HOUSING-BASED CASE MANAGEMENT

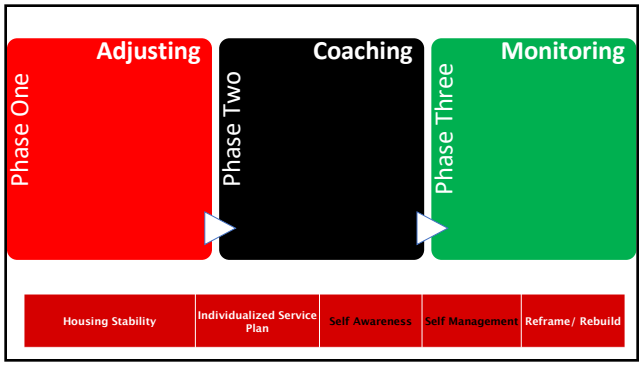
ORG CODE

73

WELCOME BACK! SESSION #2

Tracy
Associate Director

74



75

BEFORE, AT OR NEAR MOVE-IN

76

ONCE YOU ARE ASSIGNED A PARTICIPANT…

- Ask them to describe what they think the case management supports will look like.
- Ensure that they are comfortable with home visits.
- Show them what a case plan looks like.
- Let them know that honesty is the currency of success.
- Make sure that they know your primary focus is going to be on housing stability.
- Ask them what they think it means to be a responsible tenant.

77

GOOD PREPARATORY PRACTICES

- Whenever you can, only do move-ins on Mondays, Tuesdays or Wednesdays.
- Usually only one move-in per day – maximum of 2!
- Discuss/role-play the move-in before it happens.
- Book a time to meet – and then be early.
- Pick out furniture in advance.

78

ON THE DAY OF MOVE IN…

- Do a walk through. Exude positivity.
- Have your cleaning kit ready and roll up your sleeves WITH your participant.
- Arrange for furniture & basic supplies to be delivered.
- Provide orientation to building & community.
- Review fire safety plan and safe use of appliances.
- Make sure lock and keys work; discuss strategies for lost keys.
- Encourage meeting neighbors.

79

BEFORE YOU LEAVE

- Ask them the 2-3 things they think may go wrong in the first few days and what they will do if those things happen so that they stay in their place.
- Ensure next visit is scheduled within two days.

80

PROMOTE HOME MAKING = INCREASE SAFETY & BELONGING

- Buy a baking sheet and make cookies.
- Provide them a plant.
- Give them three picture frames.
- Get sticky putty to put posters on the wall.
- Go grocery shopping and make bulk meals.
- Activities to address boredom…cards, art supplies, books, tv, laptop, etc.
- Calendar
- Fridge magnets
- Dry-erase marker

81

STRUCTURING HOME VISITS TO ESTABLISH AND REACH GOALS

82

SET THE TONE FOR HOME VISITS

- Ask TV, radio, etc. to be turned off
- Ask them to hold non-urgent calls and texts. And leave your own phone alone!
- Ask that there be no guests during visits
- Be on time & stay on time
- It's okay to acknowledge, "I know this may be hard for you…"
- It's okay to note discrepancies and establish an honest environment
- Be present…listen…embracing the silence and awkward pauses
- Embrace your role as a change agent in your tone

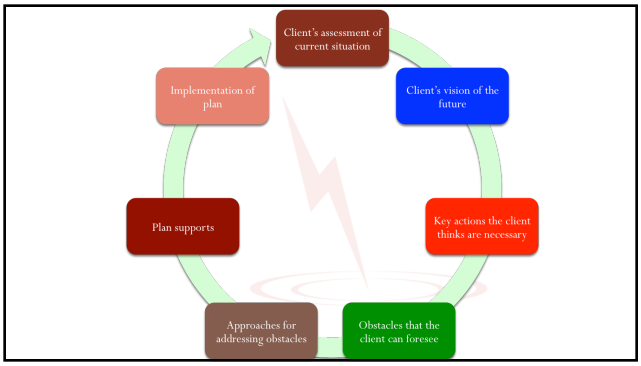
83

THE LANGUAGE OF NEEDS

As program participants enter the program they speak in the language of needs.

Over time, we transition to the language of goals.

84



85

USING AN OBJECTIVE-BASED APPROACH

Hi (name) good to see you today and we have xx minutes for our visit. As we talked about on (date of last visit) we agreed that we would talk about:

A.
B.
C.

At the end of dealing with those objectives for today we will select some objectives for our next visit.

86

MEANINGFUL DAILY ACTIVITY

Primary Areas of Concern

- Isolation
- Disinterested in suggestions
- Despondent
- No enjoyment
- Not many days of the week
- Early engagement
- Areas of interest not available in the community
- Participation requires resources

Objective Based Home Visits

- Accompany to new activities
- Introduce new opportunities
- Debrief pros and cons of recent experiences
- Readiness ruler on new activities

87

THE QUESTION YOU MUST ASK

How do you think that will impact your housing?

88

NARROWING DOWN OPPORTUNITY

How important is it to you to make a change in this part of your life?

How ready are you to make a change in this part of your life?

How confident are you to make a change in this part of your life?

89

TASKS TO AIM TO ACCOMPLISH IN THE FIRST MONTH

90

WHAT IS GOING ON?

- The "abnormal" is "normal"...ups and downs are common
- Range of emotions and actions can be misperceived as not wanting housing with support or trying to "sabotage" housing with support
- Second-guessing decision to participate in program is common

91

5 NECESSARY FUNCTIONS IN THE FIRST MONTH

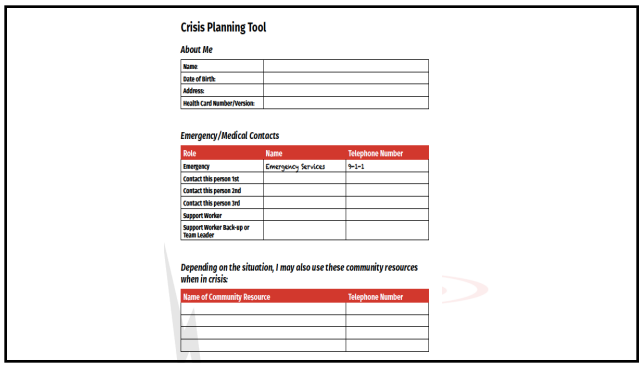
1. Crisis Plan
2. Budget
3. First Case Plan
4. Risk Assessment
5. Personal Guest Policy

92

1. CRISIS PLAN

- **Normalize it**
- Completed within the first 2 weeks
- Updated again as necessary
- Final update is at **program exit**
- May be included as part of **WRAP** or **DREEM** if appropriate

93



Crisis Planning Tool

About Me

Name:	
Date of Birth:	
Address:	
Health Card Number/Version:	

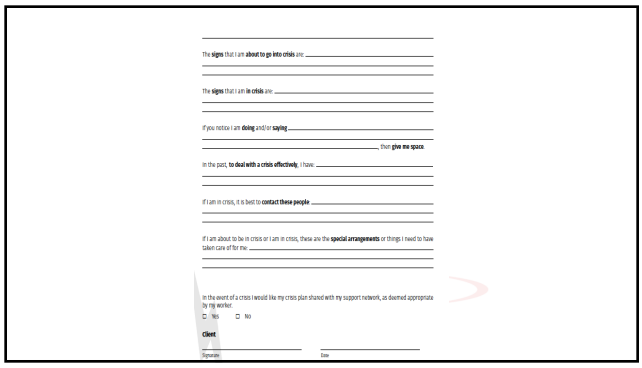
Emergency/Medical Contacts

Role	Name	Telephone Number
Emergency	Emergency Services	9-1-1
Contact this person 1st		
Contact this person 2nd		
Contact this person 3rd		
Support Worker		
Support Worker Back-up or Team Leader		

Depending on the situation, I may also use these community resources when in crisis:

Name of Community Resource	Telephone Number

94



The **signs** that I am **about to go into crisis** are: _____

The **signs** that I am **in crisis** are: _____

If you notice I am **doing** and/or **saying** _____ then **give me space**.

In the past, **to deal with a crisis effectively**, I have: _____

If I am in crisis, it is best to **contact these people**: _____

If I am about to be in crisis or I am in crisis, these are the **special arrangements** or things I need to have taken care of for me: _____

In the event of a crisis I would like my crisis plan shared with my support network, as deemed appropriate by my worker.

☐ Yes ☐ No

Client

_____ _____

Signature Date

95

2. BUDGET

- Reinforcing **basic concepts**
- Reflection leads to better information
- Does NOT have to be perfect
- Important to raise **awareness**, NOT pass judgement on how people spend or access money

96

Honest Monthly Budget

Things that I have to spend money on:		Formal ways I get money:	
Rent		Job	
Utilities		General Welfare	
Food		Disability	
Arrears		Pension	
Repairs		Inheritance	
TOTAL		TOTAL	

97

Other money that comes in goes toward:		Informal ways I get money:	
Child Support		Binning/Bottle Collecting	
Debts		Odd Jobs	
Cigarettes		Treasure Hunting	
Coffee		Baby Sitting	
Alcohol		Sex Work	
Other Drugs		Drug Running/ Dealing	
Health Stuff		Day Labour	
Household Supplies		Theft/ Pawning	
Girlfriend/ Boyfriend		Friends/ Family	
Kids		Selling Prescription	
Other Friends		Gambling	
Cable		Medical Research	
Socializing/ Partying/ Night Out		Panhandling	
Sex		Selling Crafts	
Bus		Busking/ Street Entertainment	
Taxis		Honorariums	
Gambling		Non-Medical Research	
Legal Stuff/ Fines		Other	
Other Bills			
TOTAL		TOTAL	

98

All the Ways I Spend Money:		All the Ways I Make Money:	
GRAND TOTAL		GRAND TOTAL	

Difference Between What I Spend and What I Make:	

99

3. FIRST CASE PLAN

- First time to demonstrate **SMARTER** goal-setting
- No more than **3 areas of attention**
- All 3 areas related to housing stability

100

SMARTER GOAL SETTING

- **S**pecific
- **M**easurable
- **A**ttainable
- **R**elevant
- **T**imed
- **E**valuated
- **R**evisited

101

4. RISK ASSESSMENT

- Should be completed within two weeks of being housed
- By identifying risks, the intent is to define the **people, processes, and/or technology** that can help minimize the risk, not prevent service
- Risk assessments should be updated periodically

102

Brief Risk Assessment

In the last year:

	Yes	No	Declined
Have you been charged with a violent offence, including sexual assault or domestic violence?	☐	☐	☐
Have you attended an anger management class because someone like a judge told you that you must do so?	☐	☐	☐
Has a court ordered you to take medication or follow through on a treatment order for your mental health?	☐	☐	☐
Have you thought about, planned, or attempted to end your life?	☐	☐	☐
Have you overdosed on alcohol or other drugs to the point where you required medical attention?	☐	☐	☐
Have you had falls, spells, blacked out or had seizures?	☐	☐	☐
Have you acquired a brain injury?	☐	☐	☐
Have you been diagnosed with a chronic health condition or been unable to do what you are supposed to for an existing chronic health condition?	☐	☐	☐
Have you been to the emergency room of the hospital 4 or more times?	☐	☐	☐
Have you been incarcerated 4 or more nights?	☐	☐	☐

103

Do you:

	Yes	No	Declined
Plan on harming another person or yourself?	☐	☐	☐
Have an existing chronic health condition that you are not getting health care for?	☐	☐	☐
Have an existing serious mental health condition that you are not getting care for?	☐	☐	☐
Avoid getting help when you are sick or injured?	☐	☐	☐
Engage in higher risk behaviour like sharing needles, having sex with people you don't know, or anything like that?	☐	☐	☐
Use alcohol or other drugs to the point of complete intoxication two or more times per week?	☐	☐	☐
Have any warrants for your arrest?	☐	☐	☐
Have anybody that wants to harm you or seek revenge from you violently, which may include people that believe you have harmed them or to whom you owe money?	☐	☐	☐
Have difficulties concentrating or remembering things?	☐	☐	☐

104

5. PERSONAL GUEST POLICY

- Intent is to help the participant define **who can visit, when, and who is responsible** for the actions of guests
- Can be turned into a fun project
- Idea should be introduced during the housing search, discussed during move-in, and completed during the first two home visits

105

PERSONAL GUEST POLICY

- Types of questions you may ask to help form the guest policy:
  - What **time of day** do you want to allow guests (or not allow guests)?
  - Is there anyone that you **don't want at your unit** (even though you may hang out with them somewhere else)?
  - Is there anybody you'd only invite over on certain days or certain times?
  - If someone comes over with a friend, and you don't know the person, is that alright with you?

106

PERSONAL GUEST POLICY

- Types of questions you may ask to help form the guest policy:
  - If a **guest damages something** in the building, who is responsible?
  - Are there any activities, language or other things that you do not want happening in your apartment?
  - If people want to crash on your floor or couch, is that cool with you? What if doing so is against your lease?
  - If people want to **smoke/use drugs in your unit**, how will you make sure that doesn't result in you getting evicted?

107

PERSONAL GUEST POLICY

- Types of questions you may ask to help form the guest policy:
  - If a buddy wants to "borrow" your unit for a couple of hours to **have a date with his girlfriend/boyfriend**, is that okay with you?
  - If people **get in a fight**– including a fight with you– how will you respond to that and not lose your housing?
  - Can people eat your food or use your things?
  - What can you do to make sure there are no **noise complaints?**

108

INDIVIDUALIZED SERVICE/SUPPORT PLANS

109

DOCUMENTING & TYING GOALS TO ASSESSMENT

SPDAT COMPONENT	OVER-ARCHING GOAL	SUB-GOAL	TASKS	WHO	BY WHEN	HOW IT RELATES TO HOUSING STABILITY

110

SPDAT COMPONENT	OVER-ARCHING GOAL	SUB-GOAL	TASKS	WHO	BY WHEN	HOW IT RELATES TO HOUSING STABILITY
Personal Administration & Money Management	Improve budgeting	Open a bank account	Proof of income statement	Dave	August 15	Direct payment of rent from account
			Proof of residence	Sally	August 15	Budget with money left over after paying rent
			Identification	Dave	August 15	
			Research bank options & fees	Sally	August 19	
			Practice interview	Dave, Sally and Iain	August 22	
			Go to bank and open account	Dave, Sally	August 23	

111

3 & 2 APPROACH…

What are 3 areas of lower acuity/strengths that you can acknowledge with the individual?

3 and 2

How can you transfer those 3 areas of strengths to the 2 areas that have the highest acuity that the individual may be willing to work on to decrease the likelihood of housing instability?

112

EXIT PLANNING

First introduced in Stage 3 & finalized prior to actual Program Exit

113

EXCELLENCE IN HOUSING

Exit Planning

Client:	Version:	Date:

About Us

Family Name:	
Head(s) of Household:	
Address:	
Health Insurance	

Emergency/Medical Contacts

Role/Relationship	Name	Telephone Number
Emergency	Emergency Services	9-1-1
1.		
2.		
3.		

114

Our Plan to Maintain Housing

I will continue to **pay our rent** by making sure we do the following things:

I will make sure that **we don't get kicked out of the apartment** by doing/not doing the following things:

We are **ready to live with greater independence** and without Housing Program supports because:

115

The areas in our life that **we are still working on** are:

We are going to **work on these areas by**:

Signs that our housing is **becoming unstable** are:

116

If our housing is becoming unstable **we will:**

Signs our housing **is unstable** are:

If our housing is unstable **we will:**

117

We are confident that we have the skills to:

Task	Yes	No	N/A
Clean the apartment	☐ Yes	☐ No	
Go grocery shopping	☐ Yes	☐ No	
Pay rent	☐ Yes	☐ No	
Speak with landlord	☐ Yes	☐ No	
Do laundry	☐ Yes	☐ No	
Budget	☐ Yes	☐ No	
Pay other bills	☐ Yes	☐ No	
Be responsible tenants	☐ Yes	☐ No	
Set goals & take action	☐ Yes	☐ No	
Problem-solve with a level head	☐ Yes	☐ No	
Keep emotions in check when frustrated/angry	☐ Yes	☐ No	
Follow crisis plan when necessary	☐ Yes	☐ No	
Make appointments and keep them	☐ Yes	☐ No	
Follow doctor instructions	☐ Yes	☐ No	☐ N/A
Follow psychiatrist instructions	☐ Yes	☐ No	☐ N/A
Take medicine	☐ Yes	☐ No	☐ N/A
Refill medicine	☐ Yes	☐ No	☐ N/A
Have fun without creating problems	☐ Yes	☐ No	
Fill the days with things that make us hapy	☐ Yes	☐ No	
Invite guests over and know when to ask them to leave	☐ Yes	☐ No	
Seek out help when we need it	☐ Yes	☐ No	
Keep our apartment	☐ Yes	☐ No	

118

Our Support Network

The following people are considered to be part of my support network, and we recognize that our Housing Program support worker will no longer be part of my support network:

Role/Relationship	Name	Telephone Number

Should we ever receive an eviction notice or be told by my landlord that we need to leave, we will:

We would like our exit plan shared with our support network and other social service organizations, as deemed appropriate by my worker.

☐ Yes ☐ No

119

MANAGING TIME & SANITY

120

ESTABLISH REALISTIC EXPECTATIONS

Step	Length of Time a Chronically Homeless Person / Family Is Usually Supported in the Step	Hours Invested Per Program Participant Per Week
Housing Stability	2-6 months	2-6 hours
Individualized Service Plan	6-9 months	1-3 hours
Self Awareness	1-3 months	0.5-1.5 hours
Self Management	1-3 months	0.5-1.5 hours
Reframe/Rebuild	1-2 months	0.25-0.75 hours

121

IMPECCABLE TIME MANAGEMENT

- Keep to a set schedule of visits each week (do NOT ask at the end of a visit "When should we meet again?")
- Start each day in the office preparing your files, completing emails, making phone calls
- Do 2–4 home visits each morning
- Ensure you take lunch
- Do 2 to 4 home visits each afternoon
- Complete your day in office entering case notes, filing, completing emails, making phone calls
- Do NOT answer your phone live during the day (unless it is your boss, of course)

122

Day One	Day Two	Day Three	Day Four	Day Five
Start in Office	Start in Office	Start in Office	Start in Office	Start in Office
Housing Stability Household	ISP Household	Case Review	SA/SM Household	Housing Stability Household
Housing Stability Household	ISP Household		SA/SM Household	
	ISP Household		Housing Stability Household	ISP Household
Lunch	Lunch	Lunch	Lunch	Lunch
Housing Stability Household	ISP Household	Housing Stability Household	Housing Stability Household	R/R Household
		ISP Household		R/R Household
Housing Stability Household	ISP Household	SA/SM Household	ISP Household	R/R Household
		SA/SM Household	SA/SM Household	R/R Household
Documentation	Documentation	Documentation	Documentation	Documentation

123

A MONTH…

- 140 Hour Month…
  - 44 hours Housing Stability Clients (Stage 1)
  - 33 hours Individualized Service Plan Clients (Stage 2)
  - 15 hours Self Awareness/Self Management Clients (Stage 3/4)
  - 10 hours Reframe/Rebuild Clients (Stage 5
  - 12 hours Case Reviews
  - 20 hours Documentation
  - 6 hours meetings

124

STRIVE FOR BALANCED CASELOADS

ICM Programming Maximum Case Loads Per Case Manager		
Target Population	**Scattered Site Case Load**	**Congregate/Single Site Caseload**
Individuals with High Acuity	15-20 per 1 Case Manager	20-25 per 1 Case Manager
Families with High Acuity	10-15 per 1 Case Manager	15-20 per 1 Case Manager
Transition Aged Youth with High Acuity	15 per 1 Case Manager	20-25 per 1 Case Manager

RRH Programming Case Loads Per Case Manager		
Target Population	**Scattered Site Case Load**	**Congregate/Single Site Caseload**
Individuals with Moderate Acuity	20-25 per 1 Case Manager	30-35 per 1 Case Manager
Families with Moderate Acuity	20-25 per 1 Case Manager	30 per 1 Case Manager
Transition Aged Youth with Moderate Acuity	20-25 per 1 Case Manager	35 per 1 Case Manager

125

WEEKLY CASE REVIEW

- Same time each week.
- Not optional (unless sick, on vacation, or dead)
- Phones off
- 60-90 second review of each client being supported (alternate end of alphabet to start from)
- 2 holds maximum per case manager
- Chaired by Team Leader

126

FOR EACH PERSON ON CASELOAD

- Outline most recent acuity
- Indicate acuity in previous reading
- Share the three case plan priority areas
- Outline what the three objectives are for the next home visit, and mentions whether any of those are carry-overs
- Indicate when next home visit will be
- Make key notes of importance that should be shared

127

Client	Case Manager	Back-up	Most Recent Acuity	Last Acuity	Case Plan Priorities	Objectives	Next Meeting	Key Notes
Alma, L.	Dave	Winnie	41	44	• Legal issues • Self-care & Daily Living Skills • Physical Health & Wellness	• Make doctor's appt. • Prepping for laundry • Follow-up re: beg bugs	June 2, 1100h- 1145h	
Cousts, M.	Mike	Dave	30	33	• Managing Tenancy • Substance Use • MDA	• Go to library • Discuss hole in wall • Help sort empties	June 3, 1330h- 1430h	9 month assessment due by end of month
Davis, L.	Winnie	Mike	47	40	• Legal issues • Personal Admin & $ Management • High-Risk/ Exploitive	• Budget update to address fines • Safety planning for sex work • Update risk assessment	June 1, 1600h- 1645h	Court appearance June 11 @ 0900h
Finn, J.	Winnie	Dave	27	31	• Managing Tenancy • MDA • History of Housing	• Exit plan review • Provide copy of summer recreation catalog • Set exit date	June 10, 0830h- 0845h	Should exit by June 30

128

CLOSING THOUGHTS

129

HOUSING-BASED CASE MANAGEMENT

ORG CODE

1

WELCOME & HOUSEKEEPING

Erin Wixsten
Associate

2

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OrgCode are merry misfits that disrupt the status quo to be catalysts for better outcomes.

Thought leaders in ending homelessness, we advance ideas, create and share resources, and offer training that doesn't suck.

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3

APPLYING CASE MANAGEMENT STANDARDS

4

STANDARD 1: PROGRAM PARTICIPANT IDENTIFICATION & ELIGIBILITY

Screening is completed to understand presenting issue(s) relative to program eligibility criteria.

Potential program participants can expect:

To consent

To understand the intention, process and approach

5

STANDARD 2: ASSESSMENT

In conjunction with the program participant, the case manager conducts and documents an individualized assessment using a structured process.

Potential program participants can expect:

- To identify their own solutions
- Identify their needs, values and concerns
- Choice-making
- To understand what is happening by the language used and cultural competency of worker
- Documentation of discussions and decisions

6

STANDARD 3: PLANNING

Program participant goals and priorities are documented and reflected in the strategy for action agreed upon by the program participant and case manager.

Potential program participants can expect:

- Comprehensive understanding of options
- To make informed decisions
- Documented goals with measurable criteria

7

STANDARD 4: IMPLEMENTATION

Planned services, resources and supports are initiated, coordinated and adjusted as necessary.

Potential program participants can expect:

- Person-centered relationship with case manager
- Agreed upon roles and responsibilities
- To exercise self-management
- To exercise the greatest amount of independence possible
- Regular communication
- To have discordant issues addressed and resolved
- Progress to be monitored

8

STANDARD 5: EVALUATION

A periodic reassessment is conducted to identify the program participant's current needs and to monitor progress within the participant's individualized plan.

Potential program participants can expect:

- To have current goals
- To be satisfied with the outcomes of the plan
- Stability
- Documented quantifiable impact
- Gaps in services to be identified and addressed as possible

9

STANDARD 6: TRANSITION

A process for supporting disengagement when goals are reached.

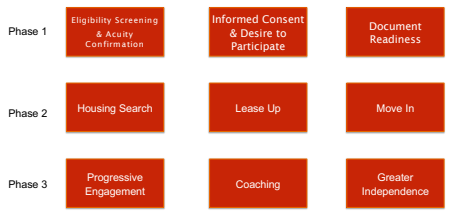
Potential program participants can expect:

- To know the disengagement criteria
- Links to alternative community resources
- To have independence maximized and supported
- Information to be shared with consent to other parties in the transition, as necessary
- To have concerns of disengagement addressed prior to disengagement

10

DEFINING THE JOB

11



12

THE HOUSING-BASED CASE MANAGER

A housing-based case manager is an organized and trained professional that acts as a positive change agent in holistically assisting individuals/families in achieving and maintaining housing, while concurrently promoting awareness and teaching strategies that reduce the likelihood of a return to homelessness in the future.

13

SERVICE REQUIREMENTS

- Trained, professional staff with knowledge of the interventions, application of standards, adherence to ethics, and applied boundaries
- Low staff to participant ratios
- Flexible hours and not 9-5
- Personalized case management delivered through home visits
- Vast system knowledge
- Structured, documented and strategic

14

THINGS THAT THIS IS NOT

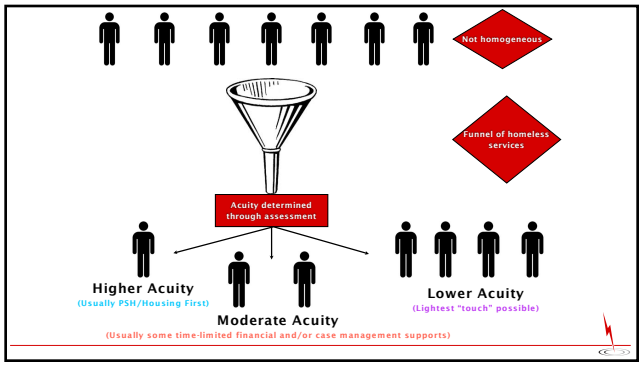
- Crisis response or crisis driven.
- Ad hoc.
- Without conflict.
- Office-based.
- Punitive.
- Perfect.
- Easy.

- Rocket Science!

15

DIFFERENT TYPES OF INTERVENTIONS FOR DIFFERENT TYPES OF NEED

16



17

WHAT HOUSING FIRST *REALLY* IS & HOW TO APPLY IT

18

HOUSING FIRST IS A PHILOSOPHY

A belief that a person/family can be housed rapidly and permanently, without expectation that they are:

- Compliant
- Sober
- Employed or with income
- A graduate of a transitional program
- Nice

19

HOUSING FIRST IS AN INTERVENTION

- An intervention requires:
  - **action** to improve a situation
  - **interference** into the affairs of another
  - **persuasion** to consider alternatives
- To deliver the intervention, an organization can use:
  - Critical time intervention or Rapid Re-Housing
  - Recovery-oriented housing focused Intensive Case Management (aka Excellence in Housing-Based Case Management)
  - Recovery-oriented housing focused Assertive Community Treatment (aka Pathways Model)

20

HOUSING FIRST IS DRIVEN BY CHOICE

- To participate in the intervention, a potential program participant must:
  - Be informed of what they are agreeing to
  - Consent to full participation
  - Cannot be coerced, forced, ordered, bribed or bargained with to participate
- To participate in the intervention, a potential program participant is given choices in where they want to live, not placed into housing.
- A program participant has an active voice in determining which goals they want to set, in which order, relative to her/his/their housing stability.

21

RAPID RE-HOUSING (RRH)

- Designed for households with moderate acuity
- Has three mandatory components:
  1. Financial assistance
  2. Housing location assistance
  3. Supports to stay housed
- Usually six to nine months in duration
- Rarely has a clinical component
- Can follow a CTI model

22

INTENSIVE CASE MANAGEMENT (ICM)

- Designed for households with higher acuity
- Has three mandatory components:
  1. Financial assistance
  2. Housing location assistance
  3. Supports to stay housed
- Usually 18-24 months in duration
- May have a clinical component
- Follows a Recovery-Oriented Housing Focused approach

23

ASSERTIVE COMMUNITY TREATMENT (ACT)

- Designed for households with highest acuity
- Has three mandatory components:
  1. Financial assistance
  2. Housing location assistance
  3. Supports to stay housed
- Can be permanent in duration
- Always has a clinical component
- Follows a Recovery-Oriented Housing Focused approach

24

PERMANENT SUPPORTIVE HOUSING (PSH)

- Designed for households with high acuity who are chronically homeless
- Has two mandatory components:
  1. Financial assistance
  2. Supports to stay housed
- Permanent in duration
- May have a clinical component
- Does not have a single defined approach

25

ALL INTERVENTIONS SERVE PEOPLE

- Ranging in acuity from moderate to high
- Usually with verifiable chronic homeless status
- Frequently with spotty housing histories
- Almost always living in economic poverty
- Frequently with traumatic histories
- Frequently with brain injury
- Frequently with mental illness and/or substance use disorders
- Frequently with chronic disease

26

IT IS COMMON THAT THE POPULATION

- Misses appointments
- Uses problematic language
- Behaves in ways that can be disruptive to a housing plan
- Does not always follow through on action items established in goal setting
- Avoids their worker or comes up with regular reasons for not interacting with worker
- Has difficulties with money management and sustaining employment

27

DOES IT WORK?

A major, large-scale study conducted by the Mental Health Commission of Canada called At Home/Chez Soi set up Housing First pilot programs in five major cities across Canada. Their finding:

"Housing First rapidly ends homelessness. Across all cities, HF participants obtained housing and retained their housing at a much higher rate than the treatment as usual (TAU) group. In the last six months of the study, 62 per cent of HF participants were housed all of the time, 22 per cent some of the time, and 16 per cent none of the time; whereas 31 per cent of TAU participants were housed all of the time, 23 per cent some of the time, and 46 per cent none of the time... Among participants who were housed, housing quality was usually better and more consistent in HF residences than TAU residences."

28

DOES IT WORK?

Furthermore, they found that:

"**Housing First is a sound investment**. On average the HF intervention cost $22,257 per person per year for ACT participants and $14,177 per person per year for ICM participants. Over the two-year period after participants entered the study, every $10 invested in HF services resulted in an average savings of $9.60 for high needs/ ACT participants and $3.42 for moderate needs/ICM participants. Significant cost savings were realized for the 10 per cent of participants who had the highest costs at study entry. For this group, the intervention cost was $19,582 per person per year on average. **Over the two-year period following study entry, every $10 invested in HF services resulted in an average savings of $21.72.**"

29

DOES IT WORK?

1811 Eastlake, Seattle, WA

Journal of the American Medical Association published that wet permanent supportive housing to has positive health and social outcomes and reduces costs.

Journal of Addictive Behaviors published findings indicating motivation to change while in a housing environment produced consistently better outcomes than treatment attendance.

American Journal of Public Health published findings that demonstrates reduction in alcohol use and is a "strong rebuttal to the 'enabling' hypothesis.

Journal of Community Psychology reports 84% maintain stable housing after 12 months.

Journal of Psychiatric Services published results that criminal history was NOT a predictive factor in housing failure & **International Journal of Drug Policy** published complimentary results, as well as decreases in jail after being housed

30

DOES IT WORK?

Gulcur, Leyla, A Stefancic, M Shinn, S Tsemberis and S Fischer. Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programmes. Journal of Community & Applied Social Psychology, 13: 171–186 (2003).

- 225 participants were interviewed and randomly assigned to Housing First or service that made treatment and sobriety a prerequisite for housing, and then interviewed every six months over 2 years.
- Housing First participants spent much less time homeless and in psychiatric facilities, and experienced much less service costs than the comparison group.

31

DOES IT WORK?

Tsemberis, Sam, Leyla Gulcur and Maria Nakae. Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis. April 2004, Vol 94, No. 4 | American Journal of Public Health 651–656

- Randomly selected 250 participants to compared Housing First with "treatment as usual" longitudinally
- Housing First group moved into housing quicker, remained stably housed and had more positive assessment of choice.
- For the control group (non-Housing First participants), the use of substance use treatment was higher; however, there were no differences found in substance use or psychiatric symptoms between the two groups.
- Housing First participants were able to achieve stable housing without negative impacts on psychiatric or substance use symptoms.

32

DOES IT WORK?

Tsemberis, Sam and Ronda Eisenberg. Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals With Psychiatric Disabilities Psychiatric Services 51:487-493, April 2000.

- Compared 242 Housing First participants with 1,600 individuals receiving linear residential treatment over a five year period
- Over the five year period, 88% of the Housing First participants remained housed compared to 47% of the individuals receiving linear residential treatment

33

DOES IT WORK?

Tsemberis, S, L Moran, M Shinn, S Asmussen, D Shern. Consumer Preference Programs for Individuals Who Are Homeless and Have Psychiatric Disabilities: A Drop-In Center and a Supported Housing Program. American Journal of Community Psychology. Volume 32, Numbers 3-4, 305-317.

- Two experimental programs examined: 1 compared a drop-in center without barriers to usual service delivery, and 2 compared Housing First to usual continuum with expectations of sobriety and treatment
- The drop in center without barriers was more successful than control programs in reducing homelessness, but after 2 years only 38% of participants had moved into housing.
- The Housing First program obtained 79% housing stability compared to 27% in the control group.
- In both instances, there were no differences in substance abuse or psychosocial outcomes.

34

THE SERVICE ORIENTATION

35

FROM A PLACE OF COMPASSION

From the Latin *pati* and *cum* meaning: to suffer with.

"Compassion is not a relationship between the healer and the wounded. It's a relationship between equals. Only when we know our own darkness well can we be present with the darkness of others. Compassion becomes real when we recognize our shared humanity." *(Pema Chodron, The places that scare you: a guide to fearlessness in difficult times)*

36

PRACTICAL WAYS TO SERVE COMPASSIONATELY

- Actively live your empathy
- Do not jump to conclusions
- Exercise active listening
- Avoid judgment
- Regardless of how or what the person presents, find strengths

37

FIERCELY SUPPORT CHOICE

- Choice is paramount to ongoing change and building connectivity.
- Regardless of the housing market, *real* choice has to be offered in housing solutions.
- Program participant has to have a say on the type of services they want to want to receive, how often they want to receive those service, how long they want services, and how intense they want services to be.

38

PRACTICAL WAYS TO SUPPORT CHOICE

- Provide meaningful information - even viewpoints different than your own.
- Teach people how to rate pros and cons of potential actions.
- Avoid providing advice or opinion.
- Use open-ended questions.
- Explore what is likely to occur based upon decisions that are made.

39

IN VIVO

- Engage people in their most natural settings.
- Attempt to neutralize power dynamic of having program participants come to you.
- Enhances empathy by seeing first hand the realities of living as a program participant.
- Increases likelihood of outcomes being realized when connections and referrals are made.

40

PRACTICAL WAYS TO DELIVER SERVICES IN VIVO

Spend more time in community than in your office.

Ask people where they would like to meet.

Be visible.

Schedule times to meet in advance.

Have clear objectives for interactions.

41

WHAT IS TRAUMA?

All trauma contains three common elements:

- It was unexpected
- The person was unprepared
- The was nothing the person could do to stop it from happening

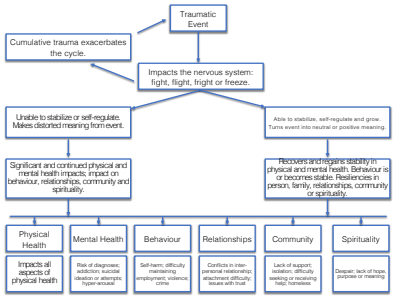
Trauma can be physical, emotional or psychological

42

PRINCIPLES OF A TRAUMA INFORMED APPROACH

- Safety
- Trustworthiness through transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice and choice
- Cultural, historic and gender issues

43



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PRACTICAL WAYS TO SERVE THOSE THAT HAVE LIVED THROUGH EXACERBATED TRAUMA

- Flexible appointments, including bringing appointments to the person
- Write out steps and tasks
- Avoid judgment
- Create emotional safety; reinforce physical safety
- Build connections outside of the program

45

PRACTICAL WAYS TO SERVE THOSE THAT HAVE LIVED THROUGH EXACERBATED TRAUMA

- Take nothing personally
- Engage in harm reduction
- Reinforce meaningful activities
- Provide an active voice in determining type, duration, frequency and intensity of services

46

PRACTICAL WAYS TO SERVE PEOPLE WITH A BRAIN INJURY

- Avoid consequential approaches to reinforcing change.
- Establish transparent objectives for each interaction.
- Be patient.
- Reinforce worthiness through acknowledgment of achievements.
- Break larger goals into smaller tasks that are measurable.
- Normalize, acknowledge and invite ambivalence.

47

DO NO HARM.

48

PRACTICAL WAYS TO APPLY A RECOVERY ORIENTATION

- Address stigma and model it.
- Provide education opportunities to deeper understanding.
- Build connections to trained peers.
- Appreciate the uniqueness of each journey.
- Be transparent of what community supports (including clinical supports) may be available, waiting times, expectations of those supports, etc.
- Establish crisis plans and approaches for maintaining housing stability.

49

HARM REDUCTION

Harm reduction is any program or policy designed to reduce drug related harm without requiring the cessation of drug use.

Harm reduction further applies to other behaviors that may be considered higher risk such as sex work or actively compromised mental health without medication and/or medical assistance, which impacts the individual and the broader community. As with substances, this is about reducing harm without cessation.

50

RE-FRAMING PERSPECTIVE OF ALCOHOL AND OTHER DRUGS

The Surgeon General has been clear: from a medical perspective we need to be considering addiction and dependency as chronic disease, not as character flaw, moral failing, or personal shortcoming.

Other researchers are helping inform a new way of looking at this:

- *In the Realm of Hungry Ghosts - Dr. Gabor Mate*
- *High Price - Dr. Carl Hart*
- *The Sober Truth - Lance Dodes*

51

AGREEMENT ON OUTCOMES

Most programs focus on cessation followed by abstinence and see recurrence as failure.

It is possible to reconsider the intended outcome from other perspectives as well:

- Reduction
- Movement from non-palatable to palatable
- Use within consumption thresholds
- Increasing periods of time between use
- Less harm to community
- Decreased ancillary harm

52

REFLECTING ON PRACTICE

53

IS HARM REDUCTION ENABLING?

…by respecting these choices and being available to deal with their consequences, the therapist intentionally strengthens the therapeutic alliance. Rather than seeing this as enabling the client to keep harming himself, the therapist understands that he or she cannot realistically prevent a client from making particular choices at the given moment. But by keeping the door open and helping to ameliorate adverse consequences when they occur, the clinician can strengthen the motivation of the client to behave in a less harmful way, and facilitate their engagement in further treatment when the client is ready to move closer to a less harmful pattern of use or abstinence.

- CAMH

54

PRACTICAL WAYS TO REDUCE HARM

Avoid judgment.

Budgeting for substance use.

Access to harm reduction supplies.

Very pragmatic, open goal setting.

Explicitly acknowledge *your* acceptance of *their* choices.

Focus on behaviour not on use or any particular exploitive action.

55

ENGAGE PROGRESSIVELY

Give people an opportunity to demonstrate what they know how to do rather than assuming they know how to do nothing.

Add more supports when people ask or when it is clearly demonstrated that more support is needed.

Do not assume that your approach to doing work is the only way to do things or always the right way.

56

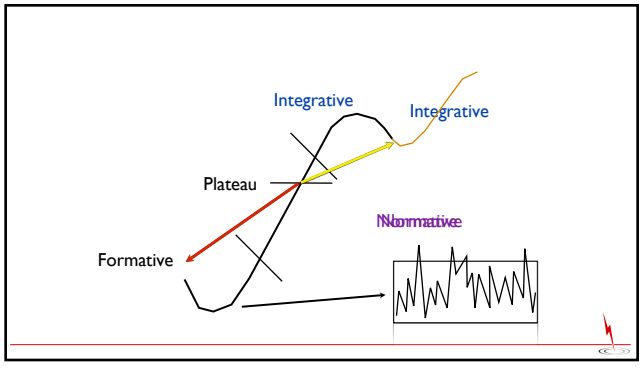
PRACTICAL WAYS TO PROGRESSIVELY ENGAGE

- Be proximate.
- Separate skill issues from motivation issues.
- Ask about the level of support they think they would benefit from.
- Use expectations rather than rules.
- Clearly establish timelines for task completion.

57

CHANGE LIFE CYCLE & FIVE ESSENTIAL AND SEQUENTIAL STEPS TO HOUSING STABILITY

58



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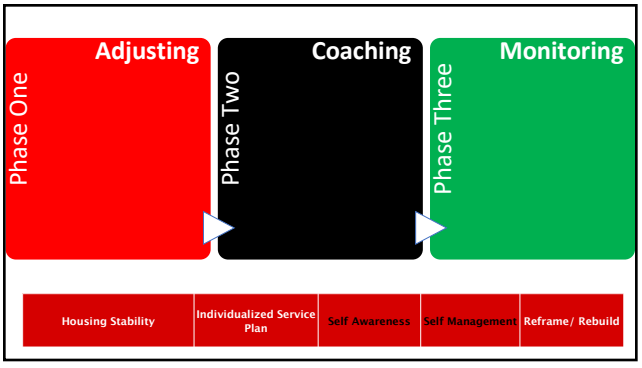


60

Housing Stability
Relationship Impacts
Support
Basic Needs
Safety

61

Individualized Service Plan
Life Stability
Meaningful Daily Activities
Employment/Education
Other System Connections
Social Awareness

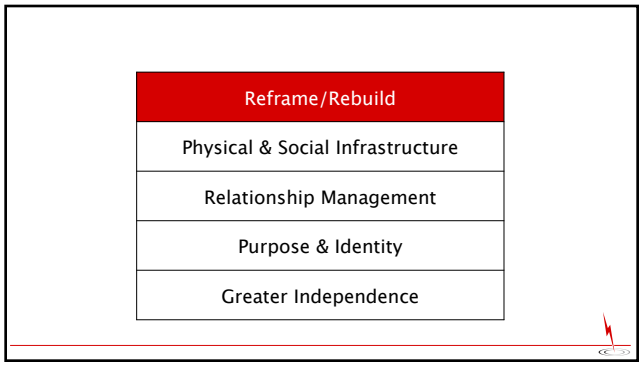
62

Self Awareness
Self Assessment
Triggers
Confidence

63

Self Management
Control
Accountability
Optimism

64


Reframe/Rebuild
Physical & Social Infrastructure
Relationship Management
Purpose & Identity
Greater Independence

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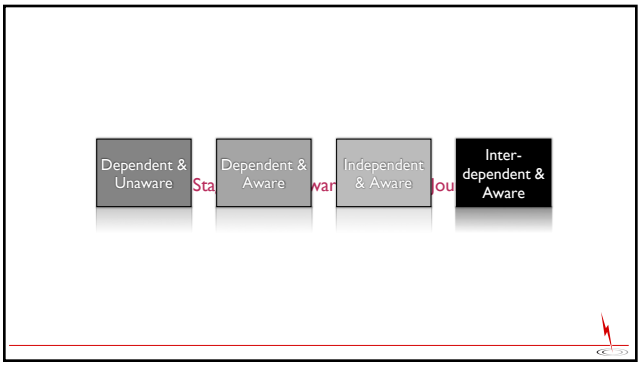
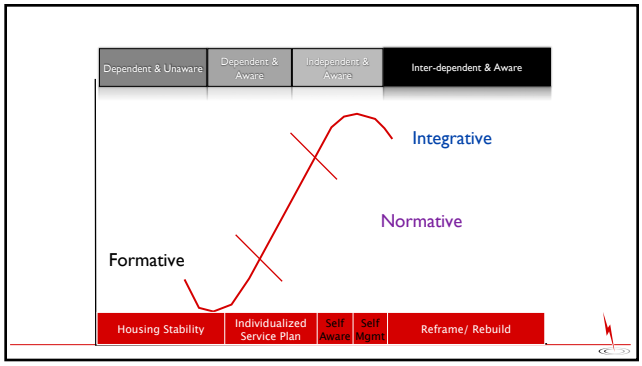

Dependent & Unaware
Dependent & Aware
Independent & Aware
Inter-dependent & Aware

66


Dependent & Unaware
Dependent & Aware
Independent & Aware
Inter-dependent & Aware
Integrative
Normative
Formative
Housing Stability
Individualized Service Plan
Self Aware
Self Mgmt
Reframe/ Rebuild

67

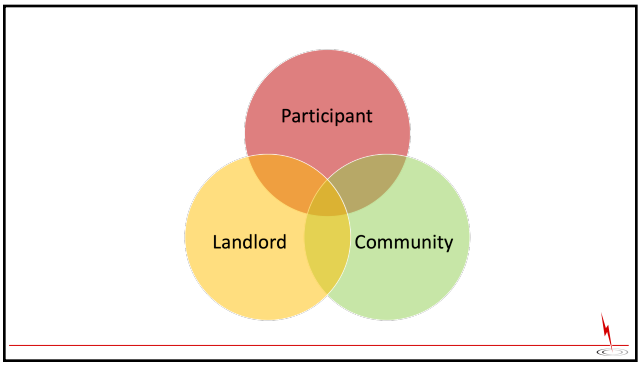

SECURING HOUSING

68

DIFFERENT APPROACHES YIELD RESULTS

- Professional housing locator
- Business plan
- Boots on the ground
- Incentivizing existing program participants
- Online resources
- Public postings

69



70

REMEMBER…

- Participation in supports is not linked to tenancy
- There are no limits on the number of times a person can/should be re-housed
- Reassessment ensures that housing instability is identified and addressed ASAP

71

END OF SESSION #1

72

Excellence in

Housing-Based Case Management

WORKBOOK

ORG CODE

"Working to Achieve Excellence in Housing-Based Case Management" is an interactive training program to assist housing support workers improve their delivery of case management. The focus is on excellence – respecting that excellence is a pursuit, not a destination in and of itself.

Through this training you will:

- ***Increase awareness and access to tools to be proactive in working with those that may disengage from the case management process;***
- ***Challenge some dominant myths in case management service delivery;***
- ***Improve your communication with clients***
- ***Increase your accountability in service delivery***
- ***Likely feel improved results in your professional performance.***

Acknowledgements

OrgCode Consulting would like to thank consumers, service providers and other professionals that have provided access to materials, knowledge and tools contained within the document, provided commentary on our approach and helped improve each version of our training related to case management excellence.

Disclaimer

OrgCode Consulting Inc. assumes no responsibility for how these resources and tools are used. OrgCode Consulting Inc. further assumes no responsibility for harm to or from clients, workers or the community stemming from the use of this resource or associated tools directly or indirectly. The use of these resources or associated tools and its consequences are independent of OrgCode Consulting Inc.

Five Essential and Sequential Steps in Case Management

Stages of Case Management

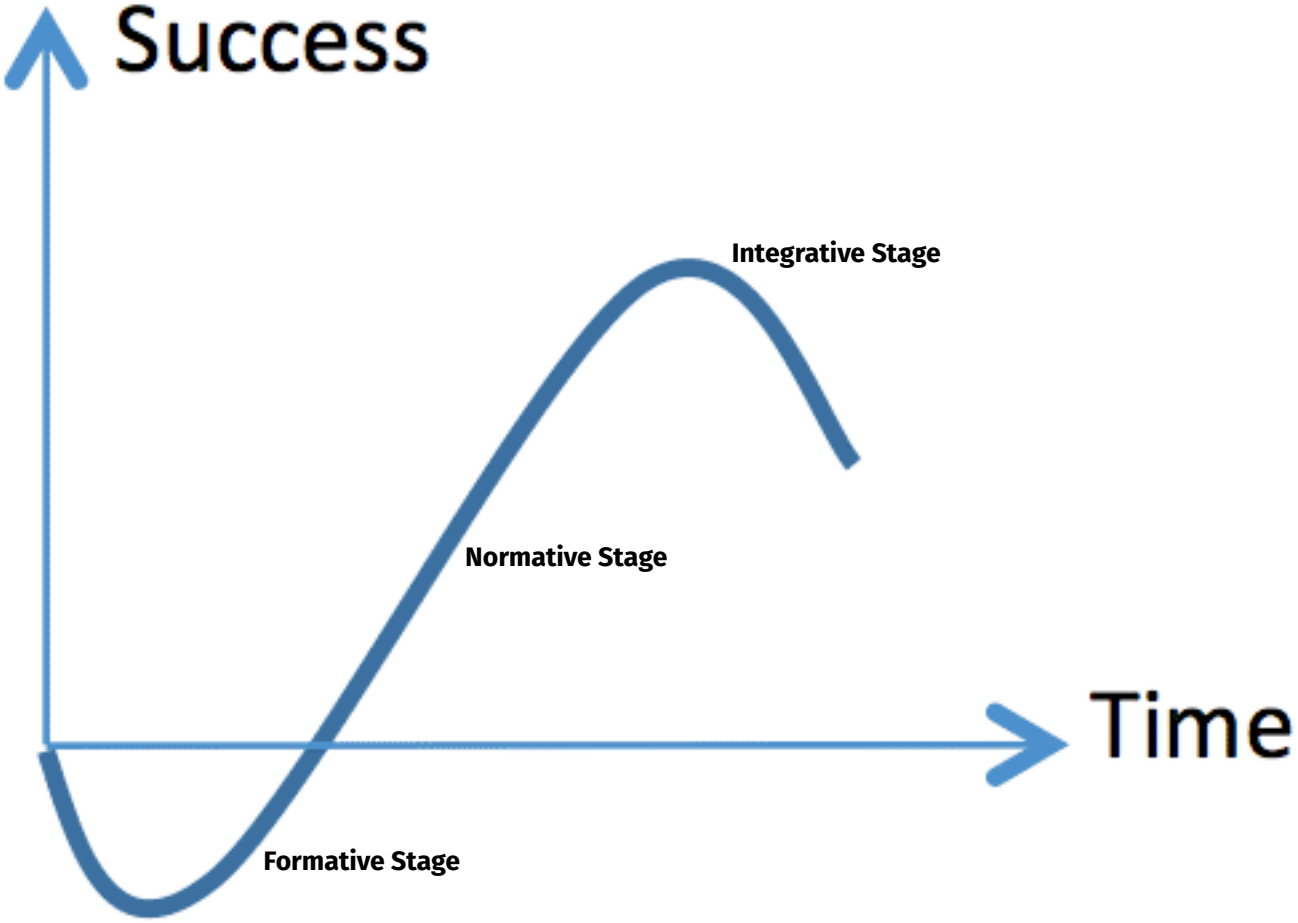
Housing Stability	Individualized Service Plan	Self Awareness	Self Management	Reframe/ Rebuild
• Relationship Impacts • Support • Basic Needs • Safety	• Life Stability • Meaningful Daily Activities • Employment/ Education • Other System Connections • Social Awareness	• Self Assessment • Triggers • Confidence	• Control • Accountability • Optimism	• Physical & Social Infrastructure • Relationship Management • Purpose & Identity • Greater Independence

Stages of Awareness

Dependent & Unaware	Dependent & Aware	Independent & Aware	Interdependent & Aware

Five Essential and Sequential Steps

Pathways to Change



Home Visits: Setting the Stage for Success

Start of the Visit

- Be pleasant
- Outline objectives
- Outline time

> ***"Hi [name] good to see you today and we have [XX] minutes for our visit. As we talked about on [date of last visit] we agreed that we would talk about:***
>
> ***A.***
>
> ***B.***
>
> ***C.***
>
> ***At the end of dealing with those objectives for today we will select some objectives for our next visit."***

- Ask TV, radio, etc. to be turned off
- Ask them to hold non-urgent calls and texts. And leave your own phone alone!
- Ask that there be no guests during visits (perhaps some exceptions for family members)
- Be on time & stay on time
- It's okay to acknowledge, "I know this may be hard for you..."
- It's okay to note discrepancies and establish an honest environment
- Be present... listen... embracing the silence and awkward pauses
- Empathy, not sympathy
- Embrace your role as a change agent in your tone

During the Visit

- Update half way through
- Keep things on track
- Ask probing questions
- Use active language
- Never provide advice

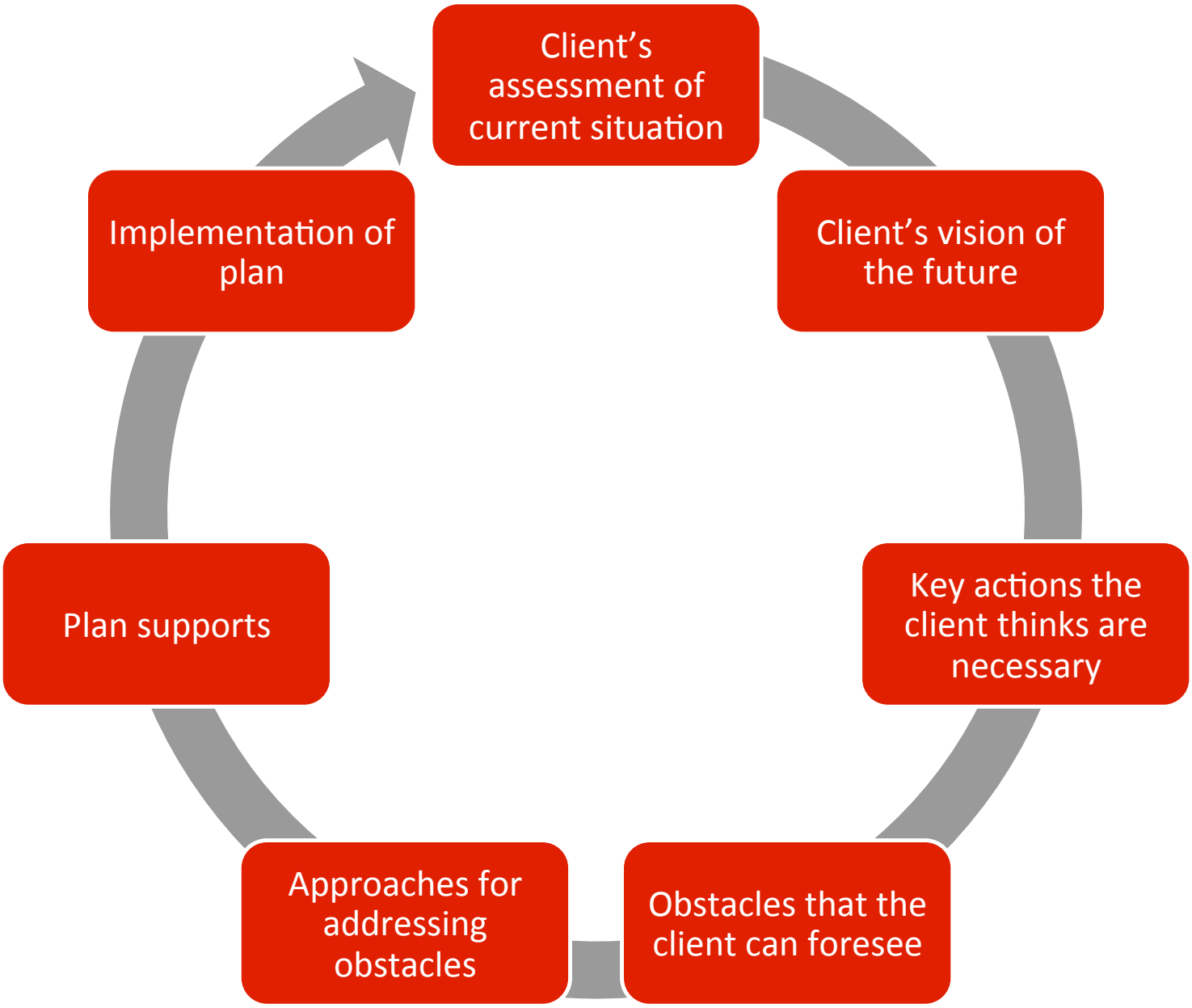
Home Visits

- Manage your own time (usually 4-6 home visits per day, maximum)
- Manage your safety
- Avoid idle chit-chat

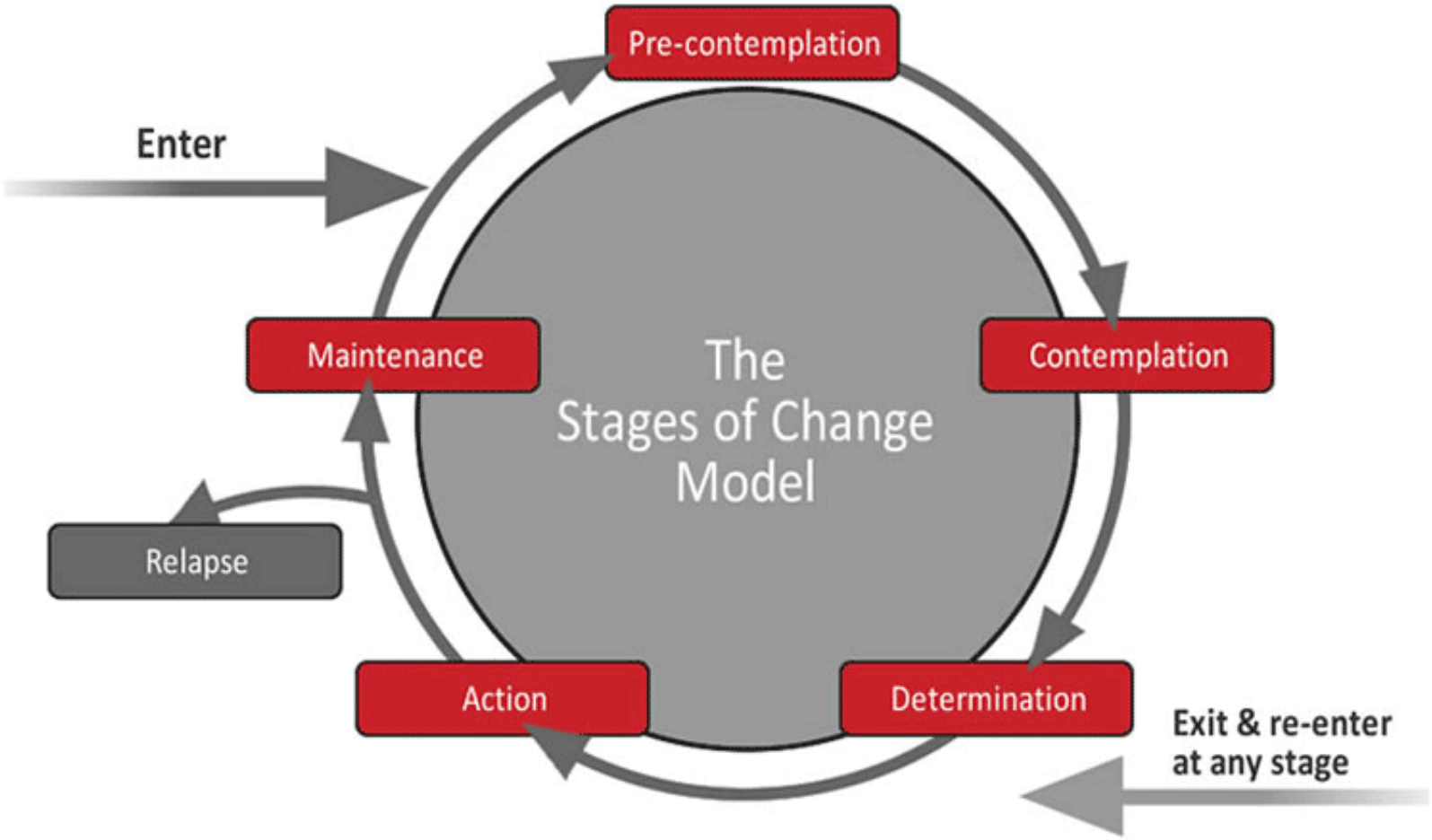
End of the Visit

- Summarize what was discussed.
- Establish objectives for next visit
- Note in the calendar the date and time of the next visit
- Find something positive to acknowledge, however small

Stimulating Positive Change



Stages of Change



Crisis Planning Tool

About Me

Name:	
Date of Birth:	
Address:	
Health Card Number/Version:	

Emergency/Medical Contacts

Role	Name	Telephone Number
Emergency	Emergency Services	9-1-1
Contact this person 1st		
Contact this person 2nd		
Contact this person 3rd		
Support Worker		
Support Worker Back-up or Team Leader		

Depending on the situation, I may also use these community resources when in crisis:

Name of Community Resource	Telephone Number

Understanding & Managing a Crisis

My **definition** of a crisis is: _____

_____

_____

Things that **cause** me to go into crisis are: _____

_____

Crisis Planning

The **signs** that I am **about to go into crisis** are: _____

The **signs** that I am **in crisis** are: _____

If you notice I am **doing** and/or **saying** _____

_____, then **give me space**.

In the past, **to deal with a crisis effectively**, I have: _____

If I am in crisis, it is best to **contact these people**: _____

If I am about to be in crisis or I am in crisis, these are the **special arrangements** or things I need to have taken care of for me: _____

In the event of a crisis I would like my crisis plan shared with my support network, as deemed appropriate by my worker.

☐ Yes ☐ No

Client

_____ _____

Signature Date

Intensive Case Manager

_____ _____

Signature Date

Risk Assessment Tool

Managing risk is a response to a specific assessment. A risk has to be defined and characterized before steps can be taken to minimize the risk.

While workers may assist individuals in helping them reduce risks, it is the individual that is responsible for their own actions. Workers do not have the power to control their clients. But they can shed light on areas where behaviours may be problematic, and do so in a respectful and engaging way that is of assistance to the client.

The focus is on the behaviour. Not the individual. A risk assessment is not a process of determining if someone is a "good" or "bad" person. It is about helping to create a series of steps that can be taken to reduce the likelihood of harm to self or others for the client.

The risk assessment encompasses the potential risks to clients, workers and the community. The community can encompass a shared living environment, others in the same program or even the general public.

It is recommended that all workers that engage with this client group are adequately trained in safely working alone, impacts of mental illness, impacts of brain injury, impacts of substance use and have knowledge of trauma.

After assessing risk, the goal is to create a risk minimization plan. Minimizing risk occurs through technology, processes or people. For example, technology can include the likes of electronic medical alerts that advise when a person has fallen or cameras at entrances and exits of buildings. Processes can include the likes of going for a walk when feeling particular emotions or confronted with specific situations or a guest policy that minimizes congestion in common areas. People can include the likes of certain clients always being visited by more than one worker at a time. There is nothing "cookie cutter" about the ways in which the technology, processes or people are used. They are specific to each situation and each person and each specific risk.

Risk Assessment

Risk Identification

Dimension 1: Observed & Known Behavior	Yes	No
Does the individual demonstrate self-neglect? *e.g., inability to meet one's needs of daily living; practice good hygiene; etc.*	☐ Yes	☐ No
Does the individual demonstrate self-neglect? *(e.g., inability to meet one's needs of daily living; practice good hygiene; etc.)*	☐ Yes	☐ No
Does the individual demonstrate anti-social behaviours?	☐ Yes	☐ No
Does the individual threaten violence or engage in other aggressive behaviour? *(e.g., posturing, challenging, demonstrate toughness by punching inanimate objects, etc.)*	☐ Yes	☐ No
Is the individual violent? *(e.g., engage in physical altercations which may include domestic violence, use weapons, etc.)*	☐ Yes	☐ No
Has the individual made racist, homophobic, sexist and/or other discriminatory comments towards particular groups or individuals?	☐ Yes	☐ No
Does the individual self-harm?	☐ Yes	☐ No
Does the individual bully others?	☐ Yes	☐ No
Has the individual attempted suicide at any point in the last three years or expressed suicidal thoughts within the past 12 months?	☐ Yes	☐ No
Does the individual harass other sexually or demonstrate sexual aggression up to and including rape?	☐ Yes	☐ No
Does the individual abuse children?	☐ Yes	☐ No
Does the individual manipulate others – through physical or verbal means – for their own personal gain?	☐ Yes	☐ No
Is the individual abused by others?	☐ Yes	☐ No
Is the individual harassed by others?	☐ Yes	☐ No
Is the individual manipulated by others?	☐ Yes	☐ No
Is the individual bullied by others?	☐ Yes	☐ No
Does the individual exhibit attention seeking behaviour?	☐ Yes	☐ No
Has the individual changed their routine in the past month?	☐ Yes	☐ No
Does the individual have difficulty expressing emotion verbally, especially when angry or upset?	☐ Yes	☐ No
Does the individual respond normally to stimuli experienced in day to day life? *(e.g., happiness at good life moments; laughter when there is a joke; sadness when something bad happens in life; pain when hurt)*	☐ Yes	☐ No
Do others have a negative reaction to the individual's behaviour?	☐ Yes	☐ No
Does the individual frequently fall?	☐ Yes	☐ No
Does the individual start fires?	☐ Yes	☐ No
Does the individual destroy property?	☐ Yes	☐ No
Is the individual at risk of eviction?	☐ Yes	☐ No

Risk Assessment

Dimension 2: Behavioral Influences	Yes	No
Are any "yeses" above related to use of substances including alcohol?	☐ Yes	☐ No
Are any "yeses" above related to compromised mental wellness?	☐ Yes	☐ No
Are any "yeses" above related to compromised physical wellness?	☐ Yes	☐ No
Is the individual aware of what triggers certain "yes" behaviours?	☐ Yes	☐ No
Does the individual have strategies and coping skills to decrease the "yes" behaviours?	☐ Yes	☐ No
Does the individual demonstrate remorse if their behaviour impacts others or hurts themselves?	☐ Yes	☐ No
Does the individual accept responsibility for his/her behaviour?	☐ Yes	☐ No
Is the individual aware of certain environments that effect his/her behaviour? *(e.g., noise; around people using drugs; confined spaces; hot room; institutional settings; group gatherings; etc.)*	☐ Yes	☐ No

Dimension 3: Conflict With the Law	Yes	No
Has the individual ever been incarcerated for a violent offence?	☐ Yes	☐ No
Has the individual ever been incarcerated for a sexual offence?	☐ Yes	☐ No
Has the individual ever been incarcerated for kidnapping or confinement of an individual?	☐ Yes	☐ No
Are there any legal restrictions in place on where the individual may (or may not) live? *(e.g., may include conditions of release or parole, restraining orders, etc.)*	☐ Yes	☐ No
Is there any legal restriction on another person that limits or prevents contact with the individual?	☐ Yes	☐ No
Have any of the offences or restrictions occurred within the past 10 years?	☐ Yes	☐ No

Dimension 4: Interaction With Health, Mental Health, Behavioral, & Addiction Resources	Yes	No
Does the individual have any medical condition that impacts their impulse control or cognitive functioning and reasoning? *e.g., Fetal Alcohol Spectrum Disorder; brain injury; organic brain disorders*	☐ Yes	☐ No
Has the individual been involuntarily admitted to a mental health facility within the past three years?	☐ Yes	☐ No
Has the individual voluntarily admitted themselves to a mental health facility in the last year?	☐ Yes	☐ No
Has the individual ever been ordered to attend anger management classes?	☐ Yes	☐ No
Has the individual ever been ordered to a service to address their substance use?	☐ Yes	☐ No
Does the individual currently have a Community Treatment Order?	☐ Yes	☐ No

Risk Assessment

Dimension 5: Alcohol & Substance Use	Yes	No	N/A
Does the individual use alcohol or substances while having a co-occurring physical health issue?	☐ Yes	☐ No	☐ N/A
Does the individual use alcohol or substances while having a co-occurring mental health issue?	☐ Yes	☐ No	☐ N/A
Does the individual use substances intravenously?	☐ Yes	☐ No	☐ N/A
Does the individual use safe and sterile products for their consumption?	☐ Yes	☐ No	☐ N/A
Does the individual safely dispose of their bottles, needles, etc. after consumption?	☐ Yes	☐ No	☐ N/A
Does the individual most frequently use alone?	☐ Yes	☐ No	☐ N/A
Has the individual had one or more overdose in the past 12 months?	☐ Yes	☐ No	☐ N/A

Dimension 6: Situational Response	Yes	No
Does the individual have a consistent negative response to men?	☐ Yes	☐ No
Does the individual have a consistent negative response to women?	☐ Yes	☐ No
Does the individual have a consistent negative response to younger workers (approximately under the age of 30)?	☐ Yes	☐ No
Does the individual have a consistent negative response to older workers (approximately 55 years of age and older)?	☐ Yes	☐ No
Does the individual have a consistent negative response to people of a specific race or ethnicity?	☐ Yes	☐ No
Does the individual have a consistent negative response to people engaging with them one on one?	☐ Yes	☐ No
Does the individual have a consistent negative response to people when meeting with two or more workers at a time?	☐ Yes	☐ No
Does the individual have a consistent negative response when in a particular environment (e.g., at a doctor's office; in their apartment; on the bus)?	☐ Yes	☐ No
Does the individual have a consistent negative response to behavioural issues being discussed?	☐ Yes	☐ No

Dimension 7: Populations at Risk	Yes	No
Is the individual a risk to themselves?	☐ Yes	☐ No
Is the individual a risk to other people that they live with or near?	☐ Yes	☐ No
Is the individual a risk to visitors of the other people they live with or near?	☐ Yes	☐ No
Is the individual a risk to other clients that are involved with the program?	☐ Yes	☐ No
Is the individual a risk to staff?	☐ Yes	☐ No
Is the individual a risk to property?	☐ Yes	☐ No
Is the individual a risk to the general public?	☐ Yes	☐ No

Risk Minimization Plan

The worker and the client should work together to develop a risk minimization plan for those elements of the risk assessment where there was a "yes".

The risk minimization plan is an iterative process – it is unlikely to be created in one sitting. It is often through a series of conversations that the risk minimization plan becomes fully developed. The development of the plan can lead to contemplation of changes in the individual's life and may have elements that become integrated into the individual service plan.

For each area where there is a perceived risk:

- try to define what exactly the risk is
- try to determine exactly when the risk is most likely going to result in harmful action
- try to figure out what process, technology or people can be put into place to minimize the risk
- focus on changing the behaviour – not the person
- use a strength-based approach to highlight how the individual can be successful in altering their behaviour

Risk Minimization Worksheet

What Exactly is the Risk?	Who is at Risk?	In which situations is the Risk most likely going to result in negative action?	What process, technology or people need to be put into place to reduce the Risk?

Exit Planning Tool

About Us

Family Name:	
Head(s) of Household:	
Address:	
Health Insurance	

Emergency/Medical Contacts

Role/Relationship	Name	Telephone Number
Emergency	Emergency Services	9-1-1
1.		
2.		
3.		

Our Plan to Maintain Housing

I will continue to **pay our rent** by making sure we do the following things:

I will make sure that **we don't get kicked out of the apartment** by doing/not doing the following things:

We are **ready to live with greater independence** and without Housing Program supports because:

Exit Planning

The areas in our life that **we are still working on** are:

We are going to **work on these areas by**:

Signs that our housing is **becoming unstable** are:

If our housing is becoming unstable **we will:**

Signs our housing **is unstable** are:

If our housing is unstable **we will:**

Exit Planning

We are confident that we have the skills to:

Task	Yes	No	N/A
Clean the apartment	☐ Yes	☐ No	
Go grocery shopping	☐ Yes	☐ No	
Pay rent	☐ Yes	☐ No	
Speak with landlord	☐ Yes	☐ No	
Do laundry	☐ Yes	☐ No	
Budget	☐ Yes	☐ No	
Pay other bills	☐ Yes	☐ No	
Be responsible tenants	☐ Yes	☐ No	
Set goals & take action	☐ Yes	☐ No	
Problem-solve with a level head	☐ Yes	☐ No	
Keep emotions in check when frustrated/angry	☐ Yes	☐ No	
Follow crisis plan when necessary	☐ Yes	☐ No	
Make appointments and keep them	☐ Yes	☐ No	
Follow doctor instructions	☐ Yes	☐ No	☐ N/A
Follow psychiatrist instructions	☐ Yes	☐ No	☐ N/A
Take medicine	☐ Yes	☐ No	☐ N/A
Refill medicine	☐ Yes	☐ No	☐ N/A
Have fun without creating problems	☐ Yes	☐ No	
Fill the days with things that make us hapy	☐ Yes	☐ No	
Invite guests over and know when to ask them to leave	☐ Yes	☐ No	
Seek out help when we need it	☐ Yes	☐ No	
Keep our apartment	☐ Yes	☐ No	

Comments:

Exit Planning

Our Support Network

The following people are considered to be part of my support network, and we recognize that our Housing Program support worker will no longer be part of my support network:

Role/Relationship	Name	Telephone Number

Should we ever receive an eviction notice or be told by my landlord that we need to leave, we will:

_____

_____

_____

_____

We would like our exit plan shared with our support network and other social service organizations, as deemed appropriate by my worker.

☐ Yes ☐ No

Client

_____ _____

Signature Date

Intensive Case Manager

_____ _____

Signature Date

Honest Monthly Budget

Things that I have to spend money on:		Formal ways I get money:	
Rent		Job	
Utilities		General Welfare	
Food		Disability	
Arrears		Pension	
Repairs		Inheritance	
TOTAL		**TOTAL**	

Other money that comes in goes toward:		Informal ways I get money:	
Child Support		Binning/Bottle Collecting	
Debts		Odd Jobs	
Cigarettes		Treasure Hunting	
Coffee		Baby Sitting	
Alcohol		Sex Work	
Other Drugs		Drug Running/Dealing	
Health Stuff		Day Labour	
Household Supplies		Theft/Pawning	
Girlfriend/Boyfriend		Friends/Family	
Kids		Selling Prescription	
Other Friends		Gambling	
Cable		Medical Research	
Socializing/Partying/Night Out		Panhandling	
Sex		Selling Crafts	
Bus		Busking/Street Entertainment	
Taxis		Honorariums	
Gambling		Non-Medical Research	
Legal Stuff/Fines		Other	
Other Bills			
TOTAL		**TOTAL**	

All the Ways I Spend Money:		All the Ways I Make Money:	
GRAND TOTAL		**GRAND TOTAL**	

Difference Between What I Spend and What I Make:	

Personal Guest Policy Tool

In general, my visiting hours are:

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Guests ARE allowed							
Guests are NOT allowed							

I make exceptions for the following people:

Name	Is allowed to visit...		
_____	☐ Always	☐ Never	☐ Other: _____
_____	☐ Always	☐ Never	☐ Other: _____
_____	☐ Always	☐ Never	☐ Other: _____
_____	☐ Always	☐ Never	☐ Other: _____
_____	☐ Always	☐ Never	☐ Other: _____
_____	☐ Always	☐ Never	☐ Other: _____
_____	☐ Always	☐ Never	☐ Other: _____
_____	☐ Always	☐ Never	☐ Other: _____

These are my house rules:

_____

_____

_____

_____

_____

Here's how I will deal with things if someone breaks my house rules:

_____

_____

_____

_____

Here's why having and following a guest policy is important to me:

_____

_____

_____

Readiness Rulers

The Readiness Rulers are a visual tool to assist your client in thinking about and making change related to specific areas of their case plan.

Using This Tool

There are two approached to using the Readiness Rulers.

You can ask your client which area of their case plan they would like to talk about, and insert that into the line above the first ruler. An example might be quit smoking. Most often the areas of the case plan named are the over-arching or impact goals.

You can arrive at a home visit and suggest in the conversation that you think it would be a good idea if they spent some time talking about (insert a goal where the client does not seem to have made much change). If the client agrees to talk about it, use the Readiness Rulers to frame that conversation.

In subsequent interactions with clients you can use the Readiness Rulers again for the same area of change. You can track progress over time on the rulers. There is no right or wrong answer in how your client marks himself/herself on the Readiness Rulers. It is a self-assessment. Once the client has completed the Readiness Rulers, the visual tool provides opportunity for you to explore how they have plotted on the rulers.

Conversation Prompts

Prompts to consider using the first time a client is using the Readiness Ruler for a particular area of their case plan:

When they have marked between 0-3:

- Why did you mark yourself there?
- Why did you not mark yourself higher?
- Why did you not mark yourself lower? (assumes they have not ranked themselves zero)
- How will you know that it is time to think about changing?
- Is there anything we can set up for you that may help you think about changing?

When they have marked between 4-7:

- Why did you mark yourself there?
- Why did you not mark yourself higher?
- Why did you not mark yourself lower? (assumes they have not ranked themselves zero)
- What would be good about taking steps more towards feeling like a 10?
- What is preventing you from being more towards a 10?
- How will you know you are ready to take the next step towards a 10?
- Is there anything we can set up for you that will help you take the next step?

Readiness Rulers

When they have marked between 8-10:

- Why did you mark yourself there?
- Why did you not mark yourself higher?
- Why did you not mark yourself lower? (assumes they have not ranked themselves zero)
- What is one thing you can do to help you feel like a 10? (assumes they marked 8 or 9)
- Prompts to consider when using the Readiness Rulers for a second, third, fourth time (etc) relative to their previous completion of the Readiness Ruler.

If the person has moved to the right on the ruler (though not quite at 10 yet):

- What has happened that made you take this step forward?
- What else could help you keep going towards feeling like a 10?
- What is one thing you can work on that will help you make that step? (Name it and specify a date for completion.)

If the person has achieved a 10:

- What helped you get all the way to 10?
- How do you feel now that you are at 10?
- What can you do to stay at the 10?
- What is the next thing you need to do to make sure the change sticks?

If the person has moved backwards on the ruler:

- Change is hard. What do you need to do to move in the other direction again?
- What was working for a while? What has changed?
- What have you learned about yourself?
- How can you use what you have learned to give it another try?

Readiness Ruler Worksheet

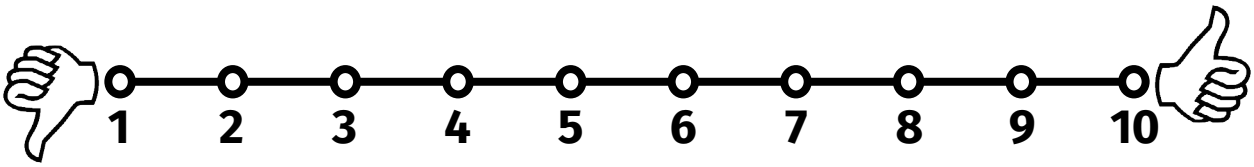
I would like to make changes to the following area of my life:

_____

_____

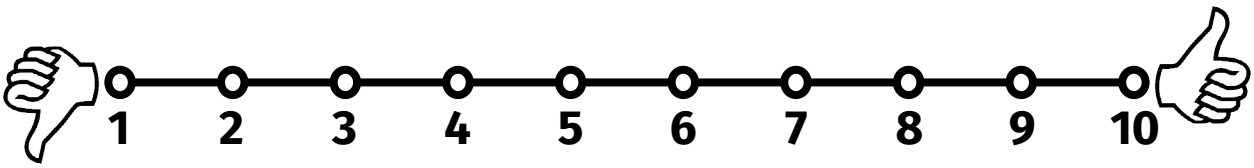
Importance

On a scale of 1 to 10, with 1 meaning "not important at all", and 10 meaning "couldn't be more important," here's how important making these changes are to me:



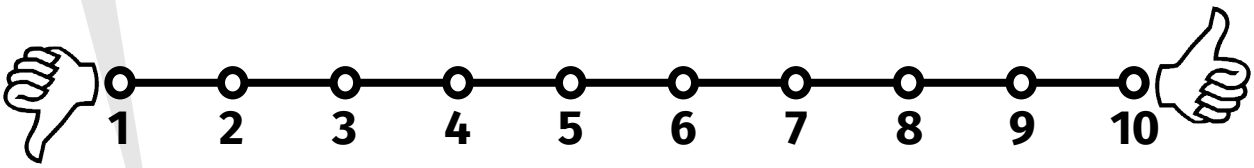
Readiness

On a scale of 1 to 10, with 1 meaning "not ready at all", and 10 meaning "couldn't be more ready," here's how ready I am to start making these changes:



Confidence

On a scale of 1 to 10, with 1 meaning "not confident at all", and 10 meaning "couldn't be more confident" here's how confident I am that I can make these changes:



A Week of Meaningful Things to Do

Instructions for Intensive Case Managers

"A Week of Meaningful Things to Do" is a tool that Intensive Case Managers can use when delivering Housing

First to help clients focus beyond the present moment. It is not mandatory, but can be helpful especially:

- In the early days of the relationship
- To help clients understand your role as an Intensive Case Manager
- To get clients to focus not just on those appointments related to the case plan (for example, dates and times you intend to visit; doctor's appointments; meetings with an employer or welfare, etc.) but also activities that they can engage with outside of those appointment times to reduce social isolation, increase community integration, and (re)build social networks;
- To help clients reflect on those activities that are the best part of their day and those parts where things could have been better.

Some clients will also want to use the calendar to help organize chores and get into routines such as noting what day garbage has to be taken out, a good day to do laundry, etc. If they choose to do so, these types of activities are best placed in the "Appointments" section.

To use the tool

1. Suggest and promote the tool and its benefits to the client;
2. Explain how the tool works;
3. Write the days of the week across the top. The column on the far left should either be the day that you are completing the tool or the first day after the use of the tool;
4. Use open-ended questions related to activity suggestions for the client to consider. Activities should include those things that would provide the client fulfillment physically, intellectually, spiritually, socially, emotionally and/or recreationally. You may want to use prompts like "What is a physical exercise or sport you'd like to do this week and when do you want to do it?"
5. Know when some specific events are occurring in the community that you can offer as suggestions for them to respond to such as "There is a fall fair on Saturday that is free and has a band coming on at 6pm. What do you think about that?" or "On Tuesday mornings there is coffee club at the Kinsmen Recreation Centre where seniors meet up. How do you feel about doing that and meeting up with some other seniors in your neighbourhood?" or "The Running Room has free group runs on Wednesday evenings and Sunday mornings. What do you say to strapping on your running shoes and trying one or both of those runs next week?";
6. Try to encourage the client to come up with at least one activity each morning, afternoon and evening;
7. De-brief the tool with the client, preferably on the afternoon of the 7th day it is used;
8. Use the "Other Notes and Reminders" for work related to these activities (not for case notes).

A Week of Meaningful Things To Do

Some helpful hints

- Take your time.
- Write out the answers for your client the first few times.
- Helping clients to get out of their apartment and reduce social isolation is one of the goals, but is not a requirement.
- If it works, provide them blank sheets to do it by themselves in the future.

A Week of Meaningful Things To Do

A Week of Meaningful Things to Do

Days of the Week:							
Morning	Appointments: Other things I plan to do:	Appointments: Other things I plan to do:	Appointments: Other things I plan to do:	Appointments: Other things I plan to do:	Appointments: Other things I plan to do:	Appointments: Other things I plan to do:	Appointments: Other things I plan to do:
Afternoon	Appointments: Other things I plan to do:	Appointments: Other things I plan to do:	Appointments: Other things I plan to do:	Appointments: Other things I plan to do:	Appointments: Other things I plan to do:	Appointments: Other things I plan to do:	Appointments: Other things I plan to do:
Evening	Things I plan to do:	Things I plan to do:	Things I plan to do:	Things I plan to do:	Things I plan to do:	Things I plan to do:	Things I plan to do:
What was the best thing about the day?							
What could have been better about the day?							

A Week of Meaningful Things To Do

Other Notes and Reminders for the Week Ahead:

Client

Signature

Date

Intensive Case Manager

Signature

Date

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