

## Excellence in Housing-Based Case Management

Approaches, strategies and tools to improve long term housing stability...especially for higher and moderate acuity populations

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Over 30 years assisting the non-profit, private, non-governmental and governmental sectors

4 member team led by Iain De Jong

Blend of practitioners, researchers, educators, policy wonks, nerds, comics, analysts, advisors & leaders

Driven towards working on complex social issues especially homelessness

Creators of the SPDAT

Working in Canada, USA & Australia

## Values & Beliefs

- Our own values and beliefs influence our practice.
- We are wired to have an emotional response to information before a logical response.

## Myths Impede Our Success

- Substance users need to achieve sobriety to be successful in housing.
- People with mental health issues need to take their meds and be connected to a psychiatrist to be successful in housing.
- Transitional housing helps people prepare for long-term housing success.
- People need to be “housing ready”.
- Chronically homeless people choose to be homeless.
- People need to hit “rock bottom” before they are ready to make important life changes.
- Shelters need a lot of programming to prepare people for success in housing.

## Housing First...

- As a **philosophy** it is the belief that homeless individuals should be assisted in accessing housing as quickly as possible with supports delivered in community.
- As an **intervention** it is the delivery of direct supports through Assertive Community Treatment or Intensive Case Management, intentionally working with those people that have most acute needs first.
- Rapid Re-housing is a program stream that aligns with Housing First philosophy

### Before and After

- |   |   |
|---|---|
| <p><b>Before Housing First:</b></p> <ul style="list-style-type: none"> <li>- oriented towards emergencies and crises (services and investment of resources reflect this)</li> <li>- emphasis on determination of how ready a person is seen for housing (less "risk" seen as a good fit for housing)</li> <li>- program volume heavy within the emergency service system</li> <li>- many rules or requirements for accessing housing and supports (lots of compliance)</li> </ul> | <p><b>After Housing First:</b></p> <ul style="list-style-type: none"> <li>- oriented towards housing and case management services in housing (services and investment of resources reflect this)</li> <li>- emphasis on identifying and serving the person with highest acuity (more "risk" seen as a good fit for housing)</li> <li>- program volume heavy within housing services</li> <li>- few rules or requirements for accessing housing and supports (not compliance based)</li> </ul> |
|---|---|

## Maintaining Fidelity...Housing First or Rapid Re-Housing

- People do NOT have to complete any mandatory programming prior to moving into housing
- People do NOT need to have a source of income prior to moving into housing
- People do NOT have to be sober prior to moving into housing
- People do NOT have to graduate from transitional housing to be considered for housing
- People receive supports based upon acuity levels and presenting issues
- Services are delivered in the person's home, not an office
- Each person has an INDIVIDUALIZED service plan
- If people lose their housing they do not lose their supports
- If people lose their housing re-housing them is seen as an immediate priority
- People are not punished for making "mistakes" or losing their housing
- People do NOT have to participate in mental health programming
- Caseloads do not exceed 20 for Housing First and 35 for Rapid Re-Housing
- Participants are prioritized for participation based upon acuity
- People exit the program once housing and life stability are achieved
- There is no intention to "heal" or "fix" people
- Support workers do not act like crisis workers
- Every person supported in housing has a crisis plan and a risk assessment completed
- The work on other life goals occurs only after housing stability is well established

## Service Orientation

1. Your job is to get people housed and help them stay housed.
2. You connect people to community resources.
3. You do not heal or fix people.
4. You believe in hope.
5. You use assessments to help guide opportunities to coach and support, not focus on barriers.

## Service Orientation

6. The people you support do the hard work. You do the hard support.
7. People can and should be respectfully challenged to change.
8. Proactive planning and support beats reactionary crisis responses.
9. People can and do recover.
10. Housing stability is your primary objective.
11. Your work is guided by evidence.

## What Does the Brain Have to Do With Our Work?

### The Brain in Transition

**Frontal Lobe:** self-control, judgment, deferred gratification, and emotional regulation don't start developing until around 16-17 and isn't completely developed until the mid twenties.

We can postulate all we want about what people should be able to do, but the fact is they can't do what their brains aren't ready to do.

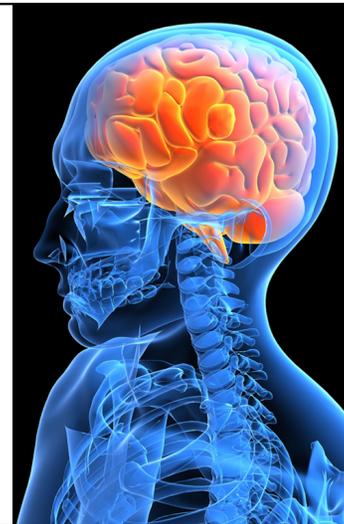


### The Brain in Transition

**Corpus Callosum:** intelligence, consciousness, and self-awareness do not reach full maturity until the mid to late 20's

My sense of self is still mostly externally defined. I am what my friends think I am.

Impact of "Presentism"



**The Brain in Transition**

**Parietal Lobes:**  
responsible for integrating auditory, visual, and tactile signals don't begin to mature until the early 20s.

I can't decode emotional signals because I am still using the amygdala rather than the frontal cortex.



**The Brain in Transition**

**Temporal Lobes:**  
appropriate emotional response and emotional maturity are still developing between the ages of 16 and 24

This is the part of the brain that let's me take another person's perspective. Until this region develops, it won't come naturally.



**We Can NOT Assume...**

- Someone wants to change.
- Someone ought to change.
- You know best.
- The present is always the best time to change.
- Being tough inspires change.
- Threatening with doomsday suggestions gets people to change.
- You can reason with anyone - and logic will win the day.

**A pathway to change discussion...**

Get out of the **RETRIBUTION** mindset:

- No coercion or threats
- No intimidation or undue pressure

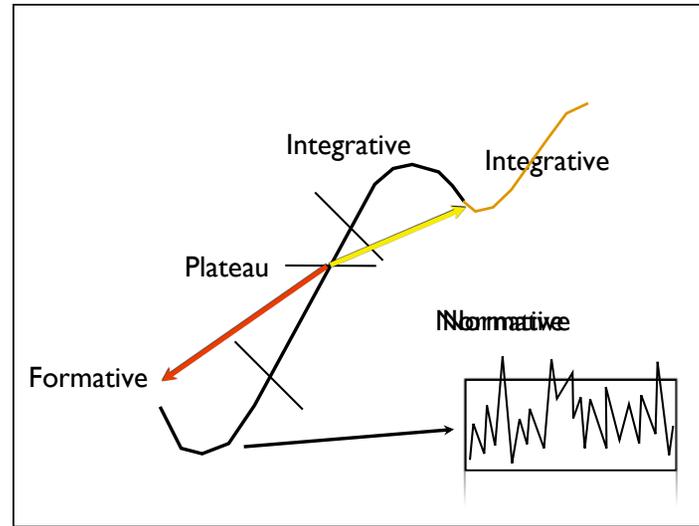
Get out of the **RECIPROCITY** mindset:

- No obligation through ingratiation
- No bargaining

Get into the **REASONING** mindset:

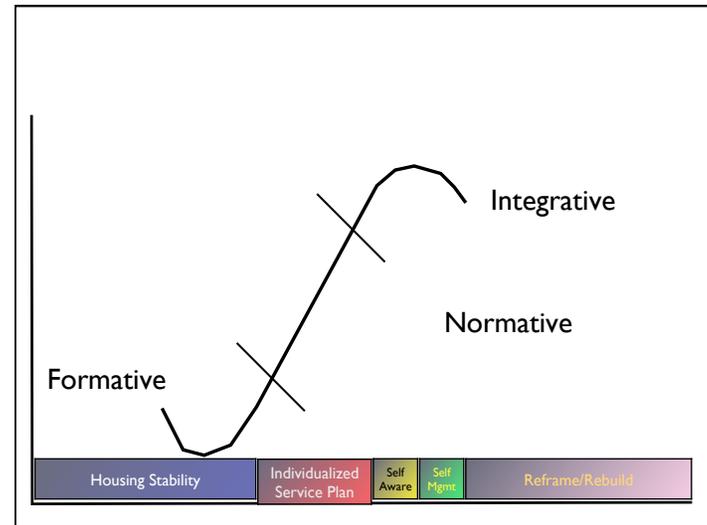
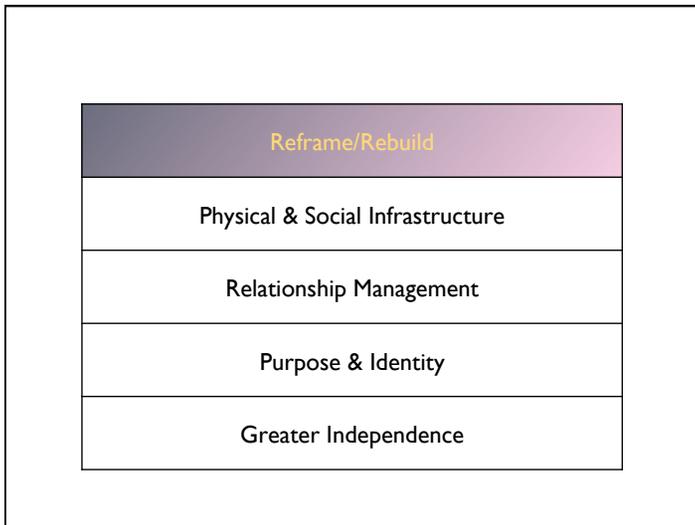
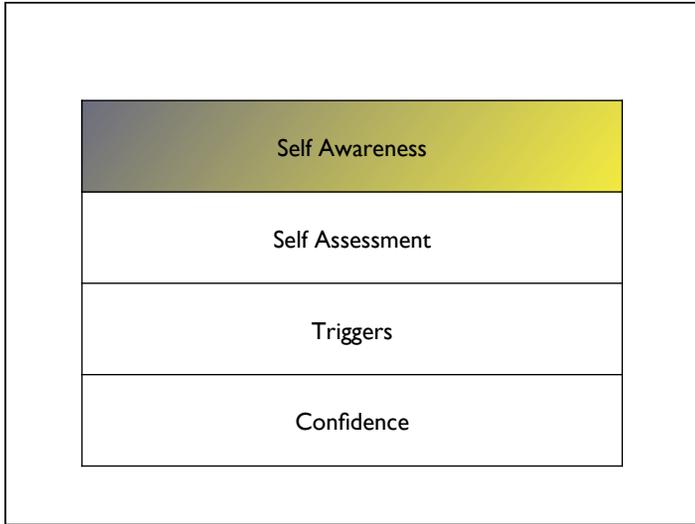
- Presentation of facts relative to needs
- Appeal to values
- Appreciate personal goals
- Assess needs

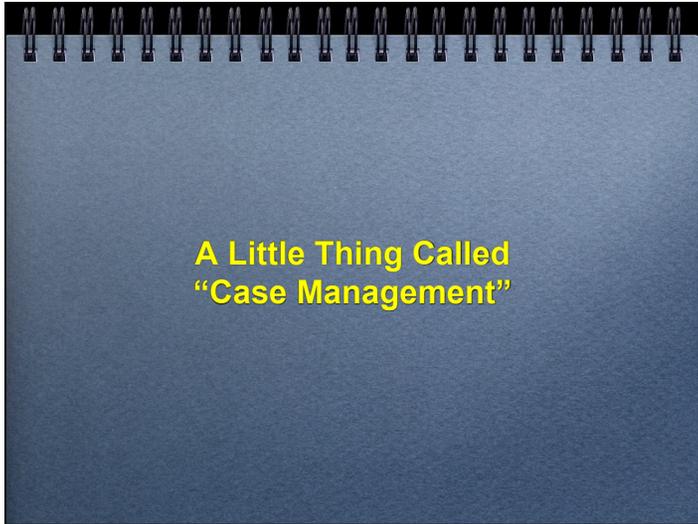
**Understanding the Journey towards Housing Stability**



HOUSING
Relationship Impacts
Support
Basic Needs
Safety

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





- A conceptual model of assistance
- Care structure
- Brokering and advocacy
- Assessment of needs
- Facilitation of resources
- Structured
- Supporting an individual's needs holistically
- Active
- Accountable to end users of services

- ### Housing-based case management
- Distinction is a focus on housing stability first and foremost before establishing other goals.
  - Housing maintenance is seen as critical to success.
  - Intent is to assist formerly homeless individuals in achieving long-term success in housing.

- ### 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.

### Service Requirements

- Professional, trained staff.
- Not Monday to Friday, 9-5.
- Face to face interaction with individuals in their homes.
- Documented, planned, sequential, and strategic.
- Ensures fidelity to practice.

### Service Requirements

- 15-20 clients per worker in Housing First; 25-30 in Rapid Re-Housing.
- Time spent with each client guided by acuity level.
- Structured case planning.
- Professional boundaries.

### Knowledge & Core Competencies of Case Managers

- History of homelessness
- Poverty
- Health & Mental Health Services
- Addictions
- Treatment
- Harm Reduction
- Housing
- Hoarding
- Income Supports /Benefits
- Corrections
- Family/Intimate Partner Violence
- Children's Services
- Fetal Alcohol Spectrum Disorders
- Brain Injuries
- Medication Management
- Trauma/Abuse

- Practice Motivational Interviewing & Exercise Active Listening
- Practice Assertive Engagement
- Assist Service Participants in working through the Stages of Change
- Ability to teach, model and reflect on actions and attitudes in a range of settings
- Broker and Advocate for services as appropriate
- Help Service Participants establish goals and an individualized service plan
- Appropriately prepare documentation
- Organize and chair case conferences
- Perform their duties safely, including working safely alone

- Perform First Aid and CPR, and maintain certification in both
- Use Universal Precautions as necessary in specific situations
- Assess risks and develop appropriate plans to help ensure continuation of service
- Complete incident reports as necessary in response to specific situations
- De-escalate and learn from conflict through effective de-briefing
- Respect privacy and confidentiality in accord with all relevant legislation
- Perform duties in a culturally competent manner
- Follow all relevant legislation

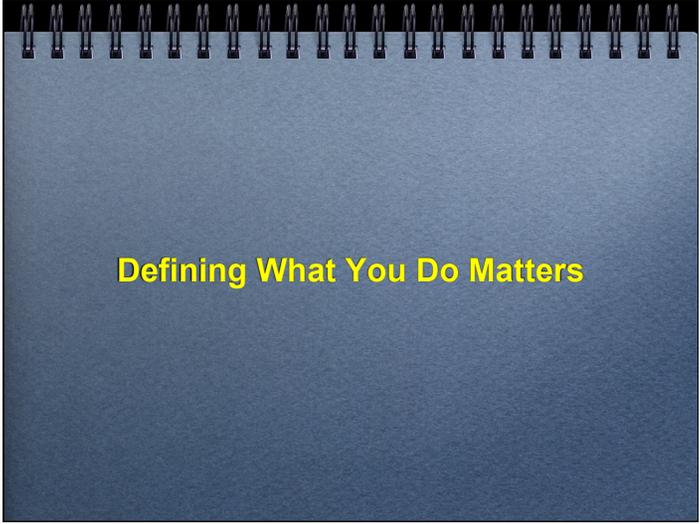
- ### Things Case Management is NOT
- A crisis response; nor is it crisis driven.
  - Doing things for clients. It is doing things with them.
  - A dependent relationship.
  - Without conflict.
  - Friendship.
  - A destination. It is a process.
  - Perfect.

- ### Who Does This Case Management Serve?
- Individuals with higher acuity, most often with complex, co-occurring issues. Most often these individuals have experienced chronic homelessness and consume considerable human service resources.
  - Individuals with moderate acuity, most often with 2 or 3 complex issues. Most often these individuals have experienced a repeat pattern of episodic homelessness.

- ### The Case Manager...
- Promotes hope through a future orientation.
  - Realizes that the person is NOT a case.
  - Appreciates that the person they are working with has their own values and own life. This makes them no better, nor worse - just different.
  - Interact without "judgment"...people are never considered "non-compliant" or "bad"...be aware of your beliefs/opinions
  - Expresses empathy, do not get stuck in a cycle of sympathy.

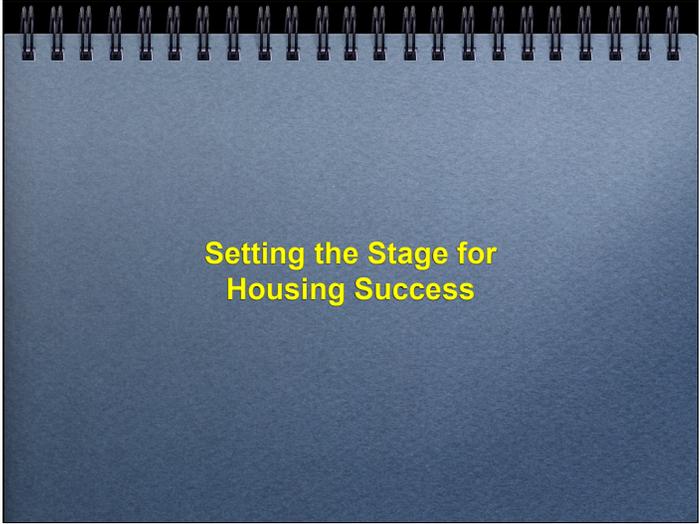
### The Case Manager...

- Accepts that reducing harm is a practical and necessary pursuit.
- Promotes positive change.
- Is assertive and persistent as necessary.
- Does not sacrifice the important for the urgent.



### Defining What You Do Matters

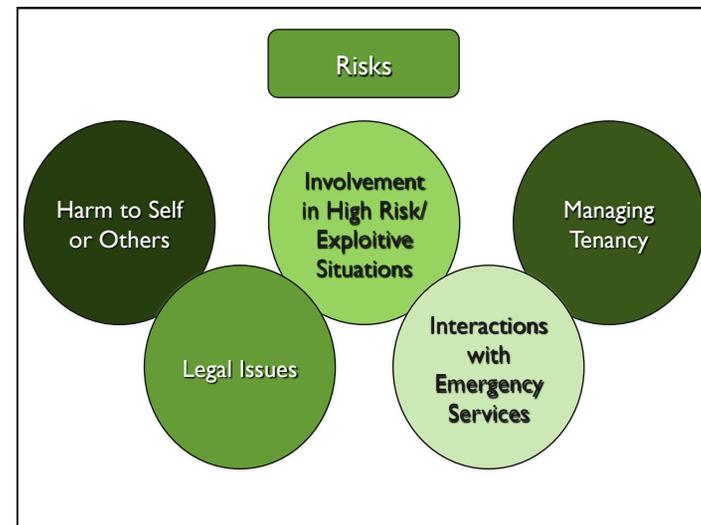
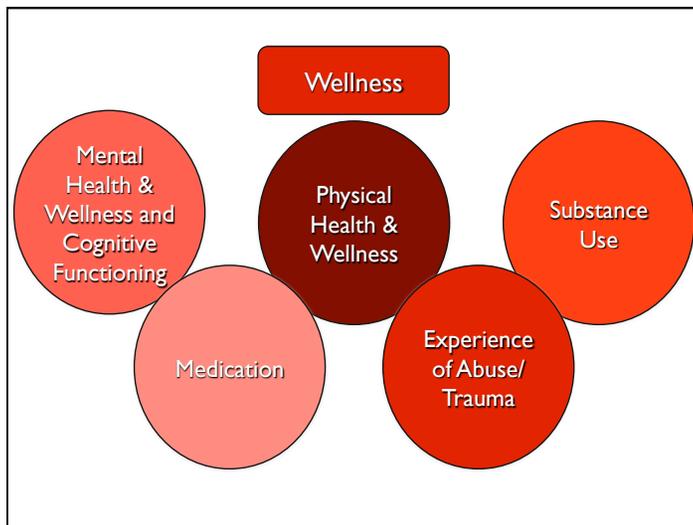
- *Do you provide clarity to the people you serve in what they can expect rather than just the rules?*

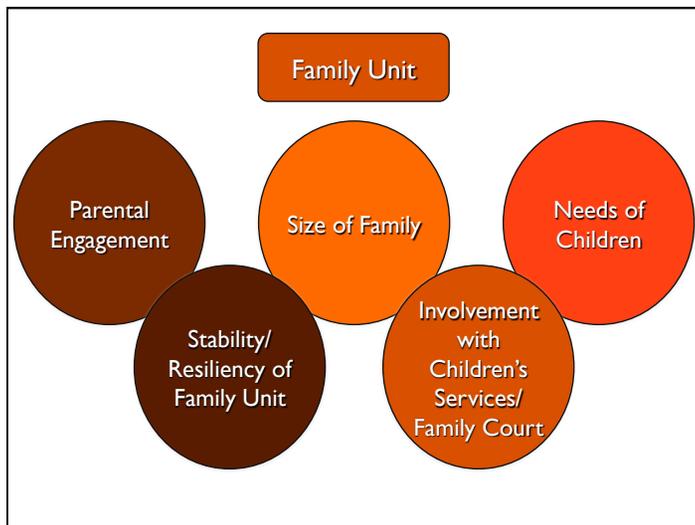
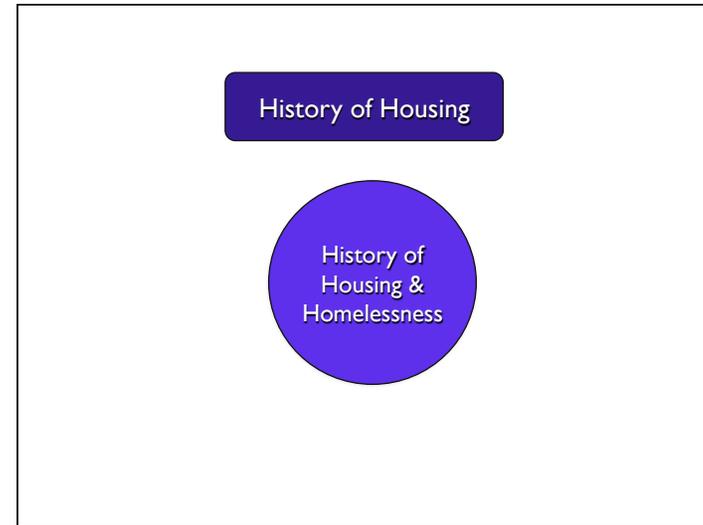
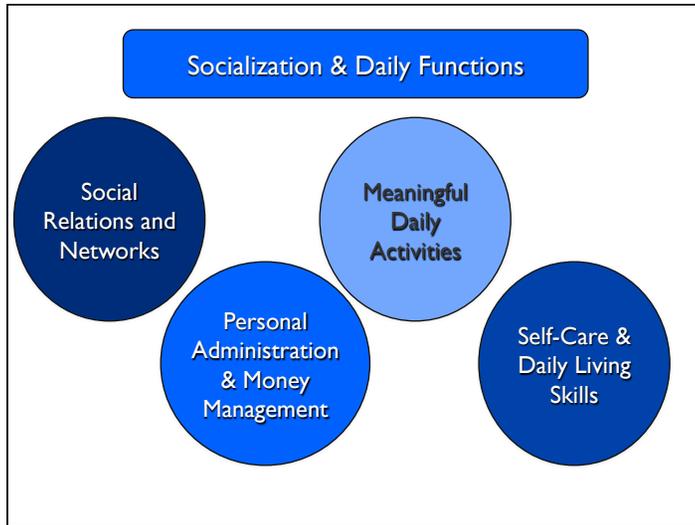


### Setting the Stage for Housing Success

## What the SPDAT Offers...

- Prioritizes who gets served next...by whom and why.
- Assesses current vulnerability to returning to/remaining in a state of homelessness.
- **Creates a road map for Individualized Service Planning.**
- **Focuses on "Homelessness Proofing".**
- Products that are written for and by housing professionals.
- Comprehensive in its view of long term housing stability.
- Has been supplemented with complementary client-centered tools dedicated to increasing self awareness, self management and long term housing stability





- Explanation of the Program in the Context of SPDAT**
- Determining the best approach to housing supports.
  - **Knowing where there are strengths to build from.**
  - Understanding what areas may present risks to housing stability.
  - **Case management/supports.**

## Optimizing the SPDAT's Impact...Warm Transfer

- Purpose: Assist in the transfer of service participant from referring agency or coordinated access to re-housing agency.
- This is a transition opportunity...maximize its potential.
- Review the purpose of the re-housing program - a support program that happen to come with housing.
- Describe why this program-service participant match was identified...SPDAT results can identify rationale.
- AND THEN...



- If they are eligible and are matched for HF/HBCM:

- Ask them to describe what they think the case management supports will look like.
- Ensure that they are comfortable with home visits.
- Show them samples of rental agreements/leases.
- 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.

- In order to receive the service, an individual/family MUST:

- Provide informed consent to participate
- Agree to case management service for the duration of their time in the program
- Accept home visits
- Want to develop a case plan and work on goals that will improve housing stability
- Provide assurance that they will pay their rent on time and in full

### The Responsible Tenant Discussion

- At a minimum...Occurs after being screened in, during the housing search, at move-in and just before the end of the first month in housing.
- Looking for the following details:
  - payment of rent on time and in full each month
  - not disturbing others in the building or community
  - following the terms of the lease
  - engaging appropriately with landlord or superintendent
  - taking care of their unit
  - meeting and working with case manager



## Stage 1: Housing Move In

### Secure Housing

- Identify if subsidy/rental assistance is available for landlords
- Take a business approach:
  - Designated housing locator
  - Attempting to make landlord more money
  - Examine opportunities in under-performing parts of portfolio
- Reach out to people already living in lower income neighbourhoods that never become homeless. Replicate what they do.
- Explore modified chronological access in non-profit housing - but do NOT use permanent supportive housing resources for moderate acuity population.

### Define Your Program & Your Role

- A liaison; not a “mini-landlord”.
- Will check-in on a monthly basis, including rent payment follow-up.
- How to contact, when and why.
- Ensure landlord knows what info you can share and what is private.
- Will work to mediate issues.

### Support in the Housing Process

- No blind referrals.
- Client accompanied to all viewings.
- Client assisted with lease signing.
- Client assisted with move-in and building orientation.

## Choice, Not Placement

- Clients actively engaged in articulating preferences and needs.
- Clients presented viable options to choose from; not placed in a unit.

## Triple A

- Options prepared for client are based upon:
  - Affordability
  - Appropriateness
  - Actionability

## For Housing to Be Considered

- Must be in habitable condition.
- Standard tenancy agreement. Tenancy not linked to program participation.
- Housing is “permanent”.
- Client has privacy and controls access to unit.

## Good Preparatory Practices

- Only do move-ins on Mondays, Tuesdays or Wednesdays.
- Usually only one move-in per CM 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.

### On the Day of Move In

- Do a walk through. Exude positivity.
- Have your cleaning kit ready and roll up your sleeves WITH your client.
- 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.

### Before You Leave...

- Ask them the 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.



**Promoting Home Making**

- Transforming the unit into a home is deliberate and active.
- Without intentionally focusing attention on home-making, people are more inclined to leave or damage the unit.

- 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 a stew or chili and freeze individual portions.
- Activities to address boredom...cards, art supplies, books, tv, laptop, etc.
- Calendar
- Fridge magnets
- Dry-erase marker



- It has been proven that...**
- Interest diminishes if first engagement is driven by crisis rather than voluntary interest.
  - Prompt follow through when there is expressed interest is important.
  - Random control trials (Katz et al, 2001) show follow-up visits soon after move-in decreases drop-out and future refusal rates.
  - Active rather than passive approaches are necessary if a participant begins to disengage or misses 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 (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; no sympathy
- Embrace your role as a change agent in your tone

## 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.*

## Managing Tenancy

### Primary Areas of Concern

- Damaging unit
- Conflict with neighbours
- Non-payment of rent
- Conflict with landlord

### Objective Based Home Visits

- Meeting neighbours
- Informing landlord of damages
- Mediating conflict
- Responsible tenant discussion

## Involvement in High Risk/ Exploitive Situations

### Primary Areas of Concern

- Sex work
- Unprotected sex
- Drug running
- Drug dealing
- Taken advantage of for work (especially development delayed individuals)
- Used/dirty rigs

### Objective Based Home Visits

- Access to harm reduction supplies
- Harm reduction
- Safety strategies

## Get the Most Out of the Visit

- *At the start and about halfway through remind them of the amount of time for the visit.*
- *Ask probing questions.*
- *Use active language.*
- *Never provide advice – your approach and connection makes all the difference.*
- *Manage your own time (usually 4-6 home visits per day maximum for HF, 5-8 visits for RRH).*
- *Manage your safety.*
- *Avoid idle chit-chat.*

## At the 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.



The First 90 Day Period is Your  
"Golden Hour"

## 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

## Your Approach & Attitude

- Professional
- Don't freak out
- Use caution not to respond judgementally
- Exude positivity
- Harness structure
- Do what you say you will do when you say you will do it
- Respectfully challenge, while avoiding "punishment"
- Don't let the cart get before the horse

Housing Stability is the Primary Objective	
Relationships	Who is allowed in your apartment and who needs to stay out? Who is most likely going to impact your housing stability and why? Who are their neighbors? What steps do they feel they need to take so that other people are not the reason they lose/get kicked out of their place?
Basic Needs	How can they turn their apartment into a home? Do they need supplies to cook, clean, bathe, stay clothed, etc.? Are they able to achieve food security on a limited budget?
Supports	Do they understand the role of the landlord/superintendent? Do they understand your role and what it entails? Are there any pre-existing supports that they need to maintain contact with at this time?
Safety	Is there anybody in their life that poses a safety risk? What will they do about it? What strategy will they use to protect their keys? Do they want/need to keep their address confidential? Do they understand the fire safety plan? Do they know how to safely operate all appliances?

### Example of how insights from SPDAT help...

- Social Relationships & Networks?
- Where they normally sleep?
- Any pre-existing supports?
- Self Care & Daily Living insights?
- Abuse/Trauma? Exposure to Higher Risk/Exploitive Situations? Harm to Self or Others? Legal Issues – conditions? Substance Use? MH & CF concerns?

### 5 Necessary Functions in the First Month

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

### Crisis Plan

- Not optional.
- Completed in the first four weeks.
- Updated again as necessary.
- Final update is at program exit.
- May be included as part of WRAP or DREEM if appropriate...Medicine Wheel Teachings

**Sample Crisis Plan Form** Version \_\_\_\_\_ Date \_\_\_\_\_

In an emergency CALL 911.

<b>Name:</b>	Date of Birth:
Address:	
Health Card Number/Version:	
Emergency / Medical Contacts:	
1.	Telephone:
2.	Telephone:
3.	Telephone:
<b>Support Worker Name:</b>	Telephone:
<b>Support Worker Back-up or Team Leader Name:</b>	Telephone:

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

Name of Community Resource:	Telephone Number

**Understanding and managing a crisis:**

My definition of a crisis is:	
Things that cause me to go into crisis are:	
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 ..... give me space.	
In the past to deal with a crisis effectively, I have:	
If I am in crisis it is best if these people are contacted...	
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...	

## Budget

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

**THE HONEST MONTHLY BUDGET**

VERSION: \_\_\_\_\_ DATE: \_\_\_\_\_

The things I HAVE to spend money on are:	The formal ways I get money are:
<b>RENT:</b>	<b>JOB:</b>
<b>UTILITIES:</b>	<b>GENERAL WELFARE:</b>
<b>FOOD:</b>	<b>DISABILITY:</b>
<b>ARREARS:</b>	<b>PENSION:</b>
<b>REPAIRS:</b>	<b>INHERITANCE:</b>
<b>TOTAL:</b>	<b>TOTAL:</b>

Other money that comes in goes to:		The informal ways I get money are:	
CHILD SUPPORT:		BINNING/BOTTLE COLLECTING:	
DEBTS:		ODD JOBS:	
CIGARETTES:		TREASURE HUNTING:	
COFFEE:		BABYSITTING:	
ALCOHOL:		SEX WORK:	
OTHER DRUGS:		DRUG RUNNING/DEALING:	
HEALTH STUFF:		DAY LABOR:	
HOUSEHOLD SUPPLIES:		THEFT/PAWNING:	
GIRLFRIEND/BOYFRIEND:		FRIENDS/FAMILY:	
KIDS:		SELLING PRESCRIPTION:	
OTHER FRIENDS:		GAMBLING:	
CABLE:		MEDICAL RESEARCH/CONTRIBUTION:	
SOCIALIZING/PARTYING/NIGHT'S OUT:		PANHANDLING:	
SEX:		SELLING CRAFTS:	
BUS:		BUSKING/STREET ENTERTAINMENT:	
TAXIS:		HONORARIUMS:	
GAMBLING:		NON-MEDICAL RESEARCH:	
LEGAL STUFF/FINES:		OTHER:	
OTHER BILLS:			
<b>TOTAL:</b>		<b>TOTAL:</b>	

All the things I spend money on equals:	
All the ways I get money equals:	

## The First Case Plan

- First time to demonstrate SMART goal-setting
- No more than 3 areas of attention
- All 3 areas related to housing stability for HF clients
- For RRH clients, 1 or 2 objectives related to housing stability and at least 1 related to reactivating building community connections/supports

## The 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.
- Role of Harm Reduction & Recovery Oriented Service

## Social Relationships & Networks

<b>Primary Areas of Concern</b>	<b>Objective Based Home Visits</b>
<ul style="list-style-type: none"><li>• Victimized or dependent relationships</li><li>• Only "friends" are still homeless – and like the friend's apartment</li><li>• Friends/family compromising wellness/tenancy</li><li>• Lack trust</li><li>• Poor interaction with professionals</li></ul>	<ul style="list-style-type: none"><li>• Interpersonal mapping &amp; connections</li><li>• Personal guest policy</li><li>• Appointment strategies</li></ul>

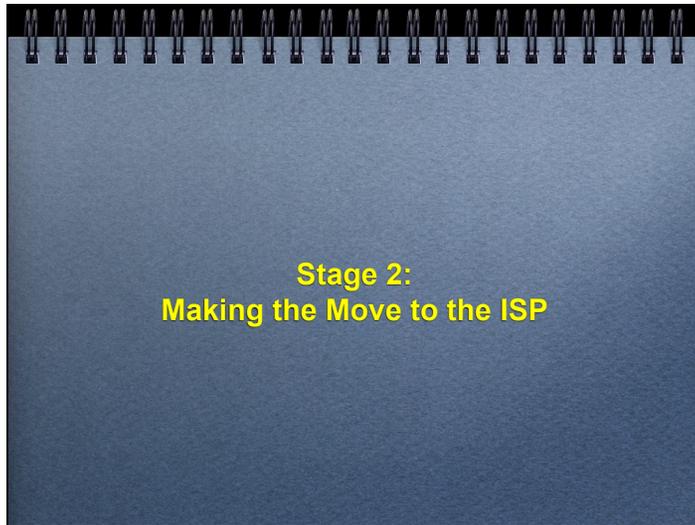
## Personal Guest Policy

- Intent is to help the client 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 the move-in, and completed during the first two home visits.

## Types of Questions You May Ask to Help Form the Guest Policy

- What time of day do you want to allow visitors (or not allow visitors)?
- Is there anyone that you don't want at your apartment (even if 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?
- 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 drugs in your apartment, how will you make sure that doesn't result in you getting evicted?
- If a buddy wants to "borrow" your apartment for a couple hours to have a date with his girlfriend, 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?



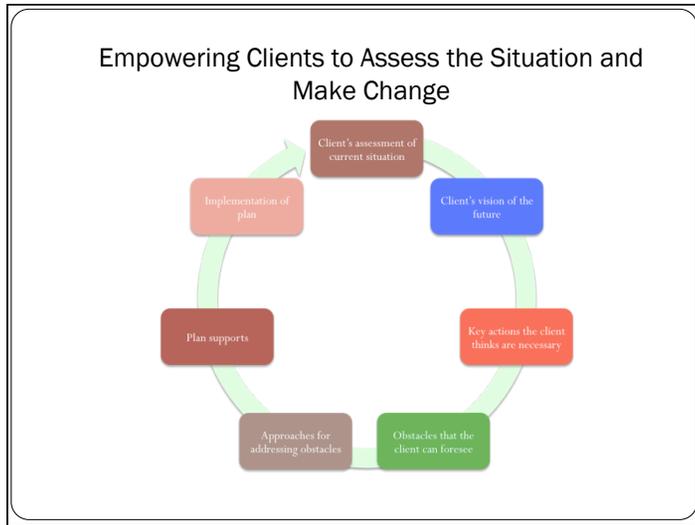
## How do you know it's time?

- Attending more home visits than not.
- No impending eviction issues.
- First case plan has traction.
- Follows guest plan more often than not.
- By slightly reducing amount of time you spend with the client per week, there has not been instability.

Individualized Service Plan	
Life Stability	What other things do you think you need to work on in your life to improve your housing stability? How will working on those things impact your housing?
Meaningful Daily Activities	What other activities, hobbies, interests do you have that you are not currently engaged with? Is there anything from your past that used to make you happy when you did it that you aren't doing anymore and would like to try again? How will being involved in these activities impact your housing?
Employment/Education	What was the last job you had - and what were the three best and worst things about it? What can you see yourself doing again? What would you like to learn more about? How do you think a job or more education might impact your housing?
Other System Connections	Are there any of your existing connections that you'd like to expand? Is there any part of your life that you think would benefit from connecting to other systems? How do you think other connections might impact your housing?
Social Awareness	What social environments are you most comfortable in? What types of events, gatherings or activities are you willing to try? What makes you comfortable and uncomfortable about engaging in those things? What do you need me to do to help you reconnect in those things? How will more social situations impact your housing?

## 15 Areas to Focus Attention...SPDAT

- Self-care & Daily Living Skills
- Meaningful Daily Activities
- Social Relationships & Networks
- Mental Health & Wellness
- Physical Health & Wellness
- Substance Use
- Medication
- Personal Administration & Money Management
- Legal
- Involvement with Emergency Services
- Involvement in High Risk/Exploitive Situations
- Harm to Self &/or Others
- History of Housing & Homelessness
- Managing Tenancy
- Abuse/Trauma



### Empowering Change Through Objective-Based Home Visits

**Client's Assessment of Current Situation**

- Raising awareness
- Outcome Star
- Recovery Star
- Readiness Ruler
- Decision-Scales
- Assessment from other professionals
- Creating conflict through assertive engagement
- Mapping progress in areas of higher acuity

**Client's Vision of the Future**

- Knowledge transfer
- Goal setting
- New experiences
- Mapping out criteria for lower acuity in the component

### 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 about making a change in this part of your life?

### Empowering Change Through Objective-Based Home Visits

**Key Actions the Client Thinks Are Necessary**

- Identify people involved in actions
- Identify processes that are part of the actions
- Identify technology or resources required for the actions
- Role playing
- Situational awareness

**Obstacles That the Client Can Foresee**

- Brainstorming
- Drawing on experience
- Feelings inventory
- Knowledge transfer

Empowering Change Through Objective-Based Home Visits

<b>Approaches for Addressing Obstacles</b>	<b>Plan Supports</b>
<ul style="list-style-type: none"><li>• Brainstorming</li><li>• Strength inventory</li><li>• Teaching</li><li>• Modeling</li><li>• Accessing other resources</li><li>• Accompaniment to appointments</li><li>• Crisis plan</li></ul>	<ul style="list-style-type: none"><li>• 5 W and H</li><li>• Documentation</li><li>• Service mapping</li><li>• Accessing other resources</li></ul>

The Question You MUST Ask

**How do you think that will impact your housing?**

**3 & 2**

- **Do not** try to tackle all components of the SPDAT at once!
- Start with identifying **3 strengths** (areas of lower acuity).
  - *What can we learn* about your ability to have made those components of your life strengths?
- Then create a list of all of the components where they scored 3 and 4.
  - **Ask them to pick 2 areas** that they would like to work on improving first.



## Substance Use

<p><b>Primary Areas of Concern</b></p> <ul style="list-style-type: none"> <li>• Using again after a period of sobriety</li> <li>• Use resulting in behavior that is impacting tenancy</li> <li>• Health issues emerging directly related to substance use</li> <li>• Not meeting daily living requirements</li> <li>• Debts</li> <li>• Passing out outdoors</li> <li>• Non-palatable alcohol</li> </ul>	<p><b>Objective Based Home Visits</b></p> <ul style="list-style-type: none"> <li>• Strategies to reduce harm</li> <li>• Budgeting for substance use</li> <li>• Support network identification</li> <li>• Meaningful daily activities during times of use</li> </ul>
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## Medication

<p><b>Primary Areas of Concern</b></p> <ul style="list-style-type: none"> <li>• Not taking meds properly</li> <li>• Not storing meds properly</li> <li>• Selling meds</li> <li>• Not filling prescription</li> <li>• Taking too many meds</li> <li>• Doesn't understand meds</li> <li>• Mixing meds with other substances not prescribed</li> <li>• Prompts to take meds</li> </ul>	<p><b>Objective Based Home Visits</b></p> <ul style="list-style-type: none"> <li>• Pharmacist consult</li> <li>• Blister packing</li> <li>• Med management schedule</li> <li>• Med storage strategy</li> </ul>
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## Personal Admin & Money Mgmt

<p><b>Primary Areas of Concern</b></p> <ul style="list-style-type: none"> <li>• Street debts</li> <li>• Not budgeting for substance use</li> <li>• Non-payment of rent</li> <li>• Unable to buy food</li> <li>• Not understanding bills</li> <li>• Insufficient funds to pay bills</li> <li>• Literacy and numeracy</li> </ul>	<p><b>Objective Based Home Visits</b></p> <ul style="list-style-type: none"> <li>• Tracking where \$ goes</li> <li>• Monthly budget – formal and informal income</li> <li>• Trusteeship</li> <li>• 3<sup>rd</sup> party payment</li> </ul>
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## Mental Health & Wellness

<p><b>Primary Areas of Concern</b></p> <ul style="list-style-type: none"> <li>• Difficulty communicating, performing daily living skills, engaging socially AND suspected mental illness</li> <li>• Disclosed mental illness and not connected to supports and/or not taking medication</li> <li>• Recent hospitalization for mental illness</li> </ul>	<p><b>Objective Based Home Visits</b></p> <ul style="list-style-type: none"> <li>• Recovery education</li> <li>• WRAP</li> <li>• Crisis Plan review</li> <li>• Feelings journal</li> <li>• Trigger identification</li> <li>• Mental Health Assessment</li> <li>• Recovery Star</li> <li>• Connecting to traditional teachings, supports, etc.</li> <li>• Connecting to MH professional(s)</li> <li>• Connecting to peer supports</li> </ul>
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## Meaningful Daily Activity

**Primary Areas of Concern**

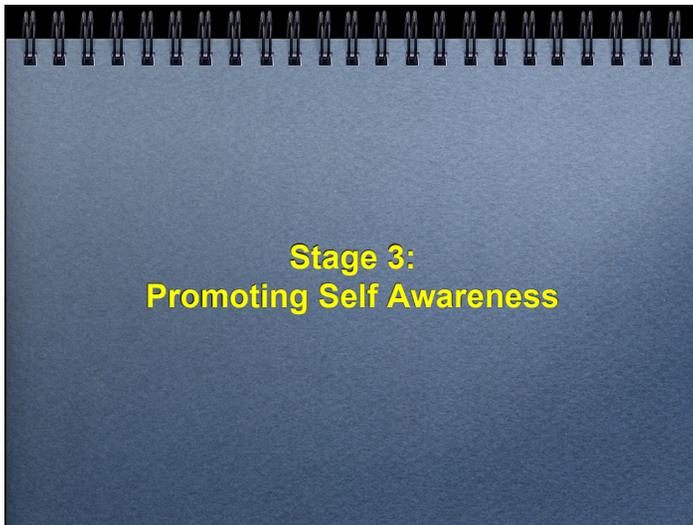
- Isolation
- Disinterested in suggestions
- Despondent
- No enjoyment
- Not many days of the week
- Early engagement
- Areas of interest not available in the community
- Participation requires resources

**Objective Based Home Visits**

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

### Promoting MDA

Days of the Week							
Morning	Appts: Other things I plan on doing:						
Afternoon	Appts: Other things I plan on doing:						
Evening	Things I plan on doing:						
Best part of the day							
What to improve							



**Stage 3:  
Promoting Self Awareness**

## How do you know it's time?

- Steady progression of not only meeting goals, but articulating what they want to work on next.
- Positive responses in social situations (even if that means knowing which situations they do not want to be in.)
- No housing stability issues.

Self Awareness	
<b>Self Assessment</b>	Do you know how to prepare for different social situations? When you are nervous, agitated, uncomfortable or frustrated in those situations, do you have things you can do to get through it? How will assessing what is expected of you in different situations impact your housing and life stability?
<b>Triggers</b>	Do you have a better understanding now of what caused you to be homeless in the past? What do you think may come up that places your current housing at risk? If those things happen, what are you going to do in order to not lose your place? How will preparing for things that may go wrong help you keep your housing?
<b>Confidence</b>	What do you think have been your three biggest accomplishments since moving into housing? Which one of your accomplishments are you most proud of that proves to yourself that you can stay housed? How confident are you to keep setting goals and stay housed?

## Introduce Exit Planning

- Explain it is being introduced because they have been able to progress.
- Remind clients there is still time to work on things in the case management relationship.
- Ask if they want you to complete one too and then compare results.

I will continue to pay my rent by making sure I do the following things:

I will make sure that I don't get kicked out of my apartment by:

I am ready to live with greater independence and without Housing Supports because:

The areas in my life that I am still working on are:

I am going to work on these areas by:

Signs that my housing is becoming unstable are:

If my housing is becoming unstable, I will:

Signs my housing is unstable are:

If my housing is unstable, I will:

I am confident I have the skills to:	YES	NO
Clean my apartment		
Go grocery shopping/ access food		
Pay my rent on time and in full		
Speak with my landlord		
Do laundry		
Budget		
Pay my bills		
Be a responsible tenant		
Set goals for myself and take action		
Problem solve with a level head		
Keep my emotions in check when angry, frustrated or sad		
Follow my crisis plan when necessary		
Make appointments and keep them		
Have fun without creating problems		
Fill my days with things that make me happy		
Invite guests over and know when and how to ask them to leave		
Seek out help when I need it		
Keep my apartment		
OTHER COMMENTS:		

I am confident I have the skills to:	Yes	No	N/A
Follow doctor's instructions			
Follow psychiatrist/mental health team instructions			
Take my medication			
Refill my medications			

I consider the following people to be part of my support network, and recognize that my Housing Support worker will no longer be part of my support network:

Name and Phone Number:  
 Name and Phone Number:  
 Name and Phone Number:

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

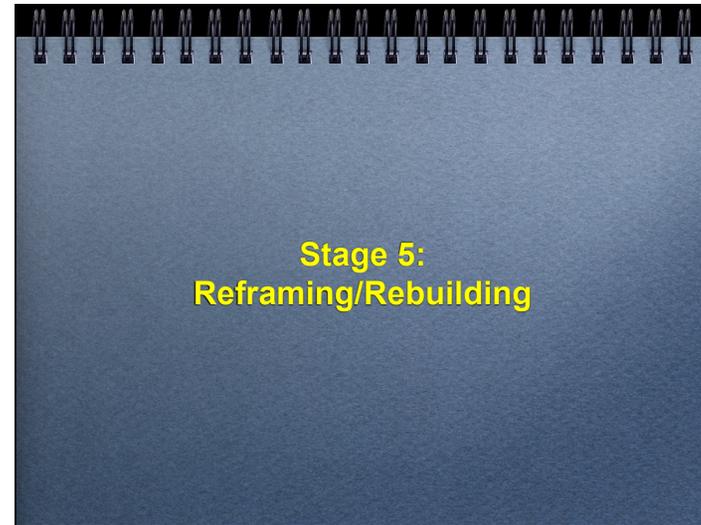
I would like my exit plan shared with my support network and other social service organizations, as deemed appropriate by my worker.  
 Yes \_\_\_ No \_\_\_



### How do you know it's time?

- Discussions are more often than not in the future tense.
- Demonstrated control of decisions, apartment and social relations.
- Sense of responsibility for actions is clear.

Self Management	
Control	Do you feel in control of your apartment? Do you feel in control of decision-making? Do you feel in control of setting goals and reaching them? Do you feel there are any others that are trying to control you, your apartment or your decisions? How will exercising control impact your housing?
Accountability	Do you feel you have made your apartment into a home? Who is responsible for your actions? Who is responsible for the actions of others in your apartment that may violate your lease or for which the landlord may take exception or be angry? Any concerns about making appointments on your own? Any concerns about budgeting? Do you feel you can meet all of your day to day needs? How will exercising more accountability in your life impact your housing?
Optimism	How do you feel about the future? If you were confronted with the same or similar experiences that caused you to be homeless in the past, do you feel you can handle them and not lose your housing? Do you think positively about the future and feel prepared to deal with crappy things that will happen without fears that you will lose your housing?



- ### How do you know it's time?
- Has continued to pay rent and utilities on time and in full.
  - No issues with landlord or neighbours.
  - Has family/friends as they would like them and which provide a degree of support.
  - Has changed (re-created when necessary) social relations that may have jeopardized housing.
  - Has consistently demonstrated the ability to set and achieve goals independent of your involvement.

Reframe/Rebuild	
Social & Physical Infrastructure	Do you feel there is any reason why you may get evicted from your housing or want to leave it? Do you have enough healthy relationships with family or friends to support you?
Greater Independence	Do you feel you know how to find and access community resources on your own or with the help of family/friends? Do you feel confident in your ability to set and meet your goals?
Managing Relationships	Do you feel there is anyone in your life that may result in you losing your housing? Have you figured out how to distance yourself from people that may put your housing at risk?
Purpose & Identity	Homelessness is now part of your life story, but doesn't define you or your potential. If I met you again in a few years, what will your life be like?

## On to Independence from HF/RRH...

- Web of supports are in place.
- Coaching through observation has made it possible for participant to demonstrate success.
- No immediate concerns for eviction.

## On to Independence from HF/RRH...

- These have been updated:
  - Exit plan
  - Crisis plan
  - Risk assessment
  - Budget
  - Case plan
  - SPDAT

## On to Independence from HF/RRH...

- Communication is key for successful transfer/exit:
  - Other community organizations involved
  - Government organizations (for example income supports) involved
  - Clinicians now involved
  - Landlord (in some instances)
  - The friends/family of the participants (in some instances)
  - The participant
- Whenever possible, hold an exit case conference with all relevant parties and the participant



**Managing Your Time (and Sanity) While Being Highly Accountable**

## A Month...

- 140 Hour Month...
  - 44 hours Housing Stability Clients
  - 33 hours ISP Clients
  - 15 hours SA/SM Clients
  - 10 hours Reframe/Rebuild Clients
  - 12 hours Case Reviews
  - 20 hours Documentation
  - 6 hours meetings

## “Typical” Day for HF Case Manager

- Start in the office
- Do 2-3 home visits
- Take lunch
- Do 2-3 home visits
- Return to office to document day, enter data in HMIS and prepare for the next day

## RRH 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 3-5 home visits each morning
- Ensure you take lunch
- Do 3 or 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)

## Sample of A Week... RRH Case Manager

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		SA/SM Household	Housing Stability Household
Housing Stability Household	ISP Household	Case Review	SA/SM Household	
Housing Stability Household	ISP Household		Housing Stability Household	ISP Household
Lunch	Lunch	Lunch	Lunch	Lunch
Housing Stability Household	ISP Household	Housing Stability Household		R/R Household
Housing Stability Household	ISP Household	ISP Household	ISP Household	R/R Household
Housing Stability Household	ISP Household	SA/SM Household	Housing Stability Household	R/R Household
Housing Stability Household	ISP Household	SA/SM Household	SA/SM Household	R/R Household
Documentation	Documentation	Documentation	Documentation	Documentation

## 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

## For Each Person on Caseload

- Outline most recent acuity - SPDAT
- 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

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 empies	June 3, 1330h-1430h	9 month assessment due by end of month
Davis, L.	Winnie	Mike	47	40	- Legal issues - Personal Admin & \$ - Signs - 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



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