

Eva was soft spoken, but had a strong personality. When I met her she had nothing, but some clothing and a few personal belongings. She needed ID, income and everything else that comes with setting up a home. Eva and I worked through the process of getting ID and setting up income while keeping our eyes open for one bedroom apartments. However, she was admitted into the hospital in February because of her health and stayed there in isolation for a month. At this time, her family from a reserve near High Level expressed support and offered for her to come home and live with them. When Eva was stable she was transferred to the High Level hospital, with the goal of moving into her sister's home. However, within the week of being transferred she became very ill again and was flown back to Grande Prairie where she passed away.

The story of Eva has touch and inspired me because she showed great determination to be successful at getting healthy, meeting her grandsons and being independent and safe in her own home. Even when she decided to live with her sister she was excited to be with her family. Yet, during the few months I was able to support her, I witnessed her struggle with accessing the Income Supports and AISH systems. And, in her case tried to help, but had difficulty myself. I know I was one of the few supports Eva had in our community and one of the few familiar faces she saw in the hospital, and know this is the case for so many people we see.

Kathleen

She is this sweet 60 year old woman who is originally from the Middle East. She needed help - she left an abusive situation in Ontario and went to Edmonton. The friends she was staying with in Edmonton made the mistake of telling the man in Ontario that she was there. She fled to Odyssey House in Grande Prairie. I accompanied her to Income Supports, took her to view several places to rent, and listened to her story. She was so grateful and couldn't believe that our service existed. "It was so helpful and made 'leaving' easier!!" she said.

Tanya

I met Sara back in September of 2008. Most people we work with share all and maybe too much information right when I meet them. Sara was very quiet, would not share any information and trying to talk to her was like pulling teeth. At that time she was staying at Odyssey House after recently leaving an abusive situation. She has come from Atikameg with hardly any belongings, no money and no bank account.

She had 3 children, only 1 with her and was 5 months pregnant. She didn't have custody of her other children, as she had been incarcerated for a period of time.

Sara found housing in November. It was a slow process, as one day she was very motivated and then the next not at all!

Sara continues to call me probably once a month needing something to help her maintain her housing. Things like help with getting taxes done, has no food, wants to move and needing to do application with Grande Spirit Foundation.

I feel like I may be the one person in her life she can call for some extra help when things are really bad. Sara even called and left me a message over Christmas holidays to see if I would take her to the hospital as she was in labour! I knew at that point she trusted me and even though the silent moods, cold stares, unreturned calls and missed meetings could be frustrating, we had a connection and all the little things that I did for her had finally paid off.

Sara is much more open with me now, but I know it has to be on her terms, I am not there to pry into her life and I am not there to tell her how to live her life. I can only imagine what she has gone through and I feel the cold and silence is her wall of protection and how she maintains her pride, and I respect her for that.

Tammy

One of my successful clients...

He was alone and had moved to Grande Prairie for 3 months. He came in the winter and was facing eviction. He had been laid off from his job as things were slowing down. He was behind paying bills and his utilities were being disconnected. He came to see us as he was unsure of where to go. I referred him to Income Supports and then went with him to his meeting. At the meeting we explained to the worker that he was facing all of these financial challenges and just needed short term help.

He was diabetic and had no medication. He was addicted to crack but had been clean for one month.

After connection to community resources and helping this person he continued to come and visit as he had a trust with Centerpoint. After a struggle to maintain his housing and get himself on a new path of life, he now has a full time job in the social services sector and is supporting people who were once in his shoes.

Rhonda