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.

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Contents

Agree, Disagree, Unsure

John

SITUATION: You have been working with John for over 3 months; he has been housed for a month. He is no longer attending home meetings with you, opening the door when you drop by, or responding to the notes you leave.

For each of the statements below, tick "agree" if you agree this is a likely reason for John's behavior; "disagree" if you do not agree that this is a likely reason for John's behavior; or, "unsure" if you neither agree nor disagree.

John is housed now and he no longer feels he needs supports. He only used the program to get off the streets. (F* off, I'm done!)**	☐ Disagree ☐ Unsure ☐ Agree
Guaranteed John is not following the landlord's "rules" and is expecting an eviction. He wants to avoid me because of this.	☐ Disagree ☐ Unsure ☐ Agree
John is unsure he wants to stay in his housing. He's lonely and unsure what he's supposed to do each day.	☐ Disagree ☐ Unsure ☐ Agree
Housing was the easy part for John. Now he thinks you'll definitely want him to stop using crack.	☐ Disagree ☐ Unsure ☐ Agree
Word on the street is that John has relapsed. John is convinced that he will be exited from the program.	☐ Disagree ☐ Unsure ☐ Agree
Every time someone tries to help this guy, he always bails. He has a history of giving up on programs after he starts them. This is his M.O. He doesn't really want to be housed.	☐ Disagree ☐ Unsure ☐ Agree
The best approach to use with John is to remind him that Case Management is a part of the program... re-engage or be exited from the program.	☐ Disagree ☐ Unsure ☐ Agree

Agree, Disagree, Unsure

Sally

SITUATION: You have been working with Sally for two months. She has expressed interest in being housed throughout that entire time, makes appointments with you to work on her housing, but either misses the appointment or is high to the point where she cannot communicate clearly during the appointment.

For each of the statements below, tick "agree" if you agree this is a likely reason for Sally's behavior; "disagree" if you do not agree that this is a likely reason for Sally's behavior; or, "unsure" if you neither agree nor disagree.

Sally keeps sabotaging the housing appointments so that she doesn't have to move forward with getting housed because she is scared.	☐ Disagree ☐ Unsure ☐ Agree
Missing appointments is a sure sign that Sally is not "housing ready".	☐ Disagree ☐ Unsure ☐ Agree
People like Sally tell you what they want you to hear ("yes, I want housing") so that you won't think any less of them.	☐ Disagree ☐ Unsure ☐ Agree
Sally may have life needs that aren't as big as some other folks, but the other folks at least keep appointments. It is more important to work with those that want to be housed and act that way.	☐ Disagree ☐ Unsure ☐ Agree
Unable to keep appointments before housing is a sure sign that the person will not be able to keep housing once they move in.	☐ Disagree ☐ Unsure ☐ Agree
Patience is key with the "Sally's" of the world – give her time and one day she will keep her appointment and be ready. There is nothing we can do in the meantime.	☐ Disagree ☐ Unsure ☐ Agree
Sally means well, but when you use as much drugs as she does it really is no wonder that she misses so many appointments and it would be a small miracle if she is ever able to maintain housing anyway.	☐ Disagree ☐ Unsure ☐ Agree

Agree, Disagree, Unsure

Jerome

SITUATION: Jerome has been housed for nine months. You thought things were going well – case plan goals were being met and he was actively engaged with home visits. Over the past couple weeks he hardly talks when you visit (when he is home) and seems disinterested.

For each of the statements below, tick "agree" if you agree this is a likely reason for Jerome's behavior; "disagree" if you do not agree that this is a likely reason for Jerome's behavior; or, "unsure" if you neither agree nor disagree.

People like Jerome get scared when they have been in the program and doing well and sabotage things to make sure you don't graduate them – and so they won't lose their supports.	☐ Disagree ☐ Unsure ☐ Agree
Hitting a plateau is normal in case planning. When he's ready, he'll snap out of it.	☐ Disagree ☐ Unsure ☐ Agree
Jerome has withdrawn because he can't think of any more goals he wants to work on.	☐ Disagree ☐ Unsure ☐ Agree
At a certain point in any case management relationship the client is going to reflect on whether or not they want to still work with you.	☐ Disagree ☐ Unsure ☐ Agree
For sure something else has come up in Jerome's life that he hasn't gotten around to sharing with you. Keep visiting and it will finally come out.	☐ Disagree ☐ Unsure ☐ Agree
Jerome has likely started using alcohol again; the depression is almost certainly related to that.	☐ Disagree ☐ Unsure ☐ Agree
His behavior indicates depression. Getting him engaged with a psychiatrist is key.	☐ Disagree ☐ Unsure ☐ Agree

Agree, Disagree, Unsure

Lisa

SITUATION: Lisa was housed after several years of homelessness and incarceration. She keeps setting goals in the five months she has been housed, but she hasn't followed through on any of them.

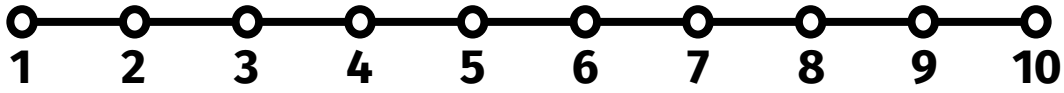
For each of the statements below, tick "agree" if you agree this is a likely reason for Lisa's behavior; "disagree" if you do not agree that this is a likely reason for Lisa's behavior; or, "unsure" if you neither agree nor disagree.

Lisa is just "playing the game". She knows she has to set goals to be in the housing program.	☐ Disagree ☐ Unsure ☐ Agree
Lisa tells you want to hear because she's ashamed of what her real goals are,	☐ Disagree ☐ Unsure ☐ Agree
She just wants the place; not the work required for long term success,	☐ Disagree ☐ Unsure ☐ Agree
Lisa's just looking for a reason to lose her housing. She'll be back in jail in no time – where she is likely most comfortable.	☐ Disagree ☐ Unsure ☐ Agree
It takes more than a year for people like Lisa to be ready to set goals and follow through on them.	☐ Disagree ☐ Unsure ☐ Agree
Most people like Lisa don't have the intellectual capacity to really understand what a goal is, or set a goal for that matter.	☐ Disagree ☐ Unsure ☐ Agree
You have to engage Lisa like a parole officer would, not a case manager, if you want her to really engage. She has to understand consequences of not following through.	☐ Disagree ☐ Unsure ☐ Agree

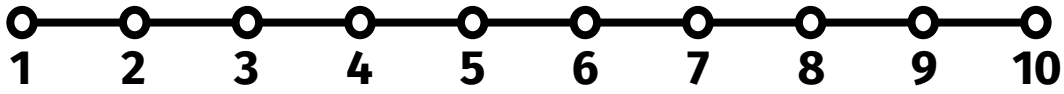
Thoughts, Values, Perceptions & Practice

Below are a number of statements. For each, on a scale of 1 to 10 (1 = strongly disagree; 10 = strongly agree) respond to each of the statements by filling the circle in the scale below the statement. Be honest in how you feel about each.

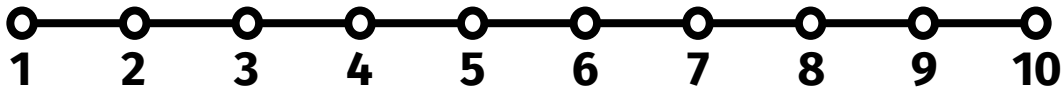
Most chronically homeless people will never be successful in scatter-site, market rate housing.



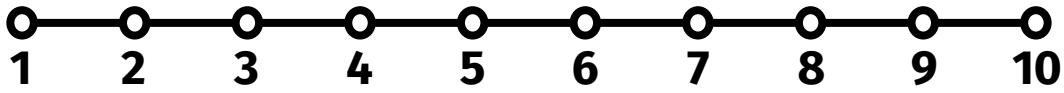
People with a mental illness should take their medications if they want to receive housing supports.



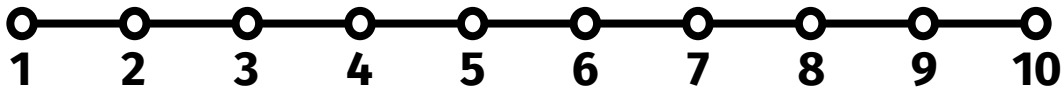
Some days I feel like I am "winging it"...making it up as I go along.



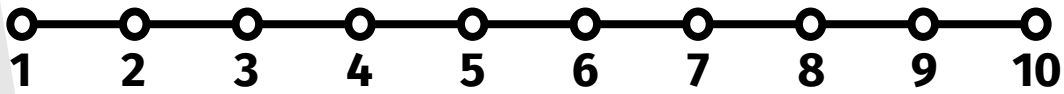
It is almost impossible to effectively support people that are still actively using drugs or alcohol.



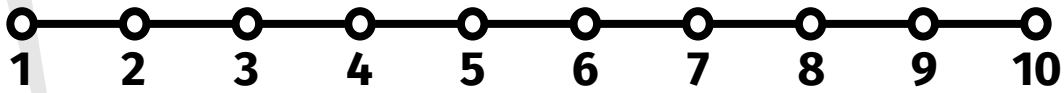
Most people have to hit rock bottom before they are ready to change their life around.



At least one day per week I feel like failure in the delivery of case management.

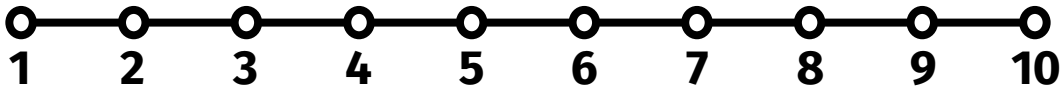


Getting people housed is relatively easy. Keeping people housed is relatively hard.

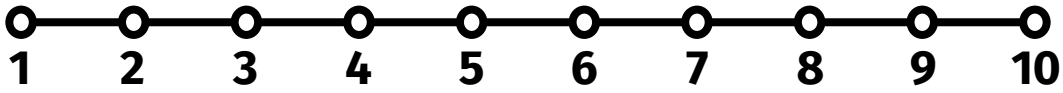


Thoughts, Values, Perceptions & Practice

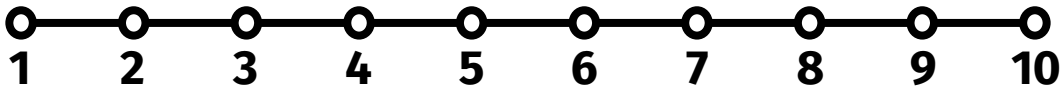
I practice excellent documentation and note taking in my case management practice.



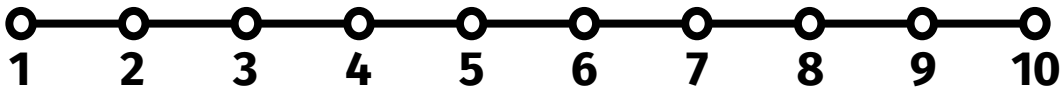
I provide my clients as many choices as possible and respect that they will make mistakes.



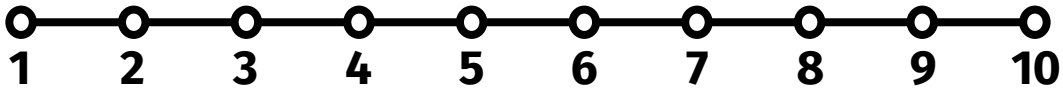
When a client loses their housing I fear it will reflect poorly on me.



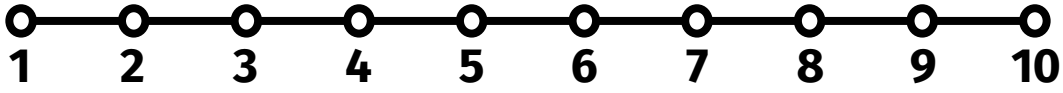
My friends/family have a good understanding of what it is I do for a living and why I do it.



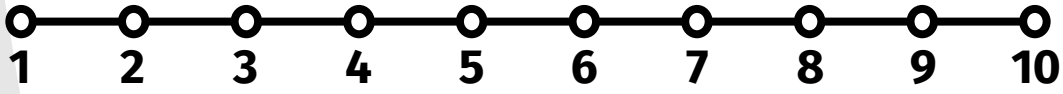
I am sometimes personally embarrassed by the behavior of my clients – as a result of their mental illness, addictions or medications – when we are out in public.



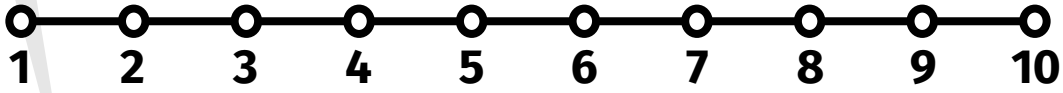
When my client has a long history of depression – especially when they have attempted suicide in the past – I have difficulties presenting housing options when I know they will be living alone and don't know any of the other tenants in the building.



I never take things that clients say to me personally – whether compliments or insults.

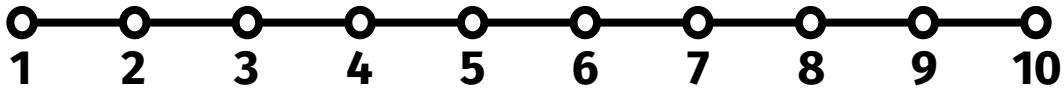


My clients that have a mental illness have far more crises than any of my other clients.

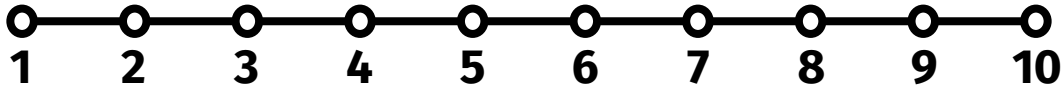


Thoughts, Values, Perceptions & Practice

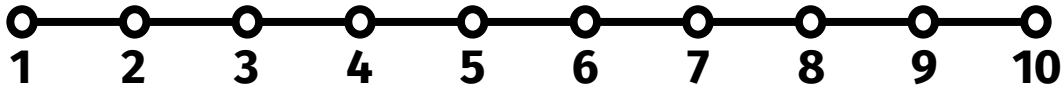
I have sometimes wished that the hospital would keep specific clients in longer until they were much more stable with their physical or mental health – even if the client wanted out.



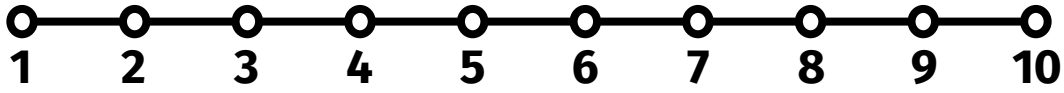
I support my clients making mistakes, so long as I feel I have provided them sufficient information from different perspectives to consider first.



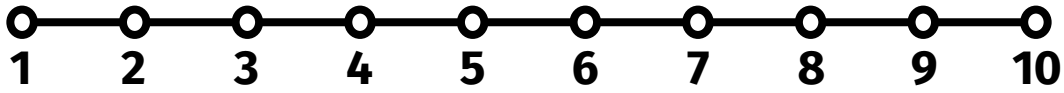
I have all the training I need to be a highly effective case manager.



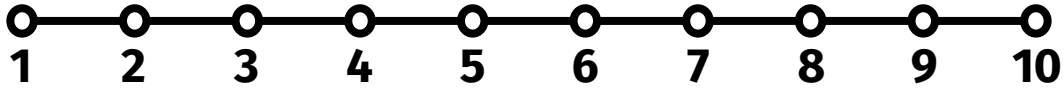
I am sometimes offended by the language my co-workers or supervisor use to describe our clients.



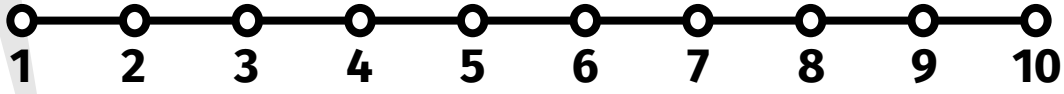
It is sometimes hard to see the strengths that clients already have.



I have some reservations suggesting housing choices in family apartment buildings when I know the client has schizophrenia.

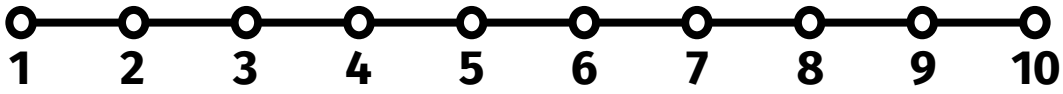


When a client has lost their housing a few times as a result of their unmanaged mental illness (e.g., not taking meds; not actively working with their mental health team; etc.) not housing them right away again can be useful for getting them to re-engage with the resources that are likely going to help them be successful in housing the next time.

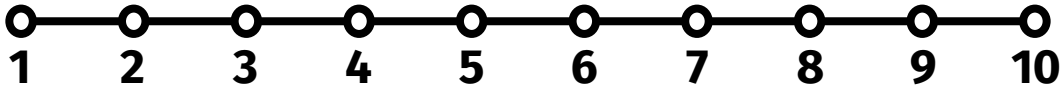


Thoughts, Values, Perceptions & Practice

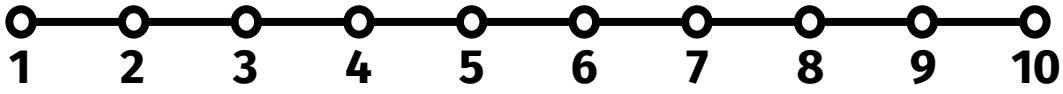
I have a strong awareness of all of the other community resources available to also support my clients.



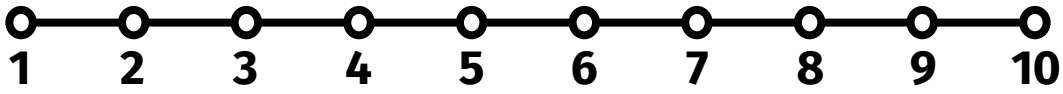
When confronted with stigma in supporting my clients, I always address it head on.



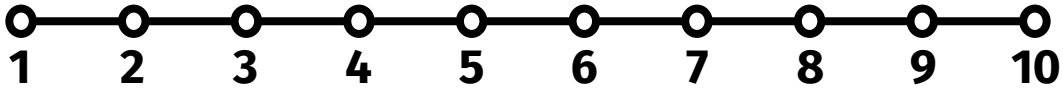
After a bad day, I have been known to engage in coping behavior myself such as using alcohol or other drugs, using food as a vice, engaging in relations I will later regret or describe as inappropriate, spending more money than I have budgeted for, etc.



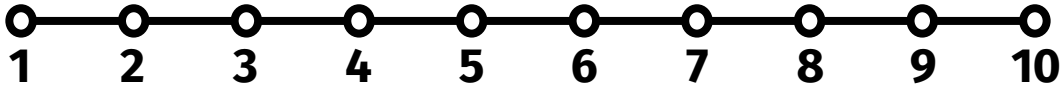
When one of my clients has a crisis I feel compelled to drop everything to support them and try to save the tenancy.



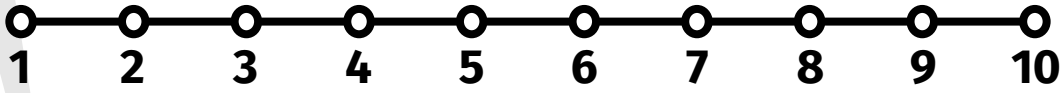
The organization that I work for has a strong professional orientation towards the work that we do.



I feel the people I work with hold me highly accountable for the work that I do and how I do it.



When I consider the behavior in public or at professional's offices of some of my clients with an addiction, mental illness, and/or history of economic poverty I can understand why they experience stigma or discrimination.



Defining Your Work

In one sentence, what problem does your job aim to solve?

In one sentence, why is solving that problem important?

In one sentence, what is the approach that you use to solve that problem?

Characteristics of Case Managers

5 positive traits I have for being a case manager:

1. _____

2. _____

3. _____

4. _____

5. _____

3 things I need to be aware of about myself to be an effective case manager:

1. _____

2. _____

3. _____

The 2 things I like most about case management are:

1. _____

2. _____

The thing I like least about case management is:

_____

The skill I most need to work on to be an effective case manager is:

_____

and I will work on this by _____

with the intent of being able to _____

by _____.

Using the SPDAT Domains to Set Goals

Using the SPDAT presents many opportunities for setting goals. Included within this booklet are three recommended methods to use the SPDATs to get results.

Note that all three of these methods require the user to be fully trained on the SPDAT and to be using the SPDAT as an assessment tool.

Professional Development

You can use the SPDAT to identify areas where you, as a case manager, could use further training. If you notice, for instance, that your clients are consistently failing to improve in certain components, this could be a sign that you could use training in how to provide effective support within that area.

3 Strengths & 2 Risks

You can use the SPDAT to sit down with clients and ask them to identify three components they consider to be strengths and two they consider to be risks to their housing. The risks are seen as things that may cause the client to lose their housing. You can use this assessment to help you client make goals about what areas in their life they would like to work on next.

1 Strength & 2 Opportunities

You can use the SPDAT to sit down with clients and ask them to identify one domain that they consider to be a strength and two domains that they see as an opportunity for improving their quality of life. The opportunities are seen in a positive light. You can use this assessment to help you client make goals about what areas in their life they would like to work on next.

Support in Domains

Professional Development

Thinking about your work as a case manager, identify which areas of support you have the most knowledge. How has your knowledge in these areas been **effective** in assisting the clients you work with?

Domain	Component	Got it	Don't got it
Wellness	Physical Health & Wellness	☐	☐
	Mental Health & Wellness and Cognitive Functioning	☐	☐
	Medication	☐	☐
	Abuse and/or Trauma	☐	☐
	Substance Use	☐	☐
Risks	Risk of Harm to Self or Others	☐	☐
	Interaction with Emergency Services	☐	☐
	Involvement in High Risk and/or Exploitive Situations	☐	☐
	Legal Involvement	☐	☐
	Managing Tenancy	☐	☐
Socialization & Daily Functioning	Meaningful Daily Activities	☐	☐
	Administration and Money Management	☐	☐
	Social Relationships and Networks	☐	☐
	Self-care & Daily Living Skills	☐	☐
History of Housing	History of Housing & Homelessness	☐	☐
Family Unit	Needs of Children	☐	☐
	Stability/Resilience of Family Unit	☐	☐
	Involvement in Children's Services/Family Court	☐	☐
	Size of Family	☐	☐
	Parental Engagement	☐	☐

Which areas of support provide an opportunity for you to improve your skill set as a case manager? What specifically would you like to make improvements upon?

Support in Domains

3 Strengths & 2 Risks Worksheet

Which **3 components** of the 20 below are your **greatest strengths**? *(Which 3 components don't you think present any risks to your housing?)*

Which **2 components** out of the 20 below present the **greatest risks** to staying housed?

Domain	Component	Strength	Risk
Wellness	Physical Health & Wellness	☐	☐
	Mental Health & Wellness and Cognitive Functioning	☐	☐
	Medication	☐	☐
	Abuse and/or Trauma	☐	☐
	Substance Use	☐	☐
Risks	Risk of Harm to Self or Others	☐	☐
	Interaction with Emergency Services	☐	☐
	Involvement in High Risk and/or Exploitive Situations	☐	☐
	Legal Involvement	☐	☐
	Managing Tenancy	☐	☐
Socialization & Daily Functioning	Meaningful Daily Activities	☐	☐
	Administration and Money Management	☐	☐
	Social Relationships and Networks	☐	☐
	Self-care & Daily Living Skills	☐	☐
History of Housing	History of Housing & Homelessness	☐	☐
Family Unit	Needs of Children	☐	☐
	Stability/Resilience of Family Unit	☐	☐
	Involvement in Children's Services/Family Court	☐	☐
	Size of Family	☐	☐
	Parental Engagement	☐	☐

3 Strengths

Why do you consider these areas to be strengths to work off of to help keep you and your family housed?

Support in Domains

2 Risks

What do you feel is necessary to **work on with these two components right away** so that you are your family are more likely going to stay housed? _____

What do you need to do for **yourself** and what type of support do you need **from me**? _____

Are there any **skills or strategies** that have helped you in the areas that you don't think presents risk that would be **helpful** to consider here? _____

Give a **timetable** for when you don't think this will be an issue anymore. _____

Support in Domains

1 Strength & 2 Opportunities

Which **1 domain** of the 5 below is your **greatest strength**? *(Which 1 area do you think presents the least risk to you becoming homeless again?)*

Which **2 domains** out of the 5 below that you feel are the areas where there are the **greatest opportunities** to make improvements in your life to help you and your family stay housed?

Strength	Opportunity	Domain	Component
☐	☐	**Wellness**	Physical Health & Wellness
			Mental Health & Wellness and Cognitive Functioning
			Medication
			Abuse and/or Trauma
			Substance Use
☐	☐	**Risks**	Risk of Harm to Self or Others
			Interaction with Emergency Services
			Involvement in High Risk and/or Exploitive Situations
			Legal Involvement
			Managing Tenancy
☐	☐	**Socialization & Daily Functioning**	Meaningful Daily Activities
			Administration and Money Management
			Social Relationships and Networks
			Self-care & Daily Living Skills
		History of Housing	History of Housing & Homelessness
☐	☐	**Family Unit**	Needs of Children
			Stability/Resilience of Family Unit
			Involvement in Children's Services/Family Court
			Size of Family
			Parental Engagement

1 Strength

Why do you consider thes area to be a strength?_____

How does knowing this is an area of strength help you and your family stayed housed? _____

Support in Domains

2 Risks

What do you feel is necessary to work on with these two domains **before other areas?** _____

_____

_____

_____

Are there **specific components** of the domains that you think present greatest risks to you and your family for not remaining housed? _____

_____

_____

What do you need to do for **yourself** and what type of support do you need **from me** to best support you in these domain areas to help ensure you do not become homeless again? _____

_____

_____

_____

What are some specific **actions you'd like to take** and in what timeframe? _____

_____

_____

_____

Five Essential and Sequential Steps in Case Management

Stages of Case Management

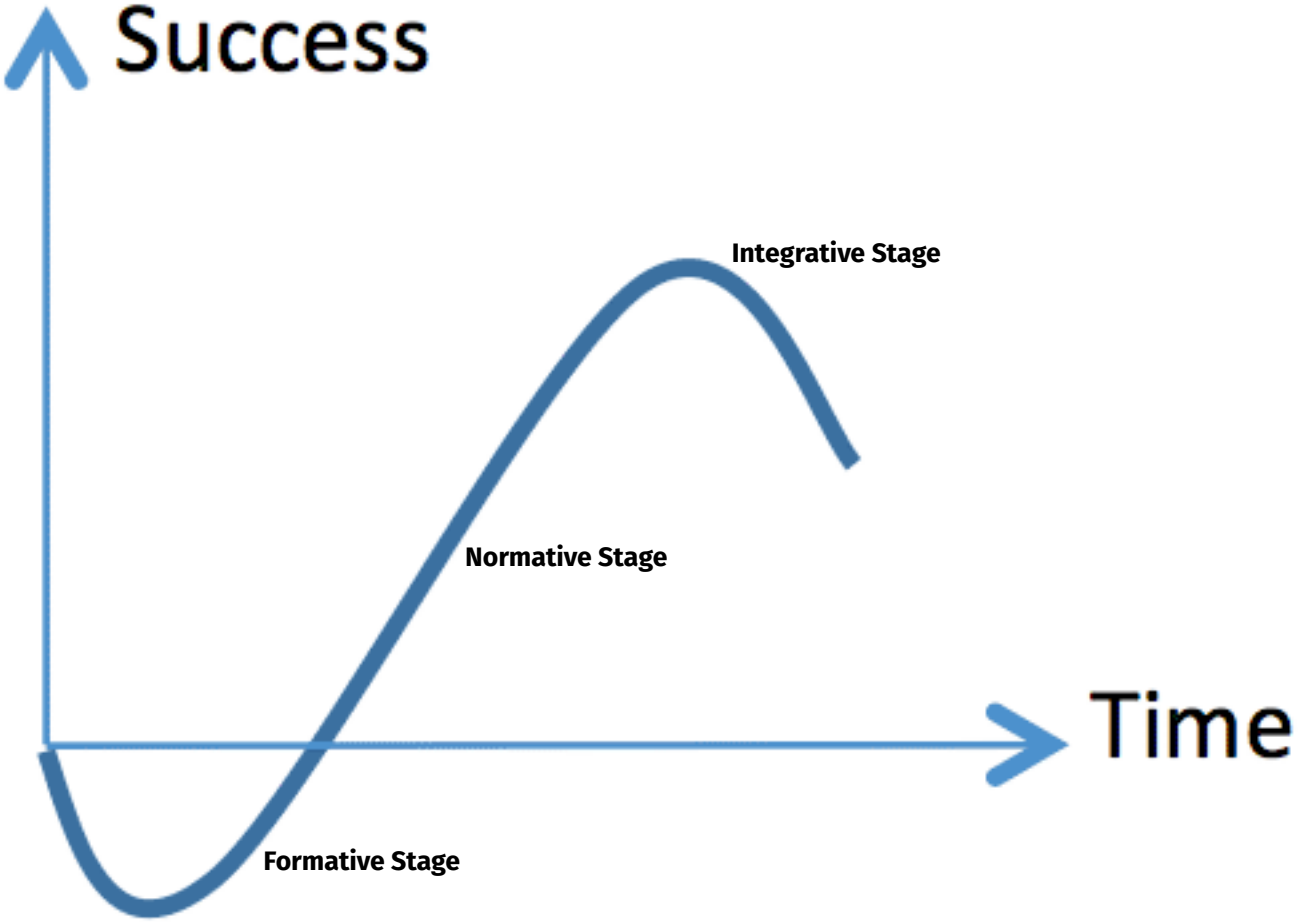
Housing Stability	Individualized Service Plan	Self Awareness	Self Management	Reframe/ Rebuild
• Relationship Impacts • Support • Basic Needs • Safety	• Life Stability • Meaningful Daily Activities • Employment/ Education • Other System Connections • Social Awareness	• Self Assessment • Triggers • Confidence	• 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

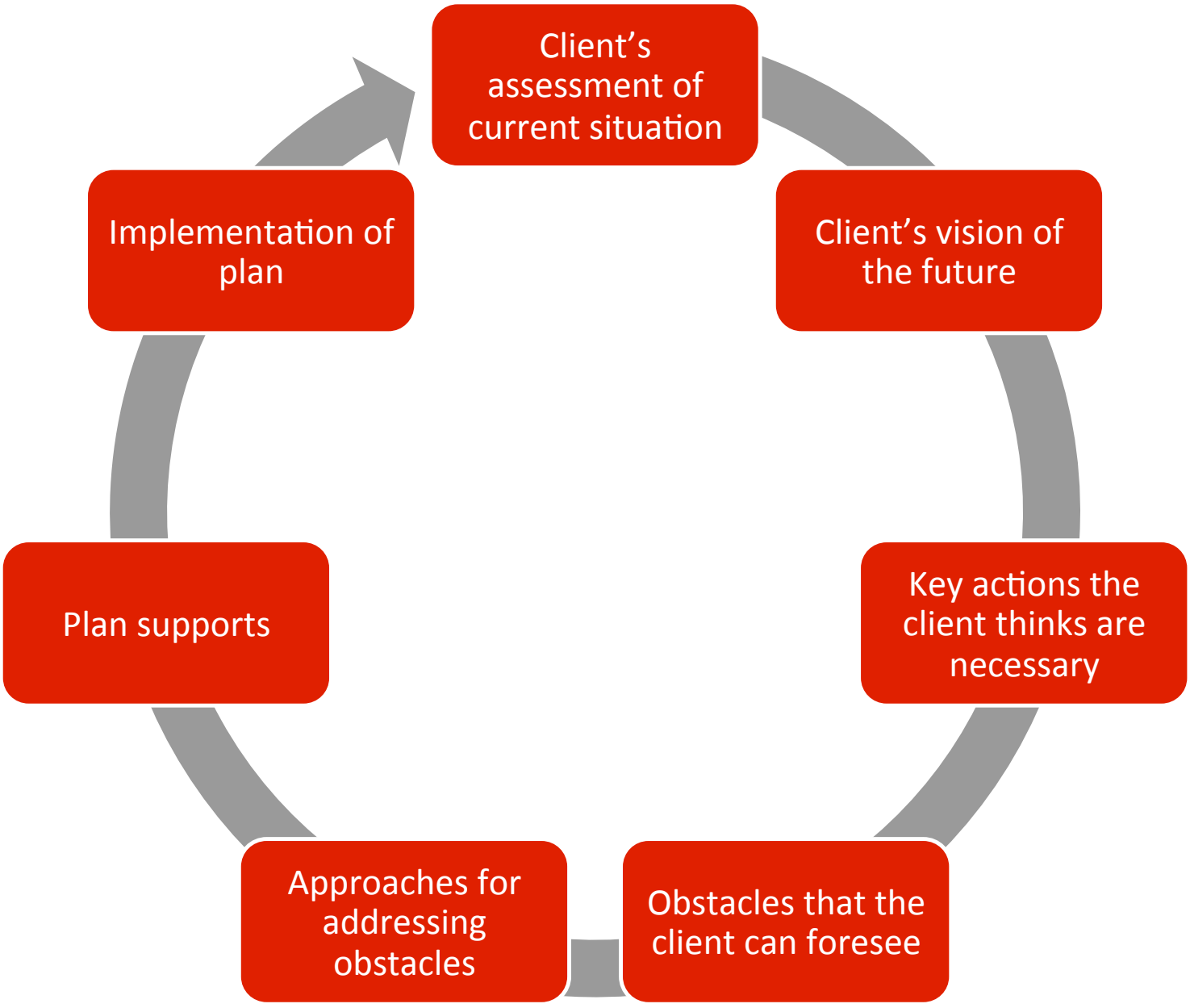
Home Visits

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

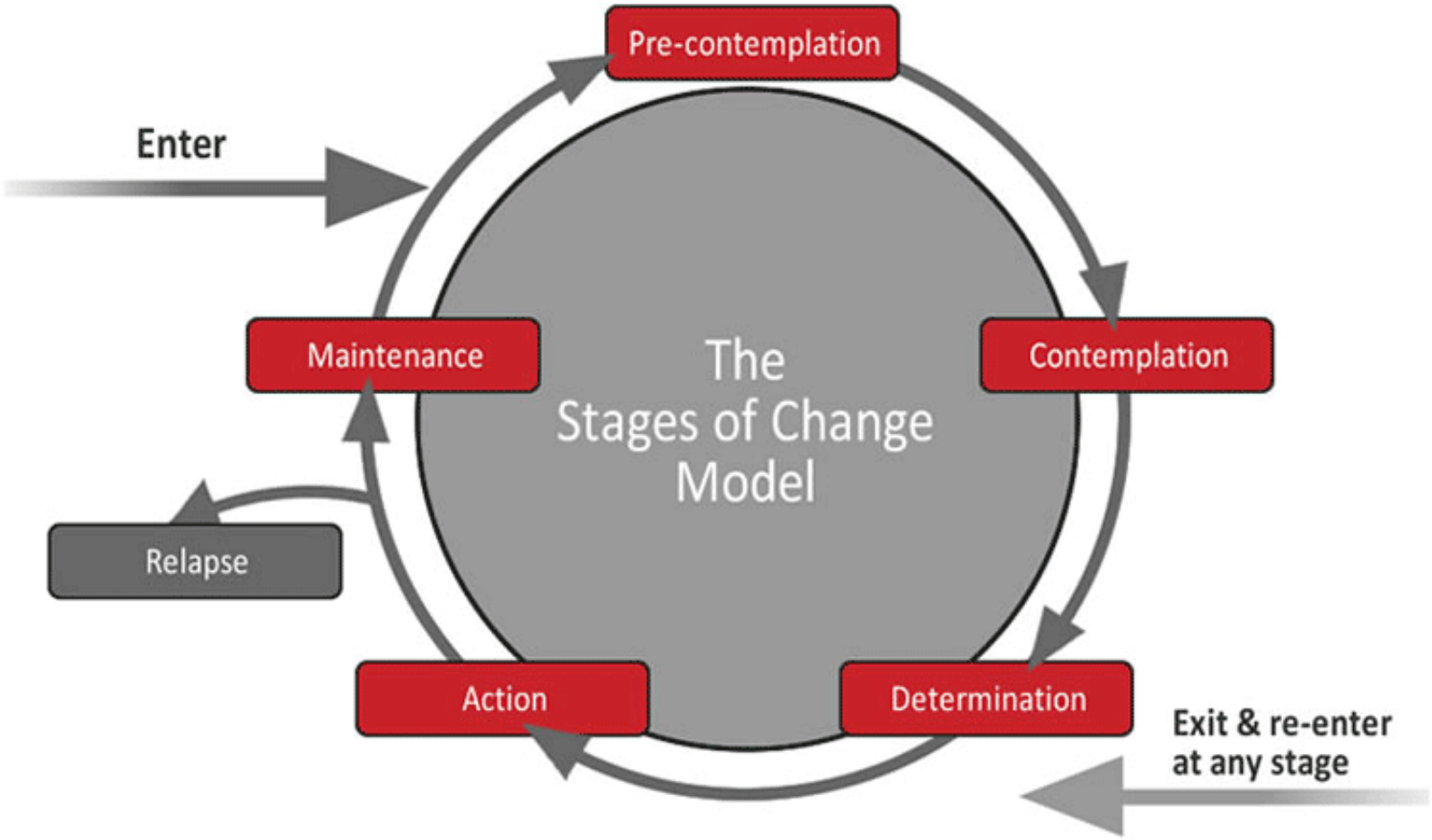
End of the Visit

- 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?

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

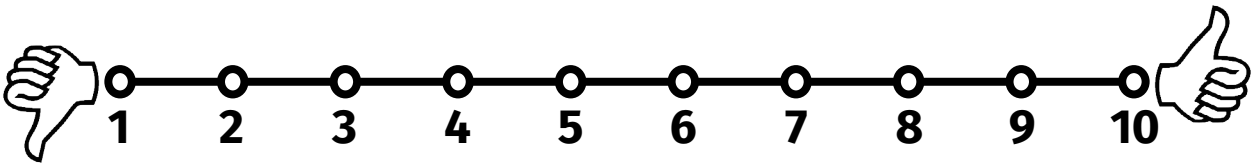
I would like to make changes to the following area of my life:

_____

_____

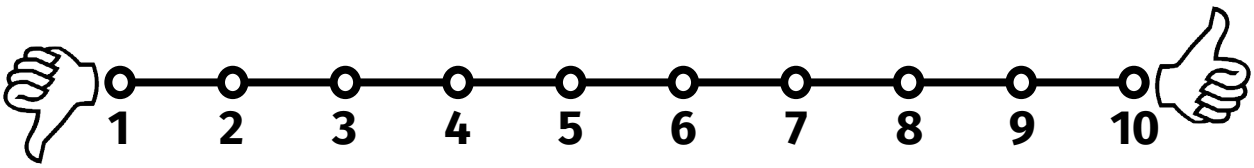
Importance

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:



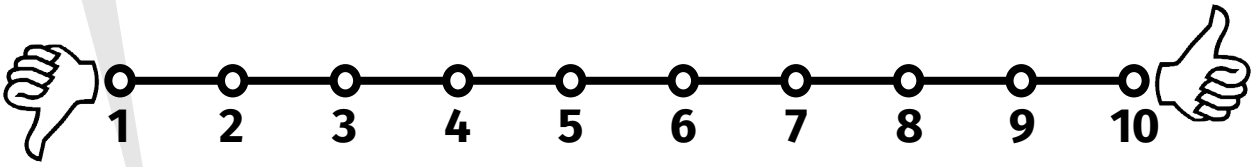
Readiness

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?							

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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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