Supporting Households Moving
Out of Homelessness

FOREWORD

Welcome to this guidebook on case management to help households move out of homelessness and remain stably housed. We know how hard you work - whether you are a nonprofit or local government leader, or a case manager working in outreach, shelter, rapid rehousing, permanent supportive housing, or community-based services.

The intent of this guidebook is to guide, encourage, and highlight best practices for case managers working specifically with households experiencing homelessness. While there are numerous resources on case management in a generalist setting, homelessness presents unique challenges and issues. The Florida Housing Coalition offers this information to serve as a framework for case managers working in homeless service settings to provide effective services to help households quickly exit homelessness, obtain and maintain stable housing, and never return to homelessness.

To complement this guidebook, we offer a seven-part Case Management Webinar Series, which is available on our website at www.flhousing.org. The guidebook and webinar series taken together offer a great resource to orient new hires, reenergize current case managers, and strengthen every organization embracing best practices and quality improvement.

If you have stories to share, or additional suggestions or questions, contact us at the Florida Housing Coalition. We are here to help you help our neighbors.

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Essential Principles

Before we get into specific guidance, let's begin with the essential philosophy and principles underlying this guidebook.

Research, data, and best practice support the fact that stable housing is the key to helping a household end their episode of homelessness and reintegrate into the broader community.[1] Therefore, the primary measures of success for case management and programs are measures of stable housing and connections to opportunity (e.g., employment, socialization, services).

Thus, the overarching framework is housing first. While the term "housing first" has been used in many different contexts, the housing first philosophy is at its core the recognition that people need housing first to end homelessness. Then, once housed in their own rental, and only as needed and desired, services are provided to help address any barriers to maintaining stable housing.

In the past, homeless service providers operated in a "services first" model requiring anything from sobriety to employment to receive services and, eventually, housing placement. These requirements and barriers created by provider agencies resulted in slow exits to housing, long lengths of stay in temporary or transitional shelter, and a backlog of people "stuck" in the crisis system. This outdated model often resulted in households with the more complex barriers remaining homeless for months or years, while becoming even less likely to engage in a homeless system that did not meet their needs.

The United States Interagency Council on Homelessness (USICH) recognizes that housing first is about changing the "DNA" of how the system responds to homelessness.[2] In keeping with Opening Doors, the federal strategic plan to prevent and end homelessness,[3] every program working with households experiencing homelessness should be working to make homelessness rare, brief, and nonrecurring. The best way to accomplish this goal is for every community to implement housing first system-wide.

This guidebook, therefore, reflects housing first principles, recognizing that stable housing ends homelessness. The housing first philosophy helps us as case managers better define our role and duties. Now each time we take an action we ask ourselves, "Is this activity helping this household obtain or maintain stable housing?" Housing first also helps case managers narrow their focus to the housing stability needs of the household in front us, rather than feeling responsible for solving complex social problems such as poverty, low wage jobs, childhood trauma, and more.

Next, moving forward with the housing first framework, let's discuss some guiding principles for case management.

1. Trauma Informed
2. Housing Focused
3. Recovery Oriented
4. Person Centered
5. Strengths Based

Trauma Informed

A trauma-informed approach is critical not only to the homeless services system, but also in our work with an individual household. The trauma-informed perspective recognizes that individuals experiencing homelessness have a higher prevalence of trauma histories;[4] therefore, our services must recognize trauma symptoms and respond in a way that is both sensitive and appropriate.

A trauma-informed approach replaces the question and mental perspective of "What is wrong with you?" to "What happened to you?"

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1 https://www.samhsa.gov/homelessness-housing

2 https://www.usich.gov/news/four-clarifications-about-housing-first

3 https://www.usich.gov/opening-doors

4 SAMHSA – SHIFT Study, available at: https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/traumas-impact-homelessness

Trauma symptoms might show up in many ways – mental health differences, substance use disorders, traumatic brain injuries, or generally "difficult behavior." Our ability to recognize these issues as symptoms of trauma, rather than "resistance" or "noncompliance," greatly changes how we provide services. A trauma-informed approach guides everything from organizational policies and procedures to how we greet someone at the front door. Later in this guidebook, we delve more deeply into the topics of trauma and implementing a trauma-informed approach.

Housing Focused

As discussed above, stable housing is always the number one goal when providing services to households experiencing homelessness. All services should be housing focused in every type of program addressing homelessness – emergency shelter, rapid rehousing, permanent supportive housing, or outreach.

Homeless service providers have the responsibility to help the client household exit homelessness and remain stably housed. Activities not focused on quick placement into housing will distract from this primary responsibility.

If clients need services beyond assistance identifying and moving into permanent housing, then they should be connected to the community agency providing those services. For example, if a household requests mental health or primary care, they should be referred to the appropriate provider. The resources within the homeless service delivery system should always be directed toward housing and services supporting stable housing.

Recovery Oriented

People in recovery are active agents of change in their lives; they are not passive recipients of services. [5] For the purposes of this guidebook, recovery is not limited to substance misuse. People can be in recovery from many different types of challenges, including physical health problems, mental illness, substance use disorders, trauma, and any combination of the above.

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5 "Guiding Principles and Elements of Recovery-Oriented Systems of Care", SAMHSA, 2009, available at: https://store.samhsa.gov/product/Guiding-Principles-and-Elements-of-Recovery-Oriented-Systems-of-Care/SMA09-4439

FIGURE 1

12 Principles to Implement a Recovery-Oriented System of Care

1. There are many pathways to recovery
2. Recovery is self-directed and empowering
3. Recovery involves a personal recognition of the need for change and transformation
4. Recovery is holistic
5. Recovery has cultural dimensions
6. Recovery exists on a continuum of improved health and wellness.
7. Recovery emerges from hope and gratitude
8. Recovery involves a process of healing and self-redefinition
9. Recovery involves addressing discrimination and transcending shame and stigma
10. Recovery is supported by peers and allies
11. Recovery involves (re)joining and (re)building a life in the community
12. Recovery is a reality

"I realize now that I never asked my clients to tell me how they really wanted things to be in their life. I didn't recognize that they had the power to create that possibility."

A recovery orientation meets participants where they are, recognizes that each person's path to recovery is unique, and doesn't judge where that person is on her path. This approach contrasts to that of providers who view themselves as the expert and view their role as imparting their knowledge to the participant. Shared decision making and collaboration welcomes the client to engage actively in the process, which in turn often hastens and strengthens that recovery process. SAMHSA developed 12 principles to implement a recovery-oriented system of care. These principles are detailed in Figure 1.

Person Centered

Person centered case management recognizes the client as the expert of his or her own life. The case manager uses as-

sessments to identify the internal strengths and motivations that each client possesses; those can then be engaged to help achieve the client achieve her goals. In this model, clients are offered choice and the case manager respects the client's choices and accepts those choices in a non-judgmental manner. Person centered case planning considers the clients' unique goals and values.

Strengths Based

All too often case planning focuses only on the barriers and challenges faced by the client. Focusing on deficits and problems does not help the client or the case manager stay solution focused. The case manager should assess for strengths, understanding that those strengths will lead to solutions that will help the client achieve her goals.

> **"It is important that the entire service system understand how to provide trauma-informed care, so that no matter what door a homeless family walks through, they can be assured a basic level of appropriate care."**
>
> <div align="right">— Dr. Carmela DeCandia
2013 SHIFT Study</div>

Strengths may be natural supports (e.g., family, faith community), emotional supports, income, and past successes. One therapist reflected on the shift to a strengths-based approach below.

"Linda Metcalf commented on why she changed her approach to working with people from a problem-focused approach to a solution-focused approach: I would explore circumstances with my clients and help them figure out what they could do to change their lives. . . .[When they didn't change] I always thought it was my client who wasn't cooperating. I regret this now, because I realize they were trying to tell me something, and I wasn't listening. Not only wasn't I listening, I wasn't asking the right questions. I was asking questions I thought were necessary to gather information, understand their experiences, and gain insight into their dilemma. I gave advice because I thought it would be helpful and because that's what they were there for. I realize now that I never asked my clients to tell me how they really wanted things to be in their life. I didn't recognize that they had the power to create that possibility.[6]"

Your clients have resilience, resources, and capabilities that will help them during your work with them and beyond. It is not good advice that will be the catalyst for change; rather, it is the belief in their own ability to change that will spark that change.

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6 Blundo, R. G., & Simon, J. K. (2016). Solution-Focused Case Management. New York, NY: Springer Publishing Company. P. 43.

CASE MANAGEMENT:
Components and Standards

Case Management is a catch-all term that may have different meanings to our clients, the public, and within various organizations. While there are several different types and names for case managers, this guidebook focuses on workers providing support services to people who are at risk of homelessness, literally homeless, and/or residing in a housing program for formerly homeless persons (e.g. Permanent Supportive Housing and Rapid Re-Housing).

You might not be called a case manager. You may have the title of systems navigator, housing specialist, housing navigator, outreach worker, case specialist, support service worker, residential support specialist, etc. For purposes of this guidebook, we will use the term "case manager" to include all these various roles within homeless services. No matter the role, case managers share some common duties, which we will refer to as "components and standards."

The most common components of case management are: engagement, assessment, service planning, documentation, and exit planning; each of these components are described in more detail in this section. You can think of each component as a piece to the puzzle. Without any one of these components, services provided will not be as effective.

Think of the standards (i.e. the quality of each component) as the clarity and color of the puzzle. Missing components form an incomplete puzzle, while poor quality standards form a low-quality puzzle.

Case managers must also "right-size" the components. Some helping relationships will be relatively brief and straightforward (four piece puzzle) and some will be extended and multifaceted (5,000 piece puzzle). No matter the duration and complexity of the case management, having all the pieces is critical.

On the next page we explore each of these components and corresponding standards in detail. Also note that several case management tools will be mentioned throughout the guidebook to assist you; these tools are provided in the Appendices.

Engagement

Engagement: Introduction

Engagement builds the relationship between the client and the case manager. Contact can first be made in a variety of ways – outreach, office visit, home visit, or contact in another setting (e.g., hospital, jail).

It is important to understand that while the first contact is when engagement begins, it is not where engagement ends. Engagement is an important part of the entire relationship – entry to exit. Case management requires continuous engagement through the relationship – we call this assertive engagement. The amount of engagement should be tailored to the individual being served, and the case manager has the duty to find the most appropriate level of engagement.

Engagement also lays a foundation for the entire helping relationship. Without that foundation, you may find the helping relationship more difficult. For example, if a participant has a difficult time trusting the information the case manager is providing, then they will most likely not follow up with your recommendations. Sometimes this may be considered "noncompliance." However, this behavior may be a consequence of the case manager engaging in a way that does not foster trust and openness.

Assertive Engagement

What is the standard for assertive engagement and how do we do it? Because engagement can happen in a variety of settings and ways, the "how" varies greatly. Below are some "pro tips" for effective engagement.

1. Throw away the "one size fits all" approach and meet the household where they are. Every household is different and requires a different level and manner of engagement. You may find that a household that has experienced homelessness for several years may require a greater amount of engagement over a longer period of time; whereas a household experiencing homelessness for the first time might be eager to follow through with appointments and recommendations. Notably, the opposite may also be true – assumptions often lead us down the wrong path, so it's important to gauge the individual needs and wishes of the person sitting in front of you.

2. Be authentic. People know when you are genuinely interested in helping and when you trust them to make decisions about their lives. They also know when they are considered just another case or "difficult" client. Authenticity will establish rapport and trust more quickly, which in turn helps the household be more open.

3. Be flexible and persistent. Consider where the household feels comfortable meeting. Keep in mind they may not feel like meeting with you at all. The important thing is to not give up. It takes time to build a trusting relationship and persons who have been homeless have been let down many times by themselves and by others. Be mindful of the ultimate goal of engagement and case management – permanent and stable housing. Do you need to offer walk-in office hours? Are you open to meeting in the client's home, in a local park, or in a coffee shop? Do you invite the household to bring an advocate or other person to case management meetings?

4. Be transparent. Explain why it is you are talking with them and invite them into the process. Do not overpromise and underdeliver, because failure to deliver will diminish trust. Being clear about what is feasible for you to assist with and following through with what you say you are going to do are paramount to building the helping relationship.

Let's break down some common ways and settings in which you may be engaging clients.

Outreach

Outreach is a critical part of any community's response to homelessness. Expecting people who are homeless to know where to go and how to access services is often unrealistic. Additionally, just because someone knows how to access the services doesn't mean they will – or that they want to. This is where outreach comes in.

Outreach is physically leaving the office or workplace to identify, assess, and refer people to appropriate housing and service options. Easier said than done. "Inreach," on the other hand, is making people come to you (e.g. having walk-in office hours). Outreach often means engaging people who have been homeless for prolonged periods

of time and have serious disabilities. HUD defines this subpopulation as "chronically homeless."[7]

Those who are chronically homeless are often less likely to be open to services, at least at first. Often, these households have been denied services due to their being viewed by the system as "too high needs" or "noncompliant". In this scenario, engagement could take a year or more; however, that does not mean that it must. Chronically homeless households should, however, be a priority population for street outreach. Their vulnerabilities exacerbate any physical and mental illness they are already experiencing and put them at a greater risk of early death, incarceration, and hospitalization.

Developing a positive helping relationship is very important in outreach. While providing necessary items for outreach participants such as sunscreen, food, and hygiene items can be part of that development, it is not the primary objective of outreach.

The intent of outreach to households experiencing homelessness is to help that household move into permanent housing as quickly as possible. Why? Housing First! Housing people who are chronically homeless, with no preconditions, leads to better physical, mental, and emotional wellness. Outreach is meeting its objective when it is targeting people who need housing the most and connecting them with housing and resources. Outreach is not meeting its objective when the standard is only measuring quantitative data, such as the number of contacts made, rather than housing outcomes.

In the following sections we take a look at engaging households in settings outside of outreach.

Emergency Shelter/Crisis Housing

People living in emergency shelter or another type of temporary housing are, in fact, in crisis. They are experiencing what's known as chronic stress. Chronic stress is long-term stress that continuously impacts our brain function. While acute stress, or short-term stress, goes away quickly and allows the brain to return to "normal," chronic stress wreaks havoc on the brain. There are too many negative consequences of chronic stress to list, but let's look at a few:

1. Chronic stress depletes good brain chemicals, which makes the person feel depressed and can lead to other mental challenges.

2. Chronic stress can impact the blood-brain barrier that protects your brain from harmful things trying to get in. When the blood-brain barrier is not functioning properly, the body becomes more susceptible to infections and more serious illness.[8]

3. Chronic stress can increase risky behaviors such as gambling, drug use, and impulsivity.

4. Chronic stress can affect your mood, cause crying spells, and increase worry, anxiety, and sadness.[9]

Imagine experiencing some of those challenges and then, on top of it all, having no place to live – fully dependent on others to provide shelter, food, and other basic needs. And then often being sheltered with dozens or hundreds of strangers. This can be devastating.

But don't despair – there is hope! Engaging households in crisis for the purpose of getting them out of crisis begins to relieve that chronic stress. Effective engagement provides an opportunity for us to partner with people experiencing crisis and let them know we are dedicated to helping them end their crisis as quickly as possible.

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7 https://www.hudexchange.info/resources/documents/Flowchart-of-HUDs-Definition-of-Chronic-Homelessness.pdf

8 http://www.bmj.com/content/313/7071/1505.2

9 More information about chronic stress is available in this TED Talk: https://ed.ted.com/lessons/how-stress-affects-your-brain-madhumita-murgia

We engage people in emergency/crisis housing situations and immediately begin planning for a move to permanent housing. When stable housing is provided, that chronic stress begins to dissipate. We do this gently and do not make demands or ultimatums. For example, someone experiencing chronic stress is most likely not going to respond well to a laundry list of tasks to continue to reside at the shelter.

Too often, a person's first engagement in a shelter is an intense assessment followed by a long orientation detailing all the rules, policies, and procedures of the facility. How much information do you think is successfully absorbed in that initial engagement? Probably not a lot.

Our initial engagement needs to be a top-notch customer service experience that lets the clients know they matter, they will be heard, and they will be treated with dignity and respect. The ultimate goal of engagement in shelter is to motivate and encourage that household toward permanent housing.

Assessment
Assessment: Assessing the Assessment
Social service programs usually have some form of assessment. Why are assessments important? Assessments help us (the worker or organization) to gather information about the household being served. Generally, assessments gather demographic information, income information, disability status, physical/behavioral health diagnoses, presenting needs, barriers, and household supports. Many assessments are in depth and gather quite a bit of information.

Have you ever stopped and assessed your assessment? Are the questions being asked absolutely pertinent to the service the household is seeking? Or are we asking unnecessary questions? Here is an example: A household enters emergency shelter. During the intake process they are asked about substance use, mental health treatment,

HIV status, and criminal history. Is providing that information necessary for sheltering? Will it help return the household return to permanent housing?

Often, we take our assessments for granted. We assume the information is necessary and gives us a better picture of the household. What we fail to realize when we have extensive assessments is 1) the information is often unnecessary and only marginally related to the services we provide, and, most importantly, 2) questioning to gather in depth personal information can be retraumatizing, intrusive, and difficult for the household.

So before we talk about how to conduct assessments, we need to evaluate our assessments and ensure the information is necessary and relates to the services we are providing. If we are a housing provider, it is only necessary to gather information that present barriers to housing.

For instance, the assumption that substance use or a mental health diagnosis directly relates to housing barriers is inaccurate. The majority (more than 99 percent) of people who have behavioral health issues are stably housed, not homeless. Gathering information on physical/mental illness and/or other disabilities is only pertinent if those are major contributing factors to the household's instability. Of course, during the ongoing case management engagement, if a household requests connection to services related to their behavioral health, then it is appropriate for the case manager to help make that connection. The initial assessment, however, is typically not the best time for this conversation.

Assessment: A Strengths-Based Approach
The majority of assessments are deficit-based, meaning the questions highlight the deficits, challenges, and barriers of the household. These assessments rarely ask questions regarding the strengths of the household, and

Our initial engagement needs to be a top-notch customer service experience that lets the clients know they matter, they will be heard, and they will be treated with dignity and respect.

Assessments are interventions.

failing to assess the household's strengths and resources leads to less effective case planning.

How will you help clients feel empowered to succeed if you do not know what strengths they possess? What if they have a great aunt that will provide financial help when they are in a bind? What if they have maintained housing stability in the past? What if they have a technical degree they have never used in the job market?

A strengths-based approach shifts the assessment process and conversation. With a strengths-based approach, the assessment focuses on the household's resources and strengths that can be called upon to address their barriers to stable housing. Gathering information related to barriers is necessary but stopping at barrier assessment ignores important information that not only empowers the family, but also enables us to see a much more complete picture and serve the client better.

Strengths are any social, emotional, and financial resources the household possesses or could call upon. Strengths-based assessments help uncover what has worked well in

the past for the household, or what could be called upon to help them in the future, rather than focusing solely on the presenting problem.

A good example of a person-centered, strengths-based assessment is having clients assess themselves in certain life domains, such as housing, income, employment, health status, and support systems. You can simply have a 0-5 rating scale with 5 being the most stable. Simply ask the client where they feel they are at on those scales, giving basic descriptions under each number. This is an effective way to gather information without asking too many specific questions that may be uncomfortable for the household to answer.

At the end of the assessment, we should have a clear picture of the needs and the household's resources to address the need. Part of our job in assessment is identifying and pointing out strengths to the household. Often, households may be asked about their strengths and have difficulty identifying them. This is an opportunity to help them identify their own strengths. Individual strengths are what the person will pull from to be a change agent for his or her own life.

Assessment: How to Conduct an Assessment

Some case managers may have already been in contact with the household at the point of assessment, which makes the assessment process a little easier. However, the assessment may be the first time you are meeting the household, so it is important to consider how you like to build rapport with others.

The assessment is your opportunity to build rapport with the household in a way that makes them feel comfortable and does not "over assess". This rapport will serve as the foundation for the entire case management relationship going forward. The focus of the assessment should not be to fill out a form; rather, this is the time for you to level the power differences and build a good relationship with the household.

For example, I used to have a lengthy assessment to complete with new clients in my first interaction with them. Instead of sitting down for up to two hours just reading off questions, I devoted that time to just getting to know them. Pen down, eye contact, authentic listening, and genuine interest in what was going on with them. I knew that everyone entering that program had the same basic needs (e.g., housing), but spending this time to find out more about the household helped me build rapport.

I also used this time as an opportunity to determine what their expectations were versus what the program really offered. You have probably experienced sitting down with clients who are not even sure why they were referred or given an appointment to see you. Using that initial meeting to provide an informal explanation of your role, program details, and other information helps build rapport and invites the person into the process.
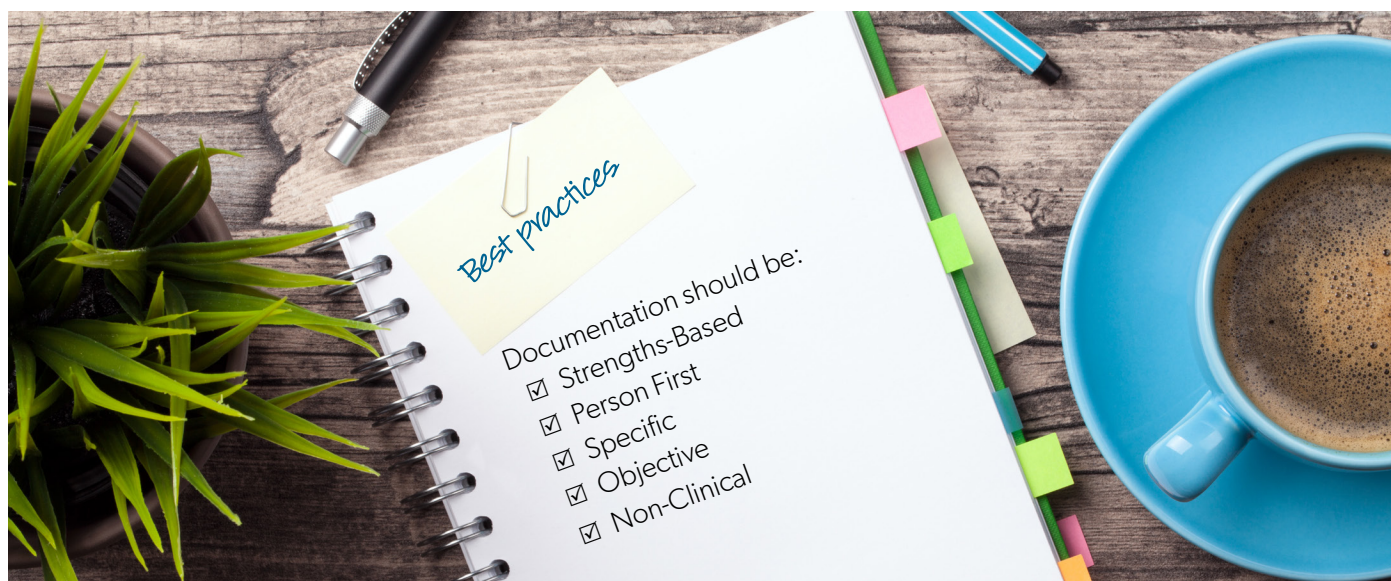
Once that initial meeting is over, a follow up can be scheduled to complete the formal assessment. The process of enrolling in the program should be clearly explained to the client: Assessment ⇨ Service Plan ⇨ Housing Assistance. Keep in mind the process will look different given your type of agency and services provided.

Another benefit to an initial informal assessment is that it provides an option for the household to decline services after finding out more information about the program. This is not intended as time for you to deter households from services or coerce them into services, rather it is an opportunity for transparency and informed consent.

Documentation

Every case manager has the responsibility of documentation. Documentation consists of case notes, action/service plans, housing plans, and all correspondence received and sent. Though documentation can sometimes seem like a mundane task and an administrative burden, it serves a vital function in case management.

Documentation helps the case manager stay organized and keep accurate records, which in turn helps with following up on action steps in a timely manner, charting progress,

Best practices

Documentation should be:
☑ Strengths-Based
☑ Person First
☑ Specific
☑ Objective
☑ Non-Clinical

FOCUSED ON
BARRIERS

Non-compliant

Lacks insight

Stubborn

Manipulative

Attention-seeking

FOCUSED ON
STRENGTHS

Not open to… unwilling to

Does not agree

Really trying to get help

identifying setbacks and solutions, and maintaining helpful engagement with the household. In addition to keeping up to date, accurate records, the language used in writing the documentation is important. In keeping with the philosophy of case management, documentation should be strengths-based, person first, specific, objective, and non-clinical.

To keep the most accurate records, documentation should be done concurrently. This means you should be making your case/progress notes at the time of the visit. Before the client leaves your office, or before you leave the home visit – you write/type the note at that time.

Three great reasons to document concurrently are: (1) you will never be behind on notes, which can feel like an insurmountable burden when you have a large caseload, (2) you can review the notes with the client to ensure that you are on the same page regarding action steps, and (3) the note will be more accurate because you are not relying on your memory to write the note.

If you think to yourself, I'll write this note up as soon as the client leaves, what will most likely happen? As soon as the client walks out the door, you'll get a phone call or someone is in the lobby waiting for you with an emergency. You'll get sidetracked and three days later you'll be trying to recall what happened during that visit. If you have forgotten something that is important to the client, and the client perceives that you have let them down, this can reduce their trust in you.

One barrier to documenting concurrently is not having a laptop to take into the field on home visits. In this case, the best option is to take physical notes and then later use those notes to document the visit in the electronic system.

In Appendix A, you will find a printable Client Visit Record that can help you jot down notes as you are meeting with client, and later formally document the visit when you return to the office. In Appendix D, we offer standards around documentation.

Strengths-based
Strengths-based documentation steers clear from negative language used to describe clients. Using strengths-based language can present a challenge if we are not familiar with it. Below is a chart showing some examples of language focused on barriers versus language focused on strengths. [10] The focus of strengths-based language helps us be more solution-focused and less negative in our perception of the client.

Person First
Simply put, person first language recognizes a person first and diagnosis or challenge second. You want to avoid terms such as "schizophrenic, bipo-

10   View a comprehensive list of strengths-based, person first language here: http://www.ct.gov/dmhas/lib/dmhas/publications/PCRPLanguage.pdf

lar, homeless". When we say or document things like schizophrenic, we are over identifying the person – implying they are just that one thing. This is an inaccurate, deficit-based perception of the person. They are a person with schizophrenia.

Think about this – if someone has cancer, we wouldn't say "she is a cancer" or "she is cancerous"; that sounds terrible and it is inaccurate. Similarly, "homeless" is not a person's identity. Homelessness is something the person is experiencing. So instead of describing someone as homeless, person first language would describe them as a person/household/family experiencing homelessness. With disabling conditions, you would describe them as a person with XYZ diagnosis (schizophrenia, a disabling condition, etc.).[11]

Specific and Objective

Documentation should also be specific and objective. Specificity is important because the notes are not just for you. A note to yourself tends to be short because you can fill in the blanks based on your knowledge of the household. However, because documentation is not just for you, it should be a full and accurate reflection of what has taken place in this client's case – whether that be office visits, home visits, a fax you sent, collateral contact information, etc.

When writing documentation think to yourself, would an outsider be able to understand what happened and what the action steps are going forward? For instance, if your client got transferred to a new case manager tomorrow, would the new case manager be able to read and understand your documentation? Would it be an accurate depiction of what has transpired and where things stand? Let's look at an example of two different notes both documenting the same thing:

Note 1. CM will follow up on birth certificate.
Note 2. CM will contact the clerk at the Florida DOH to

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11 Boston Medical Center put together an incredible "Words Matter" pledge for their clinicians, available at: https://www.bmc.org/sites/default/files/Patient_Care/Specialty_Care/Addiction-Medicine/LANDING/files/Words-Matter-Pledge.pdf

✔ Non-Stigmatizing Language	✖ Stigmatizing Language	
Person with a substance use disorder	Substance abuser or drug abuser	User
		Abuser
	Alcoholic	Drunk
	Addict	Junkie
Substance use disorder or addiction	Drug habit	
Use, misuse	Abuse	
Risky, unhealthy, or heavy use	Problem	
Person in recovery	Clean	
Abstinent		
Not drinking or taking drugs		
Treatment or medication for addiction	Substitution or replacement therapy	
Medication for Addiction Treatment	Medication-Assisted Treatment	
Positive, negative (toxicology screen results)	Clean, dirty	

check on the status of the birth certificate applied for on 3/22/18.

Note 2 is superior because it is clear from Note 2 who the case manager is going to follow up with and when the birth certificate was applied for. This information is key for the case manager following up, but also important for someone else working with the client.

Secondly, documentation needs to be objective. Objective documentation means what you are writing is impartial and unbiased. Avoid "I think" statements and opinions. Instead, state in a factual manner what the client said or did. Let's look at an example of non-objective writing versus objective writing.

Statement 1 (non-objective). The client is in denial of her alcohol problem. I think I smelled alcohol on her breath at the time of our appointment.

Statement 2 (objective). Ms. Jones and I discussed alcohol use and Ms. Jones stated she does not have a drinking problem and does not understand why everyone keeps asking her about it.

Use quotes if you need to and take your opinion out of it. Simply document what was stated or factually observed during the visit.

Non-clinical
The intent of clinical documentation is to report subjective information in order to diagnose or make clinical decisions regarding treatment. Clinical documentation often reports on subjective information – like the client's mood or affect. Clinical documentation is not the same as case management documentation.

The purpose of case management documentation is to give a clear, objective reflection of the interaction. The only reason you would need to document things like mood is when it is interfering. For example, you would document the situation if a client comes in with visible bruises, a clear crisis, significant mood change, or odd behavior that is out of character for the client.

This is especially important when documenting crisis situations. Specific observations can demonstrate the need for whatever action was taken to resolve the crisis (e.g.

involving the police, disclosure of private information). Organizations should have clear, written policies on how to document a crisis – a separate form for crisis situations, who to report the crisis to, what follow up is needed, and how to file the documentation.

Case Planning
Once the assessments have been completed detailing the client's barriers, strengths, and needs, the next step is case planning. There are three basic types of planning used in case management: crisis plans, action plans, and exit plans.

Crisis Plan
A crisis plan is created when you are meeting with a client experiencing a crisis, and safety concerns are present. The crisis plan is developed with the client, not for the client. Goals in the crisis plan are related to keeping the client safe.

A crisis plan can also be created in order to plan when it is probable that a crisis will occur. The number one thing you are trying to figure out during crisis planning is: how can this person or household become safe? Sometimes that means just spending some time talking through whatever is going on. Sometimes it is connecting the household to immediate medical or mental health help.

Case managers must be careful not to over-escalate how someone is feeling, but you also don't want to be dismissive of someone who is in a real crisis. If your client feels they are in crisis, a thorough (verbal or written) assessment needs to be done to help determine the severity of the crisis and the appropriate response.

When a client is in a serious crisis, it is crucial to inform the client of your duty to report if he is in danger of harming himself or others. Even if this information has already been disclosed to the client, it needs to be brought up again in crisis situations. Reminding them of your duty to report is not to deter a client from sharing what is going on, but to be transparent in the event information needs to be disclosed to another.

Common crisis situations include suicidal thoughts or plans, homicidal thoughts or plans, domestic violence, sexual assault, safety concerns from drug or alcohol use,

A CLOSER LOOK AT **WRAP**®

The Wellness Recovery Action Plan® or WRAP®, is a self-designed prevention and wellness process that anyone can use to get well, stay well and make their life the way they want it to be.

or child or adult neglect, abuse, exploitation, or abandonment. If you are not sure exactly what or how to report, review these frequently asked questions on the Department of Children and Families (DCF) website.[12]

When a household presents in crisis, at minimum, we need to assess the following things:

- Is the person safe? If not, where can they go that will keep them safe?
- Do they need medical attention? If yes, what hospital do they prefer?
- Do they need mental health or drug/alcohol crisis services? If yes, do they have a preference on where to go?
- Is the person suicidal or homicidal? How serious are the ideations and thoughts?

If you begin to feel unsafe in a crisis situation – for example, it's a new client and you're not sure how volatile they really are – send an email to a coworker asking them to come join you. You may ask the client, "Do you mind if I get my coworker John to help out?"

Be sure to follow whatever protocol your agency has, and fully document these situations as soon as possible and inform your supervisor. If there are police or EMT involved, generally you will likely need to complete a critical incident report. A benefit to such a report is the opportunity to review and debrief to see if the situation could have been handled any differently. Each crisis presents a learning experience.

It is important to be familiar with the local providers and the protocol for addressing these situations. You need to know who to contact in case someone is suicidal/

homicidal or fleeing domestic violence, or if there is suspected abuse or neglect, or any other crisis. Without knowledge of these resources, your client's crisis can also feel like a crisis for you or your organization.

Another type of crisis planning is planning in advance for a crisis that may arise in the future. When working with households experiencing homelessness and/or other vulnerabilities, it is not unusual for a client to experience multiple crises. These patterns of crises can often be identified in the assessment process.

If it is discovered that the household is susceptible to crisis, then planning should be done to either prevent the crisis or to help the household handle the crisis. An example of a crisis prevention and planning tool is WRAP (Wellness Recovery Action Plan).[13] Not only does the WRAP guide the person in identifying specific actions to take toward maintaining wellness, it helps her identify signs of an impending crisis, and specific actions to take to prevent or address that crisis.

Here are some questions to help plan for a crisis:
- How will you know a crisis may be coming or you're in crisis?
- Who should be contacted?
- What information is okay to share with your support system?
- How have you coped with a similar crisis before?
- What does not work?[14]

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12 http://www.myflfamilies.com/service-programs/abuse-hotline/frequently-asked-questions

13 http://mentalhealthrecovery.com

14 View a Crisis Plan Example at: http://mentalhealthrecovery.com/wp-content/uploads/2015/07/CrisisPlan2012Manual.pdf

SMART

Goals should have the following the S.M.A.R.T. criteria.

| SPECIFIC | MEASURABLE | ATTAINABLE | RELEVANT | TIME BASED |

Action Plan

After the assessment, the next step in the documentation and case planning process is to develop the client's goals and objectives. Action plans can be called many things – service plan, housing plan, or treatment plan. For purposes of this guidebook, the term action plan encompasses all. In Appendix B, we provide examples of action plans for rapid rehousing and permanent supportive housing programs.

The action plan is the primary guide in the case management relationship. The plan outlines the client's needs, and the goals and objectives to address those needs. Even though there may be a set template to complete the action plan, the plan should not be "cookie cutter" or "one size fits all".

It is critical that the client be an active participant in this process of developing the action plan and that the plan is tailored to the client. The plan is not a form the case manager completes on behalf of the client; nor is it a laundry list of things expected of the client. The plan is formed based on what the client is stating as his goals.[15]

In the health care and disability rights arena, the saying "Nothing about me without me" is often heard. This is a reminder to the helping professions that the client's views must be central to care planning and interventions. In ac-cord with this view is the Substance Abuse and Mental Health Administration (SAMHSA), saying: "Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals."

If the assessment has done a thorough job exploring the client's barriers, strengths, and needs the action planning process will be a natural next step. Goals should have the following the S.M.A.R.T. criteria.

Specific: The goal should be understandable and clearly stated. Specificity should also include who is responsible for each step to achieve the goal.

Example: Client, assisted by the Housing Locator, will obtain safe, decent, and affordable housing within 30 days of intake.

Measurable: How would we measure this goal?

Safe housing is based on client's reported feeling of safety. Decent housing means the housing has passed habitability standards. Affordable housing means the expected housing costs are less than the current HUD Fair Market Rent (FMR) for a one-bedroom rental unit.

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15 https://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/#.Wr55Ci74-DI

Alternatively, affordable could mean the client's housing costs (after subtracting the value of any housing voucher or rent assistance) are less than 40% of the household's expected income.

Attainable: Is this goal attainable based on the client circumstances and agency resources? In many markets, it is not possible to find an affordable rental unit in what are seen as the safest neighborhoods. In this case, the client should be provided options – living further away but in a safer more affordable neighborhood or living in the city in a neighborhood that might not feel as safe. Alternatively, there may be steps the client and provider could take to ensure more safety (e.g., installing a dead bolt lock with the permission of the landlord).

Relevant: Is the goal relevant to what the needs are? If permanent housing is the goal of not only the client but your organization as well, then this is an obvious yes. However, if your organization provides only employment services, this specific housing goal would not be as relevant as an income and employment goal. However, housing should still be a goal in any program serving a household experiencing homelessness. The steps under the goal may be different, however. For example, if the goal is "Client will obtain safe, decent, and affordable housing", then the steps to achieve that goal might be "1) Refer client to Coordinated Entry to complete a housing assessment and 2) Follow up with Coordinated Entry every Monday to determine housing eligibility."

Time Based or Time Limited: The goal should have a start date and an end date. Each step towards the goal should also have an end date. Setting completion dates help keep everyone moving forward and continuously working on the goal. The action plan should be reviewed at least every 30 days, in some case much more often. It may be helpful to review it at every client meeting to ensure the goals and steps are still valid. Edits can be made to keep the plan up to date and relevant.

Exit Plan

The exit planning process is important for several reasons and should be a part of the conversation throughout the relationship.

1. It details how the client will know when the end of services has been reached.

A major role of a case manager is to help clients achieve the goals they have set for themselves within the context of the specific program. The time limited services in most, but not all, programs need to be an intentional discussion beginning at the start of the relationship to provide transparency.

2. It sets a clear mark of success.

Exit planning helps the client to connect goal setting with goal achievement. Every program has specific outcomes that help guide the case manager in understanding when to close a case. Does this information get communicated to the client? Discussing what success in the program looks like and how that transition takes place will help clients from feeling "blind-sided" or abandoned when case closure is imminent. The measure of success is clear to everyone involved and the case closure is mutually agreed upon, whenever possible.

3. It provides the client with a plan for ongoing stability.

Prior to case closure, the case manager should meet with client to create a follow up plan. What resources are available for the client at this point? What support networks does the client have? The plan provides the client with information on who to contact if further help is needed after case closure.

4. It provides valuable feedback for program evaluation.

At discharge, did the client have the resources necessary to remain stable? Did the household feel they completed their goals? Is the client doing better than the initial assessment?

Just like the action plan, the exit plan takes into consideration the resources and strengths of the household. This document must be a collaborative effort between the case manager and client.[16]

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16 An example of an exit plan is provided by OrgCode at https://d3n8a8pro7vhmx.cloudfront.net/orgcode/pages/313/attachments/original/1479235667/2014-Exit-Planning.pdf?≠1479235667

Just like the action plan, the exit plan takes into consideration the resources and strengths of the household. This document must be a collaborative effort between the case manager and client

Supervision

Critical to any human services program, supervision provides a space where case managers can learn and grow in their knowledge and skills. Supervision generally includes a one on one meeting with the supervisor where the case manager is free to discuss any challenges, concerns, or ideas.

Supervision should be a safe place, encouraging growth, self-care, and offering constructive feedback. At minimum, supervisors should meet with their staff once a month for supervision and review the case manager's case load, outcomes, and goals for the next month.

Additionally, supervisors might want to include a monthly group supervision. Group supervision is different than an

agency staff meeting or case conferencing about specific clients. Group supervision provides time for the staff of a specific program to brainstorm program ideas, work on team building, and give program feedback. Group supervision may include topics such as policy changes to a program, professional development opportunities, and reviewing program outcomes.

Supervision done well can help prevent burn out, help staff feel valued, and contribute to a positive organizational culture. It should also demonstrate that the organization prioritizes quality services and clients.

The Housing Crisis Response System

An important part of working with households experiencing homelessness is to understand the system that is in place to help prevent and end homelessness in your community. In most communities, the majority of funding for homeless housing and services comes from the Department of Housing and Urban Development (HUD). HUD provides this funding to states, local governments, and Continuums of Care. HUD describes the CoC funding program as follows.

> "The Continuum of Care (CoC) Program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness."[17]

Designated CoC Lead Agencies serve a variety of geographic locations that all have a different makeup. For example, some CoCs comprise only one county while others cover up to eight counties. The CoC is responsible for bringing all stakeholders together to help create a plan to prevent and end homelessness for their area. The CoC Lead Agencies also fund projects and agencies based on locally established priorities and processes. Such competitive funding processes include HUD CoC Program, Emergency Solutions Grant, State Challenge Grant, and others.

Under the HUD CoC Program, CoC Lead Agencies are able to fund the following types of projects: Homeless Management Information System (HMIS), Leasing and Rental Assistance, Permanent Supportive Housing, Rapid Re-Housing, and Supportive Services Only (SSO), with the latter typically reserved for Coordinated Entry System implementation. State and local governments receive other funding, such as Emergency Solutions Grant, that help fund activities such as outreach, emergency shelter, prevention, and rental assistance.

The graphic below identifies the necessary components in each community to help prevent and end homelessness. The next section provides descriptions of each component.

Outreach

Outreach is a necessary component of the system to help engage households who need housing and support services but may not often access the homeless assistance system. Many of these individuals are experiencing chronic homelessness and are very vulnerable while staying outside, in abandoned buildings, or in similar places. Outreach is not simply providing bug spray, tents, and food – the long game is to help the person move into housing.

Outreach should connect the household into the Coordinated Entry system to help them become prioritized for permanent housing options. The intention of outreach should always be to connect the household to housing and necessary supportive services. Dependent upon the funding source, outreach can include engagement, case management, connection to services, transportation, and connection to emergency services.
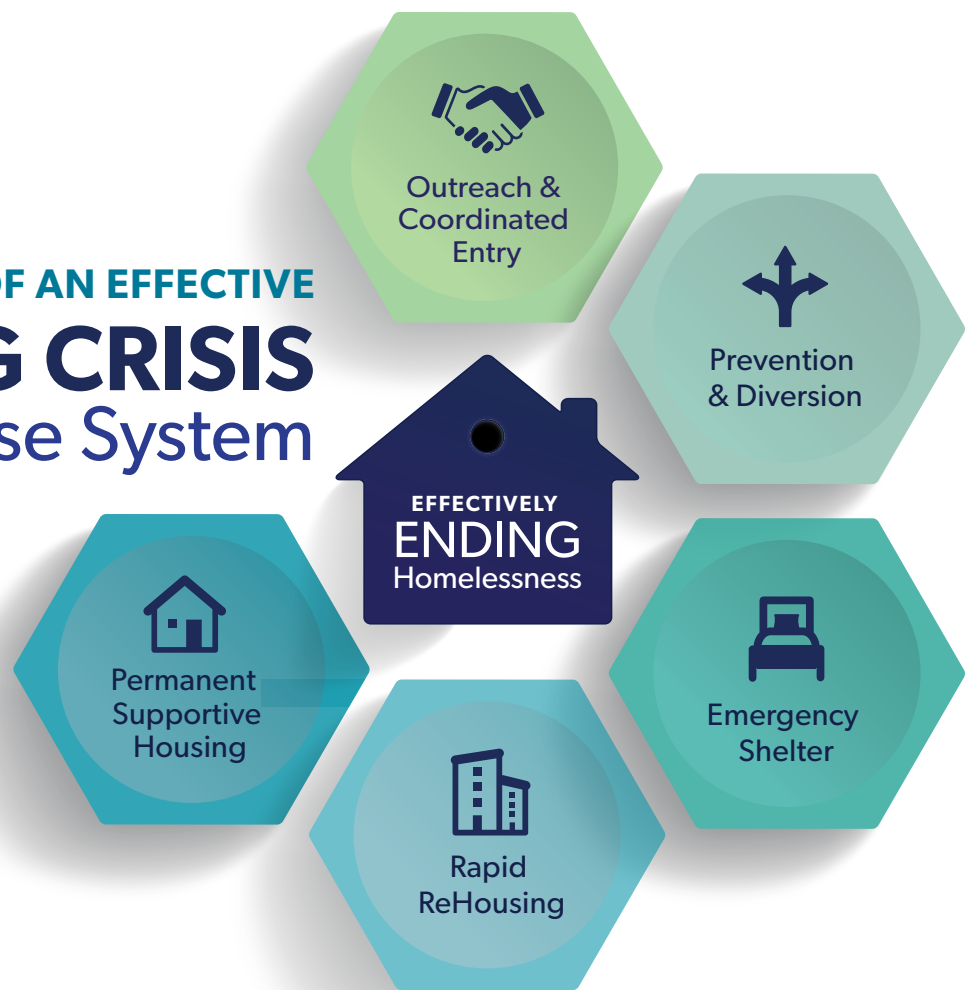
Coordinated Entry

Coordinated Entry is a process by which households experiencing, or at risk of, homelessness access the homeless assistance system and are connected to housing and resources to help resolve their crisis. The Coordinated Entry System may be referred to as Coordinated Access, Intake, or Entry. Coordinated Entry consists of four core elements.

1. **Access:** This is the process by which households can access the homeless assistance system to get help. Access can look different in each community. Your

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17 https://www.hudexchange.info/programs/coc/

COMPONENTS OF AN EFFECTIVE
HOUSING CRISIS
Response System

Outreach & Coordinated Entry

Prevention & Diversion

EFFECTIVELY ENDING Homelessness

Emergency Shelter

Permanent Supportive Housing

Rapid ReHousing

CoC might use 211, service organizations, a homeless hotline, or other agencies to help those households start the process of getting help.

2. **Assessment:** Once the household has accessed the system, a common assessment tool is used to determine the needs of the household. This assessment helps identify the household's barriers to returning to permanent housing. The assessment process may also assess eligibility for programs in the CoC. It should be noted that the term "assessment" is a misnomer here – the tool used should be more of a triage tool than a full assessment.

3. **Prioritization:** Prioritizing households is one of the most important roles of Coordinated Entry. Previously, many programs enrolled clients on a "first come, first served" basis. Now, however, based on the

assessment done through Coordinated Entry, the households should be prioritized based on their vulnerabilities. These prioritization factors can include things such as safety concerns, physical health issues, use of crisis services, whether or not they're unsheltered, behavioral health disorders, disabilities, and history of homelessness. The assessment, often along with collateral information from case managers and providers, informs how the household is prioritized. Households with the greatest barriers or highest acuity are prioritized higher than households needing less assistance. Prioritization ensures that households who truly have no other options and are the most vulnerable receive appropriate housing solutions. This list of households is often called a By-Name List, Master List, or Registry. Stakeholders should meet regularly to review the list and update vacancies in housing programs. While the CoC Lead

or another designated organization may coordinate the list, the process is a community wide effort and participation from all homeless housing and service providers is vital.

4. **Referral:** When a vacancy in a program becomes available, the prioritized household is referred to the program. At the point of referral, programs should enroll that household and provide immediate access to housing and services.

For Coordinated Entry to be most effective, all provider agencies within the homeless assistance system must participate. Coordinated Entry provides a more transparent process for households to access resources. Done well, it also makes the system more accessible and easier to navigate – for clients and providers.

Each CoC must have written standards detailing how households access the system, the assessment process, and how households are prioritized and referred. HUD requires every CoC to have a functional Coordinated Entry System. Any organization receiving HUD CoC Program and/or Emergency Solutions Grant (ESG) funding is required to use Coordinated Entry to fill vacancies in its programs; other organizations should use Coordinated Entry to fill their vacancies.

Prevention and Diversion

Prevention provides services and/or financial assistance to prevent someone from becoming homeless. The assistance is targeted to keep people in their current housing situation. Examples of homelessness prevention include mediation with landlords, legal assistance, and payment of past-due rent.

Diversion is a strategy that prevents homelessness for people at the point when they are trying to access crisis services, such as an emergency shelter. Effective diversion helps the individual or family stay housed where they currently live or helps them identify immediate alternate housing arrangements. When necessary, diversion may help by connecting the household with services, mediation, and or financial assistance to keep them from entering the homeless system. Many CoCs have embedded a structured diversion

process into the Coordinated Entry System, diverting up to 30% of households away from the homeless system.

Note that diversion is different from prevention, in that diversion catches the person at the point they are about to enter the system and diverts them to another solution. Homelessness prevention, on the other hand, assists the household prior to their accessing the homeless system.

Emergency Shelter

An emergency shelter is a facility operated to provide temporary shelter for people who are homeless. In an effective homeless assistance system, emergency shelters are "low barrier, low demand, housing-focused" shelters. They do not have barriers to entry (e.g., drug test, criminal records search); nor do they have extensive requirements once in shelter (e.g., required participation in meetings to or budgeting classes). Rather, they are focused almost exclusively on helping people get connected with permanent housing options. HUD's guidance is that the average length of stay in emergency shelter prior to moving into permanent housing should not exceed 30 days.

Rapid Re-Housing

Rapid Re-Housing is a housing intervention designed to move a household into permanent housing (e.g., a rental unit) as quickly as possible, ideally within 30 days of identification. Rapid Re-Housing consists of three components: (1) housing identification; (2) financial assistance; and (3) support services.

Financial assistance and support services should be tailored to the needs of the household. Assistance can be short or medium term (1-24 months) dependent upon the funding source. This intervention is the best way to help households with moderate to high barriers to obtain housing.

Permanent Supportive Housing

Permanent Supportive Housing (PSH) is a permanent housing solution best for many households experiencing chronic homelessness – 12 months or more of homelessness and a disabling condition. Through Coordinated

Entry, PSH should prioritize households that are the most vulnerable (i.e., have the highest acuity scores) and have no other options for assistance.

Like Rapid Re-Housing, PSH consists of three components: (1) housing identification; (2) financial assistance; and (3) support services. However, in Permanent Supportive Housing, financial assistance and support services are not time-limited; both must be available as long as needed and desired by the tenant.

Each component of the housing crisis response system is important for communities to help end homelessness. Coordinated Entry can help provide data on how many households are experiencing homelessness, the numbers of each household type and acuity level, and what types of interventions are needed. This information can help guide decisions on how to right-size each component to build the most effective and efficient system.

A Trauma-Informed Approach

A trauma-informed approach is crucial when working with households experiencing homelessness. People experiencing homelessness are at higher risk of experiencing trauma, and generally have a higher prevalence of past trauma. [18] Further, experiencing homelessness is, in and of itself, a traumatic experience; therefore, the system response needs to include trauma-informed services, shelter, and housing. The material in this section is based on guidance from the Substance Abuse and Mental Health Administration (SAMHSA).[19]

Understanding Trauma

There are three contributing factors to an incident being traumatic: (1) the event, (2) the experience, and (3) the effects. The event is the actual incident of trauma that occurs. The experience is how the brain processes the trauma and then how it immediately responds. Short-term and long-term effects are the result of how the individual experiences the traumatic event. The experience of trauma differs, sometimes substantially, even if the same event is experienced. Several factors influence the effects of trauma, such as age, frequency, and the closeness of the perpetrator.

Trauma affects how the brain responds to a situation. When the brain is "triggered" it goes into survival mode, focused only on the present potential danger, which limits the ability to think and make decisions. One way the brain is triggered is when people are asked about past traumatic experiences. Once the brain is triggered, it immediately reactivates the fear response.

Consider the implications for case managers. If the case manager is asking the client about past experiences or asking someone what's going on, the client may not be able to respond in a factual manner. From the brain's perspective the threat is actually happening again. That's why it is important to look at our assessments and other ways we are soliciting information from clients. Unfortunately, we can often retraumatize individuals through these processes.

One important study, the Adverse Childhood Experiences (ACE) study,[20] measured the correlation between childhood trauma and health risks later in life. The study found that the more adverse childhood experiences a

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18 https://www.nhchc.org/wp-content/uploads/2011/10/hh.04_99.pdf

19 See, for example, https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884; https://www.samhsa.gov/nctic/trauma-interventions; https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

20 https://www.cdc.gov/violenceprevention/acestudy/index.html

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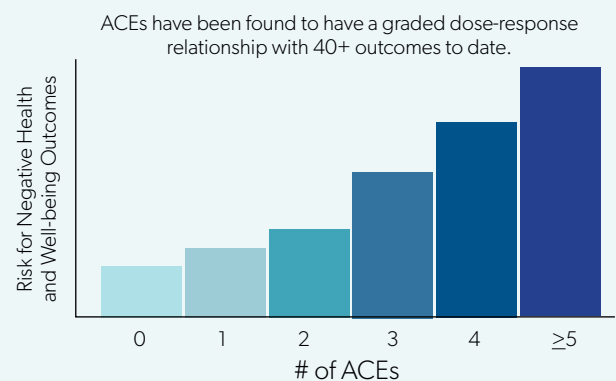## ACES can have lasting effects on….

Health (obesity, diabetes, depression, suicide attempts, STDs, heart disease, cancer, stroke, COPD, broken bones)

Behaviors (smoking, alcoholism, drug use)

Life Potential (graduation rates, academic achievement, lost time from work)

ACEs have been found to have a graded dose-response relationship with 40+ outcomes to date.

Risk for Negative Health and Well-being Outcomes

# of ACEs: 0, 1, 2, 3, 4, >5

This pattern holds for the 40+ outcomes, but the exact risk values vary depending on the outcome.

Based on image created by the Center for Disease Control at: www.cdc.gov/violenceprevention/acestudy

The National Center on Family Homelessness reports that

92%

of homeless American mothers

have experienced severe physical or sexual abuse in their lifetime.
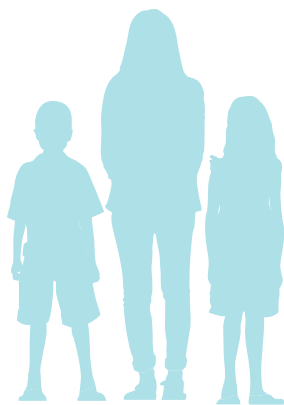
person had, the more at risk they were for things like substance use, physical health problems, poor work performance, etc. One of the researchers asked, "Is drug abuse self-destructive or is it a desperate attempt at self-healing, albeit while accepting a significant future risk?"

It is important to understand that many of our clients generally have experienced much trauma, and they may be coping with that in a way that doesn't make sense to us. Without understanding trauma, we may characterize the behavior as self-sabotage, noncompliance, or willful refusal of services.

Responding to Trauma

There are four main characteristics of a trauma-informed organization. A trauma-informed organization:

5. Realizes the widespread impact of trauma and understands potential paths for recovery;

6. Recognizes signs and symptoms of trauma in clients, families, staff, and others involved with the system;

7. Responds by fully integrating knowledge about trauma into policies, procedures, and practices

8. Resists re-traumatizing clients – intentionally or unintentionally.

Being trauma-informed is much more than learning a particular skill. It's about a complete shift in perspective in how we view the people with whom we work and how we interact with them. It's recognizing what we often label "difficult behaviors" as adaptations to trauma. A trauma-informed approach is about a way of being – our regard for those who come to us for help. While trauma disempowers clients, our response can empower them.

One skill imperative to being trauma-informed is empathy. Empathy is listening, withholding judgment, and connecting with clients authentically. It can be communicated as easily as saying, "I'm so sorry. That sounds difficult." You do not have to have been through similar life experiences in order to demonstrate empathy. It simply requires an openness to listening and responding in a genuine, compassionate manner. Further, if you have had similar life experiences, it is important to resist generalizing your feelings and process of recovery to others. Rather, one must recognize that similar events affect people differently and their paths to recovery and wellness often look very different.

Implementation

Becoming a trauma-informed organization requires intentional planning, action, and ongoing evaluation. Let's look at some considerations for policies and procedures, engagement and involvement, treatment, and training.

1. **Policies and Procedures** – Having trauma-informed policies and procedures is an organizational response that prioritizes the safety of everyone at the organization. When evaluating the organization's policies and procedures, consider the following questions:

a. What was the intention of the policy when it was created?

b. Is the policy in place for safety reasons? Is it having its intended effect (i.e. really making things safer)?

c. Do clients have a say in the evaluation and formation of policies?

2. **Engagement and Involvement** – Successful approaches understand how important it is to include the expertise of the clients served. When evaluating engagement and involvement, consider the following questions:

a. Is there a way for clients to provide feedback?

b. Is feedback taken seriously or is it often dismissed?

c. Are there clients or previous clients on the board of directors or other organization committees?

3. **Treatment** – A trauma-informed approach is different than trauma-specific interventions. Trauma-specific interventions are specific treatment modalities designed to address behavioral health and trauma. Some examples of these are Prolonged Exposure Therapy, Trauma Resolution Therapy, and Seeking Safety. It is important for clients to have access to treatment for trauma with the appropriate community providers. The role of case management is not therapy; therefore, this work should be left to professionals qualified to do this work.

4. **Training** – Training is key for all staff at the organization, regardless of their roles. When evaluating training, consider the following questions:

a. What training opportunities are available for staff?

b. Is trauma-informed care training a part of the onboarding process?

c. How do you evaluate the degree to which the organization is trauma-informed?

d. How do you evaluate staff's fidelity to a trauma-informed approach?

In conclusion, remember three important concepts for a trauma-informed approach:

- A shift in perspective from "What's wrong with you?" to "What happened to you?";

- Difficult behaviors are viewed as symptoms and adaptations to traumatic events; and

- Healing happens in relationships. Authenticity and empathy are critical for clients to feel empowered and begin to heal.

For more information, you can refer to SAMHSA's guidance on how to assess your organization and find solutions for implementing a trauma-informed approach.[21]

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21 https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf

Troubleshooting Difficult Cases

Working in human services can be very challenging work. It can cause stress and frustration, and sometimes lead to burnout, compassion fatigue, and secondary trauma. If we aren't careful, this stress can begin to impact the quality of our work and our lives. This section will discuss what makes a case difficult and how to effectively handle those cases.

There are many reasons to address what makes a case difficult, but let's review some of the most common ones.

- **Fear of failure/success:** The goals we are working on with clients sometimes encompass big life changes and that can bring up feelings of anxiety and fear. Change almost always comes with some fears, and when those changes are major, it may feel like too much change and the unknown. Being mindful that facing change causes uncomfortable feelings will help us empathize and offer support to help clients through these transitions.

- **Trauma:** As discussed earlier, it is very likely that clients have a history of trauma and/or are currently experiencing trauma. Our ability to recognize behaviors as symptoms of trauma will help us respond appropriately and diffuse or resolve difficulties.

- **Disabilities:** Many of the clients you will be working with will have disabilities. It's important that our services are competent and accommodating. Are the materials we are providing easy to understand and readable? Are we accurately assessing how much help a household needs? For example, some clients may need help filling out paperwork while others will not. It is always best to ask clients what help they may need and find ways to accommodate that or provide access to services that can.

Above are some reasons that clients present as difficult, but sometimes the "difficult" can come from us. Below are some reasons the relationship might be difficult from a client's point of view.

- **Insincerity:** People know whether you are being sincere or not. Part of the success clients experience is because we have been genuine in our work and have truly believed in their ability to meet their goals. If insincerity is detected, clients will disengage.

- **Too many cases:** You may be overwhelmed with the number of cases and tasks you are trying to manage, and that can lead to frustration over not having enough time to dedicate to each case. Progress slows down, and the quality of work begins to suffer. There is no magic number to figuring out the perfect number of cases. Caseload should be based on many factors, such as clients' acuity, intensity of services, whether home-based visits are appropriate, etc. It's important to be able to recognize when the quality of your work is declining and proactively ask for help.

- **Inexperience or lack of training:** It is simply a reality that there will be turnover and onboarding of new case managers with little to no experience in homeless services or case managers who have not been properly trained. Intentional focus on appropriate training, professional development opportunities, and supervision can make all the difference in helping the case manager gain the proper skills to work effectively with clients.

- **Lack of supervision:** Consistent supervision provides a safe setting where case managers can receive valuable feedback and review current challenges. Supervision should consist of feedback to help the case manager increase their knowledge and skills to be able to work more effectively with clients. As discussed earlier, supervision should be regular and prioritized, and may be individualized and/or group supervision in a particular program. When supervision is not prioritized, case managers do not receive the support they need from the organization.

Motivational Interviewing

When a case is difficult, and progress seems to be a standstill or slow, that is a signal that something is going on. We need to recognize that fact and address it in a non-

Motivational Interviewing:
Five Stages of Change.
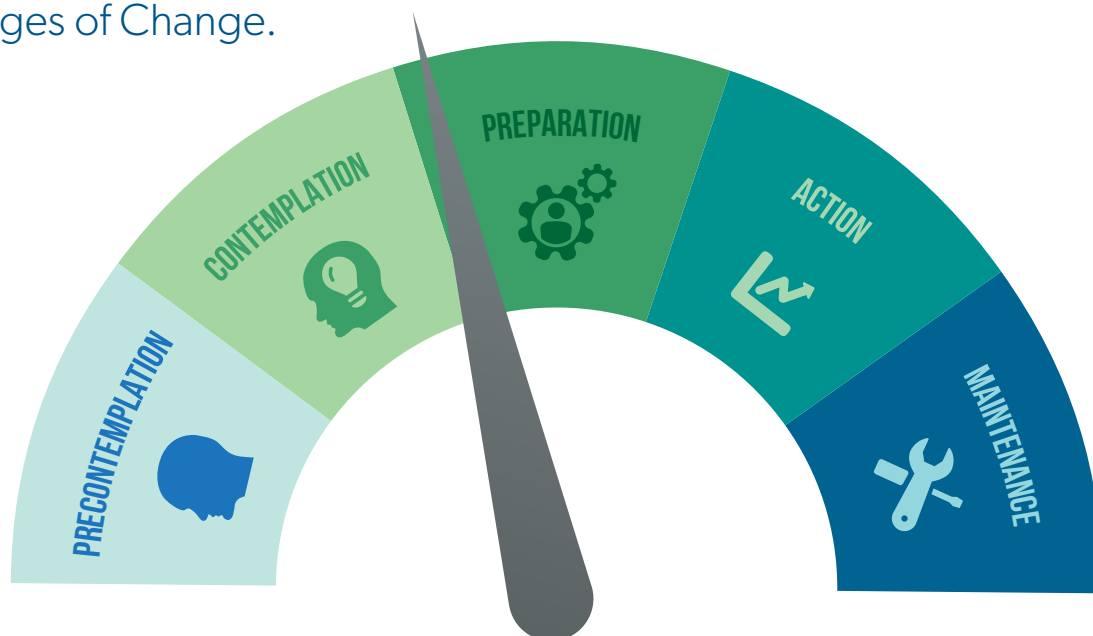
judgmental way. One great technique that helps clients progress through the stages of change is Motivational Interviewing. In this model, there are five stages of change.

1. **Precontemplation** – Clients do not even consider changing or do not think any change is necessary.

2. **Contemplation** – Clients are ambivalent about changing. Part of them wants to make the change and part of them does not.

3. **Preparation** – Clients prepare to make a specific change.

4. **Action** – Actions are taken by clients which demonstrate they are moving toward actual change.

5. **Maintenance** – Clients have incorporated the new behavior and made the change(s).

Motivational Interviewing (MI) is a style of interacting with clients to help them identify their own internal motivations and willingness to change. One of the strategies used to determine which stage of change exists for the client in a particular arena, is the use of the MI readiness ruler.

With the MI readiness ruler, clients rate themselves on a scale from 1 to 10, where 1 represents not at all ready to change and 10 is ready to make the change. Once clients rate themselves, you can find out what their ambivalence is about changing.

Let's look at an example. John has been residing at your emergency shelter for 6 months. He utilizes a lot of crisis services and does not seem to have any extended period of stability. No matter how many times you have tried to engage him, he continues to miss appointments. He has burned some bridges with housing programs because he is not following through with referrals you make. You feel frustrated and stuck because there

Motivational Interviewing (MI) is a style of interacting with clients to help them identify their own internal motivations and willingness to change

is no end in sight. It appears that John is in the precontemplation stage. Let's start with some basic questions we may want to find out.

- What are the goals listed on John's housing plan? Are these still his goals? Do we need to review/update the plan?
- Does there appear to be any discrepancy between the goals and his actions?
- Is there ambivalence?

Using the MI readiness ruler, I'm going to try and figure out why little to no progress is being made. I'm going to ask John to rate himself between 1 and 10 on being ready to make progress on his housing goal. Once a number is given we can ask the following questions:

- Why didn't you give it a higher number (e.g., why a 5 instead of an 8)?
- Why didn't you give it a lower number (e.g., why a 5 instead of a 1)?
- What do you see as the positives for leaving the shelter and moving into your own place?
- What do you see as the negatives for leaving the shelter and moving into your own place?

The questions help determine the readiness of the client for change, and what ambivalence they have about it. You can then summarize the statements, reflect them back to the client, and try to encourage and pull out his internal motivation for positive change.

Next, we'll take a look at the OARS skills for helping to facilitate conversation. The acronym OARS covers the following practices.

- **Open-Ended Questions:** Open-ended questions elicit more responses from the client. This gives the client the opportunity to talk about their own views and helps us guard against providing too much advice and getting only limited responses. For instance, we might ask, "When you think about the possibility of moving into your own place, what does that place look like?". One question that al-

ways helps steer clear of giving advice is, "How is that working for you?" This allows the client an opportunity to reflect on their actions and determine if that action is still serving a purpose for them.

- **Affirmations:** Affirmations provide an opportunity for us to point out clients' strengths and build a positive relationship. We might say, "Since the last time we met, you've really gotten a lot done! How did you manage all that?" It can also be as simple as thanking a client for showing up on time or asking for help.

- **Reflective Listening:** Reflective listening is paraphrasing what the client said and repeating it back. This helps clarify that you heard what they said. By repeating back what they said to you, it gives them opportunity to really hear their thoughts out loud. For instance, "You just mentioned you were too busy to look for a job? Is that right?" If they agree that's what they said, you can follow up with an open-ended follow-up question. If they say you misunderstood them, then you will have more clarity around their job hunt.

- **Summarizing:** Summarizing is similar to reflective listening but can also be a good way to transition to a new topic or close out the meeting. "So . . . you've put in three applications for efficiency apartments and should hear back from the landlords by Wednesday. That is a big step forward on your housing goal - congratulations. Given that progress, what are your next steps on your employment goal of finding another job to increase your income?"

MI is about listening to what the client is really saying and pulling those motivational statements out of them. It is the opposite of trying to provide advice and offer our solutions.

Use of Self
Use of self is a term used commonly in social work education. It recognizes that sometimes more important than mastery of skills or knowledge, is using who you are to relate and connect with clients. It combines your knowledge, values, and skills with aspects of your personal self like life

experiences, cultural heritage, and personality traits. [22] There are five ways in which you can demonstrate use of self.

1. **Use of Personality:** – If you ran into your client out in the community, would they be interacting with the same person as they met with in the office? Use of personality helps you be authentic and relatable to clients, thus making them more comfortable about opening up and investing in a relationship with you.

2. **Use of Belief System:** Belief systems do not just refer to religious or spiritual values. Our belief system is the way we view and understand the world around us. It is important that there is congruence between what we believe and the values and ethics of our profession. When our beliefs are not congruent, we end up judging clients. It does not always come out explicitly, but in subtle ways. For example, we may not advocate as strongly for a particular client because of what we think about the personal choices they are making. In other cases, it is more explicit, such as when we say someone is "not ready for housing."

3. **Use of Relational Dynamic:** Carl Rogers, a major influence in psychology, believed three attributes were necessary in order for the client to be open and make changes: genuineness, empathy, and positive regard for the client. These attributes help us create a positive relational dynamic with the client in which they can share openly and build rapport.

4. **Use of Anxiety:** Difficult cases produce some anxiety within us and it's okay to recognize and embrace it. What is important is to not become paralyzed by the anxiety or try to deny that you are experiencing it. Discuss it with your colleagues and supervisors to help build and develop more skill.

5. **Use of Self-Disclosure:** It's natural for us to want to share our experiences to help others, but you need to be cautious about that tendency in case management. The client may not be interested in your experiences; they may view your experiences as very different from their own, which dilutes their trust in you; and sharing may not be beneficial at all. In some cases, self-disclosure may tend to normalize their situation for them. A good rule of thumb is to get your supervisor's opinion on whether you should disclose your information. If in doubt, do not disclose.

Difficult cases are inevitable, but you have tools available to help: motivational interviewing, use of self, empathy, and authenticity. Developing these skills will help you deal more effectively with difficult cases and build your resilience over time. Another important way to build resilience and avoid burnout is self-care.

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22 http://www.socialworker.com/feature-articles/field-placement/An_Introduction_to_Use_of_Self_in_Field_Placement/

> Carl Rogers, a major influence in psychology, believed three attributes were necessary in order for the client to be open and make changes: **genuineness, empathy,** and **positive regard** for the client.

Self-Care

Working with households experiencing homelessness can be really difficult work. Self-care is important because burnout can happen so easily. If you do not have a self-care practice in place, it is inevitable that your work will be affected. Your relationship with yourself sets the tone for every other relationship you have.

To develop a better relationship with ourselves, we should first identify our core values and priorities. When we are living in congruence with our core values, then our lives feel more meaningful and we are more at ease with who we are. If your actions or feelings are not in line with who you would like to be, this is a sign that you need to refocus on your self-care practice.

Dialectical Behavior Therapy (DBT) offers some skills to help reduce emotional vulnerability and build resilience – the ABC PLEASE skills.[23]

Accumulate positive emotions – As part of your self-care practice, write down some pleasurable activities that help you feel positive. These activities should be easy and something you truly enjoy. Avoid activities you feel you "should be" doing and end up making you feel guilty if they are not accomplished. Pleasurable activities can include being in nature, going for a walk, listening to your favorite music, playing with your dogs, lighting a candle, etc. Focus every day on doing at least one pleasurable activity.

Build mastery: Identify where you are already good at something. Is there a special skill or talent you would like to improve? Building mastery includes finding something that makes you feel accomplished and continuing to challenge yourself. For example, if you like to paint, take a new class. Gaining new skills or improving an existing skill can help you feel proud of yourself. Challenge yourself with new things.

Cope ahead: Coping ahead helps you deal with difficult situations by preparing mentally ahead of time. Imagine the situation and prepare for how you are going to handle it. What are you going to say? How can you deal with it effectively? This strategy can be used personally and professionally. Playing the situation out ahead of time can help you stop avoiding it or worrying about it and decrease your anxiety.

PLEASE Skills: Treat your mind by treating your body well.

1. Treat PhysicaL illness
2. Balance Eating
3. Avoid Mood-Altering Substances
4. Balance Sleep
5. Get Exercise

Create a self-care plan to include goals for your mind, body, and spirit. Remember to be gentle with yourself and treat yourself well.

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23 McKay, Wood, & Brantley; The Dialectical Behavior Therapy Skills Workbook (New Harbinger Publications, Inc. 2007).

Working with households experiencing homelessness can be really difficult work.

⚠ Secure your own mask before helping others

Progress Note Examples

CLIENT VISIT RECORD			
Client Name:	*Mary Lamb*	**Date:**	*12/02/2018*
Type of Contact:	*Home Visit*	**Time:**	*3:30 p.m.*
Kept/Missed/RS	*Kept*	**Length of Visit:**	*30 min.*

Subject: *Housing Stabilization*

Note:
CM met with Ms. Lamb for a scheduled home visit.

Previous Actions:
-CL followed up with New Horizons and enrolled in the employment program. CL's first day will be on 1/8/19. New Horizons will provide transportation.

Actions:
- *CL requested a referral for the UCC food pantry. CM will fax a referral to UCC tomorrow.*

- *CM scheduled an office visit for 12/18/2018 at 9:00am. CM provided 2 bus tickets for an upcoming medical appointment.*

Amanda Rosado, CM

Goals Addressed:
Employment; Housing Stability; Transportation

Signature:	Date:

CLIENT VISIT RECORD

Client Name:		Date:	
Type of Contact:		Time:	
Kept/Missed/RS		Length of Visit:	

Subject:

Note:

Goals Addressed:

Signature:	Date:

Action Plan

RAPID RE-HOUSING EXAMPLE

My Goals for the next 30 days are:	Objective (tasks) I will complete to meet my goals:	Due Date of objective/task:	How RRH Team will help:	Due Date:	Progress on my objective/tasks (Date & Initial)
Housing: Maintain stable housing.	Abide by lease terms.	Ongoing.	XYZ Agency will pay $750 by Sept. 1st.	9/1/17	
	Communicate to the CM any problems as soon as possible.	Ongoing.			
	Pay my portion of the rent ($259) by Sept. 1st.	9/1/17	XYZ Agency will visit home 2x/month.	Every 2 weeks.	
Employment: Obtain full-time employment.	Fill out 5 applications.	8/15/17	CM – Complete referral to CareerSource.	As needed.	
	Visit CareerSource to meet with employment specialist.	9/1/17	CM – Assist with online applications.	8/15/17	
Goal 3:					
Goal 4:					

Client Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

PERMANENT SUPPORTIVE HOUSING EXAMPLE

My Goals for the next 30 days are:	Objective (tasks) I will complete to meet my goals:	Due Date of objective/ task:	How PSH Team will help:	Due Date:	Progress on my objectives/tasks during last 7 days: (Date & Initial)
Housing: Maintain stable, permanent housing.	Abide by terms of lease. Weekly office/home visits.	Ongoing. Weekly.	CM-Weekly home/office visits to ensure housing needs are met.	Weekly.	
Physical Health: Obtain full-time employment.	Schedule and keep medical appointments at U Clinic for HIV care.	Monthly	CM or PS-Assist with transportation as needed.	As needed.	
	Take medications as prescribed.	Daily	CCM-Follow up regarding medication adherence.	Weekly.	
Mental Health: Feel less depressed.	Schedule and keep an appointment with ABC Behavioral Health Provider.	02/15	CM or PS-Assist with transportation as needed.	As needed.	
	Make a list of meaningful daily activities (MDA).	01/30	CM-Provide list of MDA	01/30	
Benefits: Obtain SSDI/SSI benefits	Apply for disability benefits through SSA.	02/28	CM-Assist with the application process using SOAR.	02/28	

Client Signature: _____ Date: _____

Case Manager Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Staffing Form Example

Client Name			Date	Staff in Attendance *Use this section to identify staff present.*	
☐ Intake ☐ Annual Update ☐ Case Staffing					
☐ Pro. 1	☐ Pro. 2	☐ Pro.3	Change in Provider? ☐ Yes (attach audit form[*])		☐ No

Presenting Problems *Use this section for staffing new participants or for discussing clients that you are needing help with.*	Client Strengths *Examples: support systems, income, benefits, employment history, social strengths, health condition, etc.*
Client-Identified Goals (in order of importance) *Use this section to document what the client identified as their goals when asked in the intake/assessment process.*	**Staff-Identified Goals (in order of importance)** *Use this section to discuss what staff identified in discussion with client that seems to be importance to housing stability.*

Recommendations

Do not pre-fill this area. Leave it open and write in recommendations based on what is agreed up on in the staffing. This is really important!

Signature *All staff present signs the document after it is staffed.*	Title	Date

*Anytime there is a change in provider (case manager or whoever is handling their file) an audit of the file should be completed by the supervisor to ensure any missing documents can be remedied ASAP.

Client Name	Date	Staff in Attendance
Jane Doe ☑ Intake ☐ Annual Update ☐ Case Staffing	7/20/17	Jerry Lewis Mickey Mouse Cindy Crawford

☑ RRH	☐ PSH	☐ PSH-2	Change in Provider? ☐ Yes (attach audit form[*])	☑ No

Presenting Problems
- Currently homeless, staying at XYZ Shelter
- Only has 15 days left to stay
- No income
- 3 prior evictions
- Out of medication for anxiety
- No primary care or mental health care

Client Strengths
- Good employment history in food service
- GED
- Owns a car in working condition
- Keeps all documentation from case management, housing providers, identification, etc.
- Has $190 SNAP (food stamp) benefits

Client-Identified Goals (in order of importance)
- "I need my anxiety meds, I think I'm going to lose it at the shelter"
- "Please help me with a 2 bedroom apartment so I can have a place for my son to stay"
- "I'd like to get my CNA"

Staff-Identified Goals (in order of importance)
- Obtain housing within 15 days
- Obtain mental health care
- Obtain income

Recommendations

- Housing Specialist to check with XYZ Property Management and Scott Jones for 2BRs
- Housing Specialist to pull evictions off court website and see how much money is owed to prior landlords
- CM to reach out to XYZ Shelter and let them know we are working on a housing plan for RRH within 30 days in case a shelter extension is necessary
- Provide CL with information regarding Wellness Mental Health Clinic and assist with setting up an appointment if needed
- -Follow Up Appointment next week on 7/27/17 to review housing options

Signature	Signature	Date
Jerry Lewis	Housing Spec.	7/20/17
Mickey Mouse	RRH CM	7/20/17
Cindy Crawford	Housing Dir.	7/20/17

Sample Documentation Policies & Procedures

Documentation Characteristics

All documentation, including progress notes, staffing forms, critical incidents, and electronic records should be strengths-based and use person-first language. It is expected that the progress note will be thorough and easy to read. Documentation should include the case manager's name, signature, and date the documentation was recorded.

Homeless Management Information System (HMIS)

HMIS is the database in which progress notes and services will be entered. Training will be provided throughout the year by the HMIS Administrator. Employees are expected to attend initial training before using HMIS and participate in periodic training as needed. All data fields must be completed with enrollment date, HUD Universal data, household profile, and income information. It is expected that when household changes occur, those changes are recorded at the time the household reports the change. The household profile must be updated at least annually as long as the household is enrolled in services.

Progress Note Format

Progress notes should be complete and understandable. Case managers should write their names in the following format: "CM Last Name". Clients can be abbreviated to CL. Every progress note should include the date and time of the visit, the setting the meeting occurred in (e.g. office, home, jail), type of contact (e.g. electronic, phone, face to face), if the visit was kept, missed, or rescheduled, and the length of the visit in 15-minute increments. The progress note should include the purpose of the visit, any previous action items for follow up, new action items, and goals addressed during the visit. Follow up appointments should be set and documented at each visit.

Documentation Timeline

The intake progress note and file creation should be completed within one business day of the client's enrollment. All other progress notes are expected to be completed concurrently – either at the time of the visit or upon your return to the office. Progress notes should be completed no later than 48 hours after the contact. Notes should be printed and filed in the case file in chronological order with the most recent visit on top.

Privacy, Security, and Confidentiality

HMIS and physical files are the two ways client information is stored. HMIS user names should never be shared with anyone, including coworkers. HMIS should not be accessed on public Wi-Fi. Files are to be stored in a locked file with the key in a secure location. Files are never to be taken outside the office.

Client information may only be shared outside of the office with a signed release of information. Upon intake, clients should be asked to sign an HMIS release and any other necessary releases of information. These releases should be maintained in the client file. Within the organization, client information should only be discussed on a need to know basis, and never be shared in a public setting (e.g. waiting room, hallways, common areas), or in an email including identifying information.

Client information should never be viewable in front of other clients. For example, client information should never be left on top of a desk, on a copier/printer, or in some other shared area.

Clients have a right to request their information. Clients can complete a release of information for their own records. Record requests should be provided within a reasonable timeframe.

Case Planning

Case managers are required to visit clients once a month at minimum. The initial client staffing should direct how many visits are expected each month to help the client achieve their goals. Staffing meetings are held weekly and allow for time for new cases and cases that need attention. Staffings are solution-focused and focus on the strengths and resource the household has to help them resolve their housing crisis.

The initial action plan should be completed within two weeks of enrollment. Action plans should be housing-focused and include steps clients can take to obtain and maintain housing. Action plans are updated at least monthly. It is encouraged that the plan be discussed at each visit to ensure the plan goals are being worked on.

All services are voluntary for clients; however, it is expected that case managers will use assertive engagement to continue to try and reach the clients. Dependent on the project, some clients may be required to meet with the case manager at a certain frequency. Clients should be made aware of this requirement at enrollment.

Every attempt should be made to engage the household. All attempts should be documented in HMIS as a progress note. After 30 days of no contact, a letter should be mailed to the client informing them that you are trying to reach them, and then request client to call or come in to make contact. If contact is not made within 30 days of mailing the letter, the client's case should be discussed at the next staffing. The supervisor will recommend next steps for either re-engaging the household or beginning case closure. The client should be notified by an attempted phone call and letter of the date of intended case closure and the process for receiving help in the future.

Critical Incidents

Critical incidents are any client incident that involves emergency services, police, fire and rescue, or psychiatric and other hospitalization. A critical incident form should be completed immediately, detailing who was involved (client, staff, emergency services, etc.). As much information should be collected as possible including names, positions, agency names, and contact information. A progress note should also be completed immediately. The progress note and critical incident form should be submitted within four business hours to the immediate supervisor. After review and signatures, the critical incident form will be filed with the progress note. If the client is hospitalized, attempts should be made to obtain a release of information for care coordination.

Resources

RESOURCE	WEBSITE	NOTES
Florida Housing Coalition	www.flhousing.org	Provides affordable housing resources, training, and consulting to help communities end homelessness and increase access to affordable housing.
HUD Exchange	www.hudexchange.info	Information on all HUD funded programs and regulations on eligible activities for programs (e.g., HUD CoC PSH, ESG Rapid Re-Housing).
National Alliance to End Homelessness	www. endhomelessness.org	Provides webinars, tools, and other resources to help homeless programs such as emergency shelter, PSH, and Rapid Re-Housing.
OrgCode Consulting, Inc.	www.orgcode.com	OrgCode's website has several tools (e.g. budgeting forms, exit plans, crisis plans) to help with housing-based case management; also includes VI-SPDAT and SPDAT, and an insightful blog.
Substance Abuse and Mental Health Services Administration (SAMHSA)	www.samhsa.gov	Provides a national registry of evidence-based practices, webinars for professional development, and up to date information on substance abuse and mental health treatment.
Corporation for Supportive Housing (CSH)	www.csh.org	Provides guidance on developing and operating supportive housing; also provides webinars on topics such as voluntary services, Medicaid billing, and supportive housing.
DCF Office on Homelessness	http://www. myflfamilies.com/ service-programs/ homelessness	The statewide contact coordinating resources and programs; also includes contact information for all Continuum of Care Lead Agencies.

ACCESS AN ELECTRONIC VERSION OF THE

CASE MANAGEMENT GUIDEBOOK FOR

Supporting Households Moving Out of Homelessness

AND OTHER VALUABLE RESOURCES UNDER THE PUBLICATIONS TAB
ON THE FLORIDA HOUSING COALITION'S WEBSITE AT:

WWW.FLHOUSING.ORG