Calgary Homeless Foundation

Standards of Practice

Case Management for Ending Homelessness

2011 Edition

Accreditation Process

&

Standards Manual

Canadian Accreditation Council
Since 1974

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Standards of Practice

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Canadian Accreditation Council of Human Services

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PREAMBLE

Calgary's updated *10 Year Plan to End Homelessness* identifies as a key goal, to coordinate and strengthen the homeless serving system. One strategy to ensure this is the development of standards of quality care amongst different organizations providing Housing First services to homeless Calgarians. Case management has been recognized as a key intervention for sustaining housing.

A combination of case management and housing supports is the most successful approach to ending homelessness because individuals and families must be able to find permanent and affordable housing, accompanied by the appropriate services and supports to ensure that they remain housed.[i]

Providing case managed supports over a period of time reduces both the length of time of homelessness and the reoccurrence of homelessness.[ii] In one study, those with complex needs showed a 100% increase in the number of days successfully housed when their case managed supports were balanced with appropriate housing.[iii] In another study in Fayette County in the US, only 3% of people accessing case managed supports returned to a homeless state following completion of service.[iv]

The purpose of Housing First is to reduce barriers so people are supported to sustain their housing and prevent future homelessness. The purpose of this document is to provide a set of common standards of practice for case management to ensure that no more than 10% of people in Housing First programs return to a state of homelessness.[v]

THE STANDARDS PROCESS

The Calgary Homeless Foundation (CHF) engaged in an 18 month process to develop these standards. We conducted interviews with the local community, national and international experts, people who had or are experiencing homelessness, and included a review of the relevant literature (including case management standards from other disciplines) to determine best and promising practises in case management specifically in a homelessness context. Though programs funded by the CHF are contractually obligated to adhere to these standards, due to the comprehensive process to determine best practices and the opportunity to ensure consistent and standardized processes across the service system, other case management programs working with people experiencing homelessness are encouraged to adopt these standards.

In 2011 the CHF will initiate a review process with funded case management programs to ensure appropriateness and practical relevance of these standards. In 2011-2012, the CHF will work with key stakeholders to determine a process for ongoing review and adaptation of these standards as part of its system planning work. The 2011/12 initial phase of implementation will be used to enhance standards with learning's and strengthen these for continued relevance. Funding contracts will include the standards as a requirement for funding for case management services.

DEFINING CASE MANAGEMENT

Case management for ending homelessness is: a collaborative community based intervention that places the person at the centre of a holistic model of support necessary to secure housing and provide supports to sustain it while building independence.

For case management in this context to be successful it must be focused on the right- matching of services, it must be:

- person-centered
- adaptive
- individualized
- culturally appropriate
- flexible
- holistic
- multi-disciplinary
- include advocacy that leads to self-advocacy
- focused on establishing networks and relationships
- and include coordination and engagement

KEY PRINCIPLES

1. *Active Engagement to ensure successful completion*

   Case managers' primary responsibility is to ensure successful transitions from homelessness into a permanent experience of being housed. Prior to any discharge, the case manager must complete a formal due diligence protocol to ensure all efforts have been utilized to engage, stabilize and support the person. All program discharges will include a formal, documented process.

2. *Support people's rights*

   Case managers need to build a successful relationship with people to be able to support their choices and decisions based on their identified goals.

3. *Specific, purposeful treatment*

   Case managers need to work with each person individually with specific care plans based on that individual. When working towards the person's goals, the case manager should provide them with the highest calibre of services available to help their individual needs.

4. *Collaboration with others*

   Service provision is not the job of one individual, but of a community. Case managers engage several different kinds of care providers to help people achieve their goals. The person accessing services therefore has a group of people supporting them, and all of these people must work together and communicate effectively as a team.

5. *Ethical and accountable work*

   Case managers need to provide effective, organized, and individualized care to meet the needs of the people they work with. They need to promote self-care and independence, and keep up to date with changes in the goals or needs of the person. Case managers need to use care resources ethically and within the financial means allotted.

6. *Culturally competent*

   Case managers need to provide services that work with the person's beliefs, values, and practices. Case managers should be competent to the differing needs of different people and become aware of cultural knowledge to aid them in being culturally conscious and effective in supporting people.

   —From the National Case Management Network[vi]

Morse[vii] expands the above principles in case management specifically for ending homelessness:

- Outreach that is assertive and persistent to engage people on their terms
- Active support to help people access needed resources
- Person-centered and focused, based on what the person wants
- Respect for person's autonomy
- Trust and strong relationships are a must

THE STANDARDS

The standards of practice for case management are separated into five categories:

- Privacy and Information Management
- Activities of Case Management
- Training and Core Competencies
- Processes of Case Management
- Service Delivery

OVERVIEW - CANADIAN ACCREDITATION COUNCIL

MISSION

The Canadian Accreditation Council of Human Services (CAC) is dedicated to a peer review process based on best practice standards, ensuring human service organizations focus on service excellence.

VISION

The Canadian Accreditation Council of Human Services is the nationally recognized benchmark for standards excellence.

PRINCIPLES

- Person Served-Centred Services
- Ethical Practices
- Continuous Improvement
- Solid Business Practices
- First Nations, Métis and Inuit Involvement
- Cultural and Diversity Inclusion

OBJECTIVES

- To develop standards for the accreditation of human service organizations
- To develop and provide training to support accreditation
- To support organizations and programs to develop governance structures, monitoring systems and researched-based practices
- To accredit human service organization with a specific focus on programs and service delivery
- To achieve excellence in the delivery of services

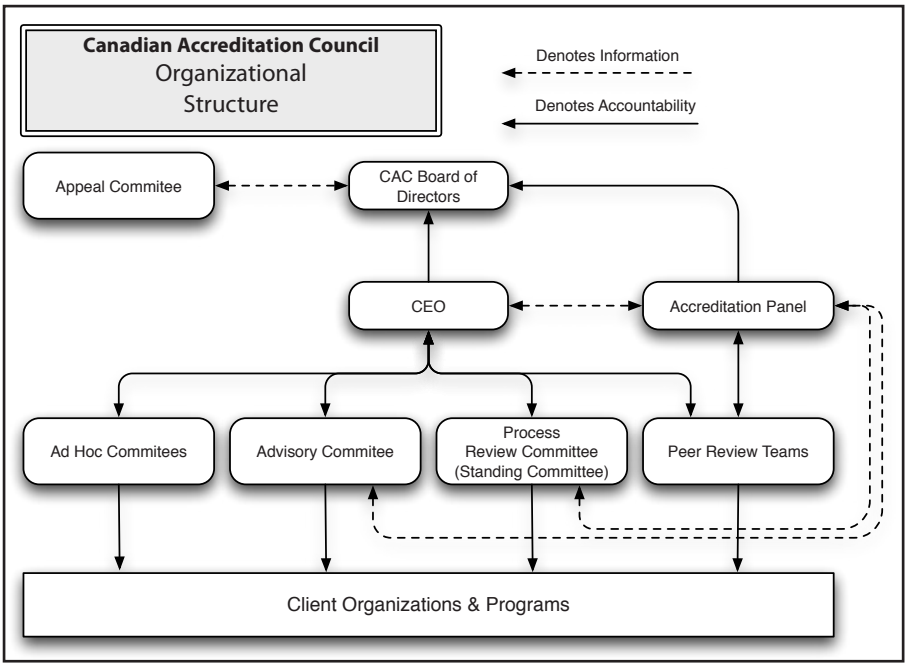
HISTORY

CAC is a Canadian based, not-for-profit accrediting body grounded in its strong grass roots history and its commitment to an evolving future of excellence in practice.

CAC was founded in 1974 and has evolved from being a program of Alberta Association of Services for Children and Families (AASCF), formerly Alberta Association of Child Care Centres, to being an independent not-for-profit corporation. Since becoming an independent organization, CAC has revised standards, improved processes and broadened the focus to include a wider range of human service and health based organizations. CAC works in partnership within a network of organizations and individuals to develop and refine not only our standards but our accreditation process.

CAC remains true to our grassroots history and is committed to the delivery of quality programming, evolving practice, personalized service and the provision of ongoing support.

STRUCTURE



CANADIAN ACCREDITATION COUNCIL REVIEW PROCESS

CAC has a long history of supporting programs and organizations as they move towards service excellence. From our inception, our founders have been committed to the development of process that would teach rather than impose regulations. It is CAC's belief that accreditation should support the internal development of programs by building capacity through the application of the accreditation process.

The review process has evolved since 1984 to provide a complete evaluation of the organization and the program and services they provide. Our experience in accreditation processes have demonstrated that although standards can be well documented (within policy, procedures and file reviews), the experience communicated during interviews with personnel and client may reveal a different reality. To ensure that standards have been fully implemented into practice the CAC review process measures organizations and programs on multiple levels.

The objective measurements are performed in the review of policies, procedures, documents and files along with the on-site observation made by the Review Team.

The subjective evaluations are performed during the interviews of senior management, supervisors, direct service staff, and the client. Through the interviews the review team assesses how each individual perceives their role and the current practices used within the service delivery model. This information is then measured against the documentation (files, tracking records) to determine the level of implementation of practice and the compliance to standards.

As the client is the focus of the delivery of the service it is important that their experiences are evaluated. Adjustments are made during the review process in order to accommodate client who may have emotional, cognitive or physical impairments. In general, when interviewing clients, conversations around their experience will focus on four main areas:

Safety and Well-Being: Reviewers will engage with the client in conversation to determine whether the client feels safe in the environment, with the staff as well as with the services that are being delivered. Reviewers will also evaluate the sense of well-being the client feels at this particular point in their life (such as if they are happy, hopeful about the future, encouraged, empowered, etc.).

Inclusion: Reviewers will evaluate what level of control the client has in making decisions about their life. Is the client involved, being included or leading the decisions about their life or are the personnel making the decisions for them? It is CAC's belief that clients need to feel they have control over their lives and are encouraged to lead the decision making process whenever possible.

Accommodated for their Uniqueness: In the past individuals who required services were forced to adapt to a program in order to access the services. CAC believes each person is unique and requires service providers to respond to each client in a manner that is reflective and accommodating of their uniqueness. The Reviewers evaluate examples provided by the client in regard to how the program accommodates them and responds to their specific situations and choices.

Achieving Goals: Reviewers will evaluate whether clients feel they are moving toward achieving personal goals or if they feel stuck and have no defined direction. The Reviewers will evaluate examples provided by the client and examine documentation to determine the level in which the program supports, guides, advocates, or facilitates opportunities for the achievement of their goals.

All information from the interviews of clients, (including their experiences and disclosures) will be compared to the documentation in the files and the organization's records and policies. This is to ensure that the best interests of all clients are being considered and supported throughout the delivery of services.

SUPPORT FOR QUALITY IMPROVEMENT

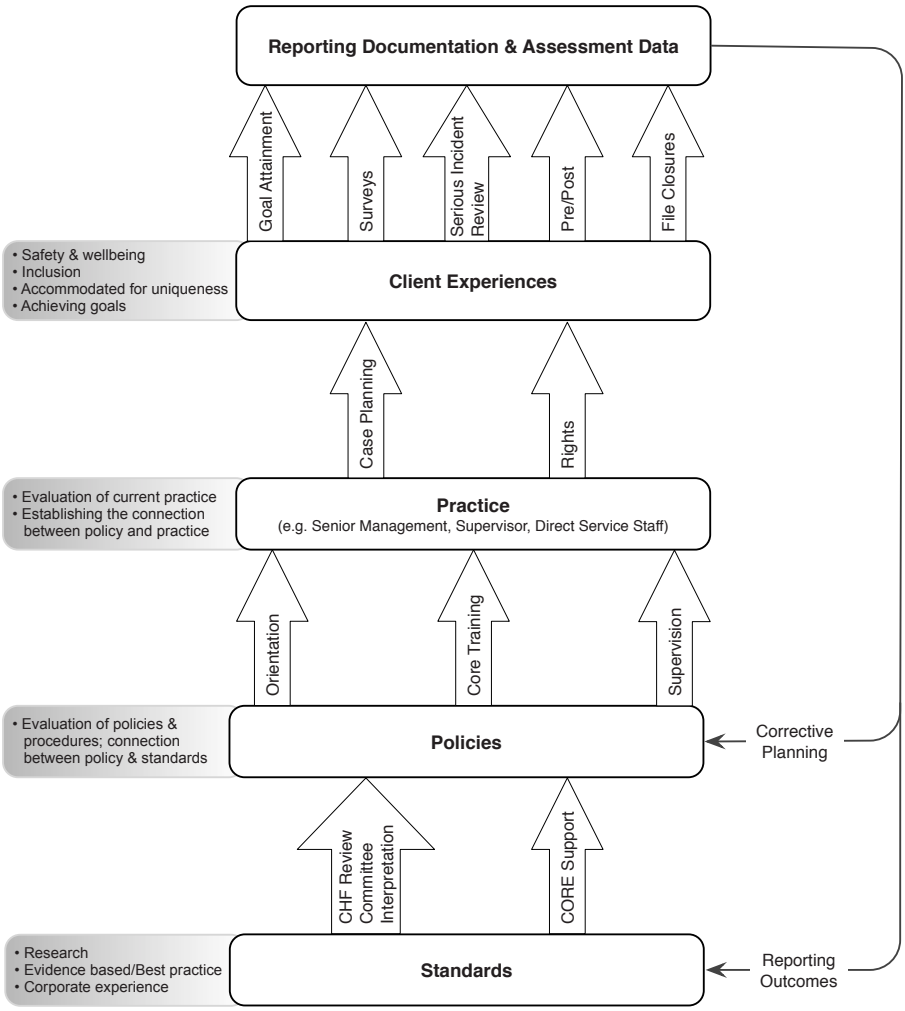
The review process measures the level of congruency within the organization's hierarchy (senior management, supervisors and direct service staff) with respect to working within the service delivery model to achieve the goals established for the organization and their respective programs.

CAC ensures that organizations are grounded in CHF standards which are clearly represented in their policies. Once satisfied that the policy is congruent with standards, the policy is then compared to the practice in the program to ensure there is consistency at the practice level. In the practice evaluation all levels of staffing are interviewed to determine if there is a clear and consistent understanding of practices throughout the program.

Once the practice is evaluated, the review process proceeds to examine the experiences of clients to ensure an experience of the client is congruent with the practices and policies of the program.

Finally, the quality improvement activities are reviewed to verify that what is reported was observed and evaluated by the review team. Throughout this process the Review Team is aware of the emerging pattern of practices and will engage the organization throughout the process for additional information or insight into what is being observed.

EVALUATION PROCESS



STANDARDS

ACCREDITATION STANDARDS

Standards provide for the structure and process to ensure safety, excellent practice, outcome measures and quality assurance systems in all programs.

The intent of having standards and an accreditation process is to:

- Assist organizations to become better service providers by supporting opportunities to learn and adapt
- Enhance service delivery through an increased focus on structure, internal processes, outcome measurements and established quality assurance
- Provide programs a strong foundation from which to build
- Provide organizations with both professional and public recognition of their achievements

Accreditation standards are a series of descriptive statements that outline how a program structures its systems and practices.

Standards are divided into five areas:

1.0 ***Privacy and Information Management***

2.0 ***Activities of Case Management***

3.0 ***Training and Core Competencies***

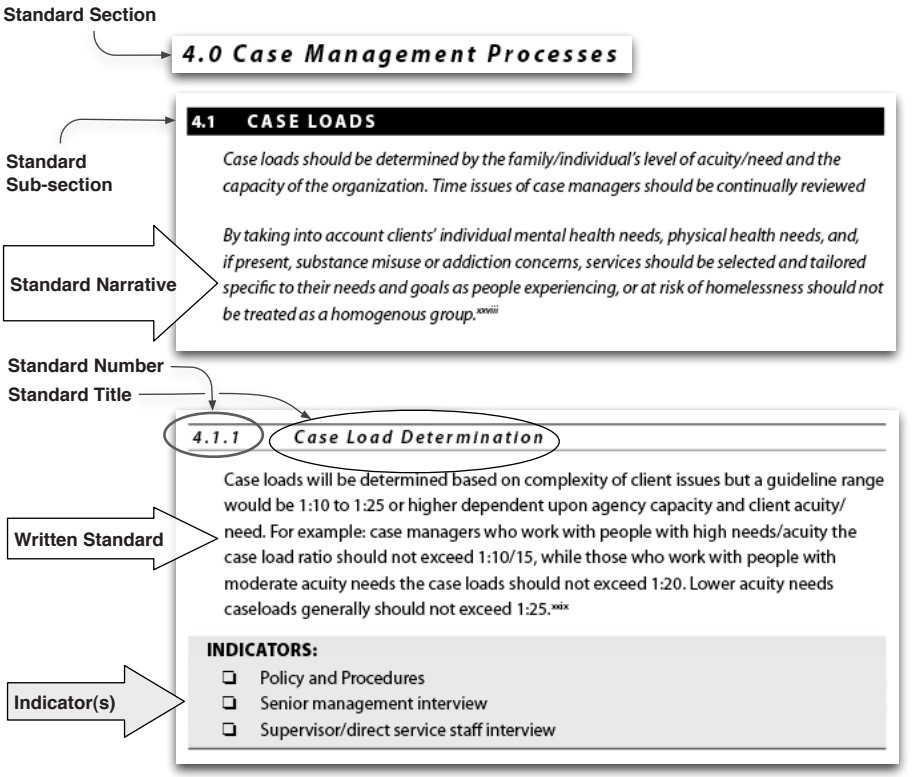
4.0 ***Case Management Processes***

5.0 ***Service Delivery***

READING THE STANDARDS

Each standard is comprised of six parts (see following example):

- Standard Section
- Standard Subsection
- Standard Narrative [this may include background or context]
- Standard Number and Title
- Written Standard
- Indicator(s).



INDICATOR

For each standard there are indicators which are used to direct the evaluation of the services. The indicators include:

Policy: The organization ensures that the program has policies to address all aspects of the standard. Policies are the written basis for operation and provide a clear directive for decision making.

Procedure: The directions for daily operations that are conducted within the framework of policies and include detailed step-by-step outlines to accomplish specific tasks.

Interviews: Senior management, supervisors and direct service staff are interviewed as to their practice. Clients are interviewed as to their experience within the program. It is expected that practice and experience are congruent to program policy and procedures.

File Review: Senior management, supervisors, direct service staff and clients files are reviewed on-site to assess compliance. Only those records/documents identified within the standards need to be seen by the review team. Random selections of client closed files are included in the review.

On-Site Observation: The team observes and assesses practice on-site.

The indicators are measured to determine the level of demonstrated practice in relation to the standard measurements are determined as follows:

Measurement scale

Level	Measurement of Implementation
5	**Exceptional implementation of practice** – Organization has evidence to support innovative practices and has established new benchmarks of excellence with a high degree of consistency within the delivery of the program/services.
4	**Commendable implementation of practice** – Organization has evidence to support the established practice with a high degree of consistency within the delivery of the program/services.
3	**Proficient implementation of practice** – Organization has evidence to support established practice with a proficient level of consistency within the delivery of the program/services.
2	**Incomplete implementation of practice** – Organization has the structures to support practice (policies, forms monitoring systems etc.), but lacks full implementation or evidence to support the practice.
1	**Insufficient implementation of practice** – Organization lacks the evidence and/or cannot consistently demonstrate practice.
0	**No implementation of practice** – Organization cannot demonstrate practice.

ACCREDITATION

Accreditation refers to a formal review process by which a recognized body, generally non-governmental, assesses and recognizes that a program meets applicable predetermined and published standards.

PURPOSE OF ACCREDITATION AND COMPLIANCE TO STANDARDS

There are a number of approaches used to understand accreditation and compliance to a set of standards:

- At one end of the continuum are programs that see the value of accreditation and use the accreditation processes and standards as a tool to demonstrate excellent practices
- At the other end of the continuum are programs that see no value in accreditation and are only responding to pressure from an outside body, usually the funder

Research supports that programs that understand and value accreditation as a viable tool to assess and ensure quality service delivery are more able to ensure quality assurance, consistent practice and positive outcomes, while learning and growing as part of the experience.

CAC works diligently to assist programs to build capacity through the application of standards and the accreditation process. CAC supports programs in utilizing the accreditation process as a useful and meaningful tool to establish excellence in service delivery, practice, support and outcomes.

CONDITIONS OF ACCREDITATION

Programs that demonstrated the required compliance to CHF standards are granted accreditation status by the Accreditation Panel. Programs are accredited for a period of 3 years.

The Accreditation Panel requires that programs of the organization demonstrate compliance to the CHF standards and accreditation reporting processes on a consistent basis.

CAC accreditation status is not transferable:

- From one program type to another
- From one location to another (unless previously discussed with CAC and is being operated by the same management and staff)
- From one owner to another

NEW ORGANIZATION

Organizations may initiate the accreditation process prior to the programs becoming operational. They may submit their pre-site materials (policies and procedures) as soon as they have been developed, which may be months prior to hiring staff or providing service to clients.

The on-site review will not be performed until the program has had clients in it for at least six (6) months. Normally the on-site review will be scheduled in the first 9 - 12 months of operating.

Programs will complete the pre-site and on-site review within 2 years of applying for accreditation. If the on-site has not been completed in the timeline, the program will be withdrawn from the process and re-apply to re-start the CAC accreditation process when they are ready to undergo the review process.

EXPANDED PROGRAMS

Organizations with CAC accredited programs are permitted to expand those existing program(s) up to 25% of the originally reviewed services. Once an organization expands services to exceed 25% a written notification is required to inform CAC of the type and nature of the expansion. CAC will endeavor to support the growth and development of the programs; however, will reserve the right to determine the capacity of the organization to support the proposed expansion of services. If it is determined that the organization does not have the capacity to support the expansion of services the program will be required to undergo the Interim accreditation process.

EQUIVALENCIES WITH OTHER ACCREDITING BODIES

Programs that are accredited by another accrediting body may apply for an equivalency to have the program also accredited by CAC (i.e. programs shared with other organizations that use another accrediting body or have some programs currently accredited by another body) using a modified CAC accreditation process:

- Programs will submit an Application for Equivalency, along with current accreditation certificate, to be exempt from a full accreditation process, at least 6 months prior to the anticipated site review date
- The program prepares a comparison document between the CHF standards and the standards of the other accrediting body (on a standard by standard basis), identifying standards that are fully or partially comparable as well as any gaps where there is no comparison. Once this document is complete it is submitted to CAC (minimally 4 months prior to the site review date)
- CAC will forward this document to the Adhoc CHF Committee for review and recommendation
- The CHF committee will identify the standards not found to be covered by the other accrediting body and recommend a process to have the missing standards addressed (i.e. a partial review of the program which may involve interviews, review of documents and on-site observations)

CAC accreditation will be granted by the Accreditation Panel upon consideration of the documentation for equivalency, certificate of accreditation by the other accrediting body as well the On-site Report addressing the missing standards (if any).

MAINTAINING ACCREDITATION BETWEEN REVIEW YEARS

Programs must operate in compliance to CHF standards.

Programs review their compliance to the standards on an annual basis and forward to CAC an Annual Declaration of Compliance to standards. Annual Declaration of Compliance will report:

- Updates to changes in address, contact information, location, senior management, ownership and/or legal status
- List of Programs/Services (identify new and/or closed programs within the last year)
- Type of programs with accreditation expiry dates
- Changes in program, (name, size, focus and/or location)

In addition, it is an expectation that programs will notify CAC (within 30 days) of the following:

- Serious incidents involving the death or major injury to a client or staff
- Change of ownership of the program or organization
- Location change for the program
- Program closure
- Program re-opening
- The organization is found to be negligent by the courts or a judicial inquiry
- Allegations made against organization staff or programs which are investigated and are substantiated

Failure to comply with the preceding may result in the accreditation status of a program being suspended or revoked.

RE-ACCREDITATION

Prior to the expiration of accreditation status the program must submit an application for accreditation and will undergo the accreditation process again. It is an expectation that programs will be re-accredited before the current accreditation lapses. The process for re-accreditation is initiated with enough time to allow for the completion of the self-study, on-site and possible follow-up (if deferred by the Accreditation Panel) to be completed before the current accreditation lapses.

If the program fails to renew their accreditation status and is not currently in the re-accreditation process, the program will be considered as having a non-accredited status.

EXTENSIONS

If, due to unforeseen circumstances:

- A program cannot be re-accredited before the expiration date of accreditation or
- A program needs more time to prepare and wishes to re-schedule the on-site review

The organization may request an extension.

The request for an extension will be provided by the organization in writing and kept on file. CAC will forward the request to the CHF committee for their approval. Once an extension is granted, the accreditation status of the program remains in effect as it was prior to the extension, until the date specified.

WITHDRAWAL FROM THE ACCREDITATION PROCESS

Programs may choose to withdraw from the accreditation process prior to the on-site review or discontinue the accreditation process before the On-Site Report is presented to the Accreditation Panel on either an initial or follow-up review. The status of the program prior to withdrawal will remain in effect:

- "Accredited" - until the date of expiry or
- "Non-Accredited" - if accreditation has lapsed or has not previously been granted

A program may re-start the accreditation process at any time. This would involve a new Application and all relevant fees. The program would be treated the same as any other program undergoing accreditation.

NON-ACCREDITATION

Programs have a status of not accredited with CAC if they have:

- Not yet undergone an accreditation process
- Allowed their accreditation to lapse
- Been revoked due to failure to comply with the process
- Been denied accreditation status by the Accreditation Panel

WEBSITE

Once CAC has a signed application the status of the program is listed on our website www.cacohs.com as:

- Not-accredited – in process (this comment is present for both new and deferred programs)
- Accredited (please note – expiry dates have been removed from the website)
- If a program's accreditation has expired and has not been renewed, the program is removed from the website
- If a program has been suspended it will be displayed in red and a comment of suspended will be listed
- If a program has expired but is in the process of being accredited, the comment will be "in the process"

NOTIFICATION OF STATUS

Once the Accreditation Panel has made a decision as to accreditation status, this information is transferred to the website and becomes public information.

TRAINING

TRAINING AND WORKSHOPS

Training and workshops are available to assist with planning and/or preparing for accreditation. Notices of upcoming training are posted on the website and information is distributed prior to the actual dates.

Training sessions are offered throughout the year:

- Reviewer Training
- Team Lead Training
- Orientation to Accreditation
- EMP First Aid
- Suicide Awareness Training
- Self-Harm Training
- Suicide Intervention/Self-Harm Training

One or two day workshops specifically designed for a program are available on request:

- Preparing for Accreditation
- Establishing and Maintaining a Quality Improvement System
- Data Management
- Program Specific Orientation to CAC Accreditation
- Leadership and Governance
- Policy Development
- Information Management
- Evaluation and Quality Improvement
- Working within an Ethical Framework
- Rights and the support of individual choice
- Health and Safety
- Administration and Management
- Service Delivery
- Working within a Culturally Specific Community
- Risk Management Planning
- Medication Administration Training

Please be advised that although training is required for accreditation, it is not required that it be taken through the Canadian Accreditation Council - Training Centre.

CORE SUPPORT

The Accreditation Fee includes the services provided by the CORE Support staff during the accreditation process as well as during the intervening years.

The CORE Support staff is assigned to an organization upon the completion of the application for accreditation services. This staff member will be a resource for the organization to guide their personnel and program(s) through the accreditation program. The CORE Support staff will be responsive to the needs of the organization and will provide the level of support the organization requires during the self-study and on-site portion of the review.

The CORE Support staff will provide an initial on-site visit which is designed to orientate the organization to the review process, standards and to better support the implementation and application of standards to their particular programs. It is not the role of this staff member to do the work, but to work with organization key personnel to guide their activities and provide the information, knowledge and interpretation of standards to support their efforts to achieve accreditation.

The organization will determine role and involvement of this staff member as they prepare and undergoing the accreditation process. As this staff member is designed to be a support to the organization, what they see and hear during the preparation phase will not be included within the on-site portion of the review as that portion is evaluated by independent peer reviewers.

CORE Support staff is available to assist with:

Coordination of the accreditation processes and the implementation of standards

Ongoing support of the program's efforts to achieve success

Review and support of development of governance structures, monitoring systems and evidence-based practices

Enhancement of capacity through access to resources, networking opportunities and training

CORE SUPPORT ROLE AND BENEFITS

Support includes:

- Access to sample policies, forms, tools and processes to track practice
- A half day meeting between the CORE Support staff and the program (management and/or staff) early in the process, to address expectations, timelines, review of the accreditation timeline work-plan and preparing for the Pre-Site and On-Site Review
- On-going phone and email communication with the program's assigned accreditation contact during the self-study phase of the accreditation process offering assistance with:
  - ✓ Interpretation of the intent, meaning and implementation of standards
  - ✓ Suggestions for policy development, including the need for clarity, simplicity and comprehensiveness
  - ✓ Problem solving and suggestions with processes to enhance service delivery (staff competencies, difficulty assessing training, etc.)
  - ✓ Development and maintenance of quality assurance systems, risk management, strategic planning, policy development etc
- Networking with individuals in other programs who are willing to share resources and expertise
- Referral to independent consultants for those programs that want an outside body to develop their policy manuals
- Training and supporting Reviewers and Team Leads in understanding and fulfilling their roles in relation to the accreditation of programs

There is a high correlation between the amount of contact with CAC staff while preparing for the On-Site Review and the success of a program in the accreditation process. We strongly encourage organizations undergoing accreditation to use the knowledge and expertise of the CORE Support staff.

We welcome contact. There are always questions about intent, meaning, application or implementation of the standards. Questions are encouraged as it is through dialogue and understanding that clarity is achieved.

Support may be accessed from CAC staff via phone, email, website and in person either at the CAC Head office or on-site at the program location.

The most recent standards and tools may be accessed electronically by contacting CAC. All tools and forms may be requested in order to support planning and identify areas to be addressed with staff and clients.

REVIEW TEAM

A "Peer Review Process" is the means by which programs are evaluated against the standards for accreditation. Volunteer Reviewers are people who work in the field or have expertise in the program area under review. The Reviewers are the evaluators who review written materials (files/documents) and policies, complete on-site observations and interview staff and clients. They also gather the information for the On-Site Report reflecting the level of compliance of the program to the standards. The On-Site Report is shared with the program at the end of the on-site and presented to the Accreditation Panel, along with the program's response. The Accreditation Panel, also comprised of volunteers, is the body that grants accreditation status to a program.

REVIEW TEAM

The Review Team (Team Lead and Reviewers) generally consists of one Team Lead, 2–5 Reviewers from separate organizations and a CORE Support. Members of the Review Team are most often from organizations within the same geographical region as the program under review.

Every effort is made to put together a team that incorporates broad experience, cultural diversity and knowledge of the program areas. To ensure the on-going development of Reviewers, new Reviewers are included in reviews as part of their training.

CONFLICT OF INTEREST/RIGHT TO VETO A TEAM MEMBER

While CAC selects the members of the Review Team, the program has the right to veto a particular person on their team because of a perceived or real conflict of interest, past history and/or personality clash.

To prevent any conflict of interest or bias:

- Team Leads and Reviewers are prohibited from accepting a paid contract or employment from a program that they have reviewed until the conclusion of the accreditation process
- It is equally prohibited for a program under review to offer employment to any of the team members during the review or until the accreditation has been completed

Responsibilities

Team Members (Review Team)

It is expected that all team members:

- Understand the intent of the standards and the accreditation process
- Review, understand and rate the program's policy manual and the self-study materials
- Participate in the pre-site meeting and all meetings throughout the review, in order to share information and clarify areas of uncertainty
- Are accurate and professional in the completion of all assigned tasks
- Provide support and feedback to fellow Reviewers in the completion of their tasks
- Maintain confidentiality of information gained during the accreditation process
- Positive comments, suggestions for improvement (to or from the program undergoing accreditation) and requesting permission to use a form, etc. are acceptable and are not viewed as breaches of confidentiality.

Team Lead

Team Leads are volunteers who have completed Reviewer and Team Lead training and have fully participated in several reviews. Team Leads:

- Chair meetings - pre-site, introduction at the beginning of the on-site and the exit interview
- Review the comments for all non-compliant findings from the pre-site meeting with the Program Liaison
- Delegate duties and responsibilities to the team members
- Facilitate discussion towards consensus in team decision-making and make the final decision when consensus is not achieved
- Share preliminary findings throughout the process and keeps the Program Liaison informed of the progress
- Speak on behalf of the team to Program Liaison
- Resolve any issues arising between staff or clients and team members

CORE Support

During the on-site review the role of the CORE Support personnel will be to:

- Provide administrative support and consultation to the Program Liaison preparing for the review and to the review team
- Ensure consistency around interpretation of the intent and the meaning of specific standards
- Ensure consistency of decision making during the reviews

ELIGIBILITY TO BECOME A REVIEWER

Reviewers are senior management, supervisors, direct service staff and people with review experience who have retired or left the field within the last 3 years.

Process

Individuals interested in becoming reviewers need to register for reviewer training.

- All new applicants must complete reviewer training. Reviewers who have not been active for longer than one year will be required to attend a half day refresher training course to review any changes in the standards
- The final decision to accept a person as a reviewer, to continue to utilize their skills as a reviewer or to select someone for a particular review rests with CAC staff
- A current copy of your criminal record check or a signed declaration from the program of employment declaring that a current criminal record check and other required checks are clear and on file
- During training reviewers will be required to present the signed declaration from their program stating that they have the required documentation on file as well as a copy of their current resume and application for training. Reviewers will also be required to sign an oath of confidentiality at the end of the training

Team Lead and Reviewer Training are offered in various locations, depending upon the need for reviewers and availability to take part in the training.

BENEFITS OF BEING A TEAM LEAD OR REVIEWER

Programs find it very useful to have their staff participate in reviews as:

- Reviewers are able to learn new ways of doing things, gain insight and are exposed to tools and processes that can be taken back and adapted to fit into their own programs
- Reviewers can assess the status of their own programs in comparison to the programs they are reviewing and either be positively reinforced in their progress or analyze areas they can work on developing
- Participation sheds new light on the steps needed to prepare for their own review
- While reviewers are not given an honorarium, all of their out-of-pocket expenses are covered such as meals, mileage and hotels (if required).

ACCREDITATION FEES

The CAC is contracted by the CHF to support funded programs achieve accreditation. To this end, the CHF will cover the costs normally incurred by the CAC to deliver the accreditation process for funded programs. If programs would like to be accredited as a non-funded program, please contact the CAC for a schedule of fees. Please note the **CHF will not cover** the costs incurred by CAC due to Postponement or Appeal of accreditation by the program. Please consult with the CAC regarding the fee schedule for these services.

INTEREST ON LATE FEES

Fees are invoiced with a payment due date of 30 days. Outstanding invoices of 60 days or more will be charged a 1.5% per month per outstanding amount due.

POSTPONEMENT/WITHDRAWAL FEE

There is no financial penalty when more than 90 days notice is given from the scheduled on-site and the new date is within the timelines defined above. Please refer to the current fee schedule for charges to the program if there is **less than 90 days** notice given from the scheduled on-site date.

PACKAGE FEES

It is the program's responsibility to have complete **pre-site packages** sent directly to all of the review team members. Programs that submit pre-site materials that are not complete or poorly organized will be asked re-submit the materials with enough time to have the pre-site meeting as scheduled. If CAC needs to copy and/or distribute the materials, a cost of **$75/ hour plus the cost of photocopying and couriering** the re-worked package to each team member will be added to the invoice of costs.

For the *Program Response* **it is an expectation that materials submitted to the Accreditation Panel are anonymous and have all identifying information removed**. Having CAC staff "white-out" identifying information (e.g. program names, logos, identification on the top of faxed pages etc.) will result in an administrative fee of $75/hour added to the final invoice to the program. **Only the reference number should appear on all documentation**.

COSTS ASSOCIATED WITH APPEALS

A flat rate will be charged to the organization should they decide to appeal. This would cover the cost of travel, accommodation (if any) and time spent preparing materials for the appeal committee meeting. If the result of an appeal is to re-review a program, the costs associated with the re-review will be assumed by CAC.

COSTS OF RESPONDING TO COMPLAINTS

The program will be responsible to cover all the costs associated with CAC responding to a complaint. Costs will be based on a cost recovery basis.

ANNUAL FEE

Annual fees are due on the 1st of May (30 days after invoicing) along with the Annual Declaration of Compliance. Accounts outstanding over 90 days will result in a suspension of the program's accreditation status. Annual fees are used for the processes involved with the maintenance of accreditation status for the duration a program is accredited.

SUMMARY – PROCESS OF ACCREDITATION

For more in-depth information about the accreditation process, please see *Stages of the Accreditation Process*.

Information is shared with programs regarding the process, costs, supports available and timelines.

The **Application** form is submitted to the CAC office.

CAC will develop a **Timeline Work Plan** based on the dates provided by the program to guide the stages of the accreditation process. Once this work plan is developed and signed off by the program the **dates are fixed**. **All requests for extension require CHF approval**.

The program undergoes a **Self-Study** process—examining and possibly adjusting their policies and practices to comply with the standards. On-going support from CAC is available throughout the process.

Pre-site materials (policies, procedures and supporting documentation) are sent to the Review Team 3 months prior to the on-site review.

Minimally 8 weeks prior to on-site, the Review Team participates in a **Pre-Site Meeting** to review the materials and provide feedback to the program staff.

The **On-site Review** is performed by the Review Team who will conduct interviews, review files and carry out an on-site observation of materials.

An **Exit Interview** will be held at the end of the review, during which the Review Team will share the On-Site Report.

If there is an **Unresolved Conflict** between the team and the program, the program may request a review of the conflict by the CEO (refer to On-Site Conflict Resolution).

The **Accreditation Panel** will review the information presented and makes a decision:

- Grant accreditation for a period of 3 years
- Defer accreditation
- Deny accreditation (non-accreditation status)

The program has the right to **appeal** a decision of the Accreditation Panel.

Plaques and certificates are presented to the program upon the successful completion of the accreditation process.

An **Annual Declaration of Compliance to Standards** is required for all programs in the intervening years between accreditation and re-accreditation.

STAGES OF THE ACCREDITATION PROCESS

APPLICATION

The program initiates contact with CAC to discuss having their program accredited.

CAC provides the program with an overview of the process, information about the supports available and the timelines.

An initial package of information is forwarded to the program which includes the Application.

The Application is available on the CAC website: www.cacohs.com

Submission of the signed Application formally begins the process of accreditation.

Once CAC has received the signed Application, staff will contact the program to confirm the information about the program, the timelines and the support available during the process.

CAC will ensure that there is a common understanding between the program and CAC to determine:

- The tools to be used to prepare for the accreditation process
- The dates involved with the process as are documented on the Timeline Work Plan.

Setting the Date for the On-Site

Dates for on-site review are established on a first-come, first-served basis and are scheduled 6 - 9 months from the time of submission of the signed Application. One extension may be requested. It should be noted that programs have a **maximum of 2 years from the time of applying for accreditation to undergo the pre-site and on-site review** part of the accreditation process.

If the process is not completed within the above timelines:

- Accreditation status lapses
- A new Application is required

SELF-STUDY

The Self-Study is the process the program undergoes:

- To become aware of its status in regards to compliance with the applicable standards
- To prepare for the on-site review

Depending on the comprehensiveness of the policy manual and the experience of the staff, the **self-study may take from a few weeks to several months to prepare and complete**. The self-study consists of:

- Developing an accreditation work plan that will define what needs to be done, the staff to carry out the action and the timeline in which the work will be done
- Reviewing internal policies and practices and assessing their compliance to the standards
- Ensuring staff and clients are aware of policies
- Ensuring that practice is consistent with policy
- Referencing of policy and procedures to be submitted for the pre-site meeting (pre-site self-study)
- Preparing for the on-site
- Moving towards compliance with standards may involve:
  - ✓ Creating new policies and/or procedures
  - ✓ Adapting current policies and/or procedures to comply with the standards
  - ✓ Orientating staff and clients to new or changed policies and procedures
  - ✓ Training staff
  - ✓ Ensuring clients are aware of, and participate in, the areas requiring their involvement
  - ✓ Upgrading processes

Using the Self-Study

The standards, self-study and work plan have been developed to assist those responsible in the program to work through the standards, assess what is already in place and what needs to be developed to attain compliance.

Suggestions on getting started:

- Address each standard individually to identify that all of the components have been addressed in the program's policy and practice
- If policies and procedures are not already developed, they will need to be discussed, addressed within the context of the program, written and shared. Once the policy or procedure is in place, the self-study is used to reference the policy that addresses each standard.
- Once policy has been addressed the next steps are to ensure that staff are aware of and consistently working in the framework of the program policy. The on-site interviews and file reviews assess practice in relation to program policies and standards.

Assistance from CAC is readily available throughout the accreditation process via phone, email and the website. **If there are questions or concerns please contact CAC staff**. Clarifying issues early prevents miscommunication and enhances a positive working relationship between CAC and the program undergoing accreditation.

PRE-SITE MEETING

Excellent practice must be demonstrated in the program's policy. It is the responsibility of the program to ensure the policy is aligned with the standards or the practice will be found to be non-compliant.

CAC is the only accrediting body that provides a pre-site review of policy months before the actual on-site review. All parts of the process are transparent with the goal being to enable programs to be successful in achieving accreditation status.

Compiling the Pre-Site Self-Study Materials

One of the final steps of the self-study is to complete the pre-site package for the team members. The pre-site package includes the completed Pre-site self-study, policies and procedures.

On the Self-study:

- Beside each standard, reference the applicable policy or policies by policy number, identifying which document it can be found in as well as the page number of the policy
- If the standard includes multiple components ensure that all components are to be addressed
- If policies addressing a standard are found in different parts of a policy manual, all the relevant policies need to be referenced on the self-study

An organizational chart and a complete list of senior management, supervisors and direct service staff needs to accompany the pre-site package. The staff list needs to indicate:

- Title and status (i.e. supervisor, full-time, casual etc)
- Length of time within the program
- Staff who identify as Aboriginal

The list will be used to select the people to be interviewed.

The easier it is for the team to find required materials, the better the experience is for everyone involved. Team members are given direction that a pre-site review of policy and procedures should take between 1-2 hours. If team members have invested 1 hour of time and are still in the early part of the policy manual, they are to connect with the CAC CORE Support for further instructions.

If the pre-site materials are disorganized or not properly identified, the program will be required to re-organize the package and re-send it to all members of the team.

If the pre-site package needs to be re-worked, there is a possibility that the on-site review may need to be postponed, depending on the timeframe.

- If a team member is not able to find the policy and procedure addressing a standard, the team will assign a finding of non-compliant with a note indicating that the policy or procedure was not found
- Policy manuals are organized to meet the needs of the program they are designed for and have policies ordered in a way that is logical from the perspective of the people using the manual. It is not unusual that a particular policy may cover more than one standard or that a particular standard may cover more than one policy and be found in different parts of a manual
  - ✓ It is easier for the team to have the full manual(s) submitted along with the self-study, outlining the page numbers where the policy and procedure can be found. If the team has a question or concern, the team as a whole can go back to a particular page for the policy reference
  - ✓ Some programs will compile and present the pre-site materials standard by standard with all of the policies and procedures following each standard. This approach works only if every standard is tabbed and easily referenced
- Ensure that the page numbers entered onto the self-study are accurate. Many times manuals are submitted with the wrong page numbers

Distribution of Pre-Site Materials

The self-study, policy manuals and staff list are directly mailed or couriered to each member of the Review Team, including the CAC CORE Support at least 3 months prior to the desired on-site date.

CAC administration sends an email prior to the due date of the documents to the contact person of the program:

- Confirming the names and addresses of the review team members and directing where the materials are to be mailed or couriered
- Restating that all Team Leads, Reviewers and the CORE Support require a complete copy of the materials – either in hard copy or in electronic format
  - ✓ If the program chooses to submit their materials electronically, they must be organized by standard number (i.e. 1.1.1, 1.1.2, etc.) and presented in one document. If a reviewer requests to have a hard copy of the pre-site materials, it is the responsibility of the program to provide one

- Confirming the date that the materials need to be delivered to the team members (The team reviews the materials individually prior to the pre-site meeting and needs a minimum of 3 weeks to do so)
- Providing a sample copy of an interview schedule
- Confirming the time, date and contact information for the pre-site meeting and on-site review

The pre-site meeting is scheduled minimally 2 months prior to the on-site review.

The purpose of the pre-site meeting is to:

- Review program policies and procedures
- Ensure that the program policies and procedures are compliant to the standards
- Identify gaps in policies and procedures
- Provide direction and support to address issues
- Plan for the on-site review

Pre-Site Meeting

Each member of the review team is provided with a copy of the program's pre-site materials and each member individually reviews the materials against the standards and comes to the meeting prepared to discuss their ratings.

All standards with indicators that call for Policies and Procedures are addressed and rated as Compliant (C), Partially Compliant (P) or Non-Compliant (N) .These ratings, with commentary for all N and P ratings are entered on the Pre-Site Report. Generally, the pre-site meeting is a conference call with the team meeting for a short time prior to inviting the program representative(s) to join them.

The purpose of the pre-site meeting is for the Review Team to collectively review the findings and rate the policies and procedures. The program representative is invited to be involved in the meeting to hear the team's rationale for their findings. The role of the program representative is to respond to questions posed by the team and not to debate findings. The inclusion of the program representative is at the discretion of the team. Benefits of program representation are:

- Ensures that the team understands the practice within the program
- Allows for clarification (if needed) as to the processes and practices
- Ensures that the program understands the rationale for all non-compliant findings
- Allows for a discussion as to how a non-compliant finding may be addressed
- Affirms what supports are available through either CAC or team members

A copy of the Pre-Site Report is sent to the program and arrangements are made for the on-site review. The Team Lead will ensure that all members of the team are knowledgeable of their roles and responsibilities during the on-site review.

ON-SITE REVIEW

The on-site review is scheduled for a minimum of 2 days, but may be more depending on the size of the program being reviewed and will involve:

- Interviews with senior management, supervisors, direct service staff, and clients
- Review of staff and client files
- Review of on-site documents
- Observation of practice within the program

Preparing for the On-Site Review

Consents

It is the program's responsibility to ensure that all required consents have been obtained prior to the team arriving on-site. The onus is on the program to ensure that all stakeholders, clients and staff have been informed and are consenting to the accreditation review process. Once the review team is on-site they will proceed with the process of interviewing, reviewing files and completing the work defined within the accreditation process.

- Since the team will randomly select people to be interviewed and files to be reviewed, consents should be inclusive of all staff and clients
- The team is sensitive to the fact that a few people may refuse consent (less than 5%) but will not be able to conduct the review if the sample size is not large enough to reflect accurate results

The On-Site Report will reflect the sample size and findings of the team. If the sample size is not considered representative of the program the team will forward this information to the Accreditation Panel which may impact their decision.

On-Site Interview Schedule

The program prepares the on-site interview schedule. The sample schedule, emailed prior to the pre-site meeting, provides direction as to scheduling and the CORE Support is available to assist with suggestions.

The Team Lead or CORE Support will contact the program prior to the on-site with the names of the staff who have been chosen to be interviewed. The program will identify the clients to be interviewed and the Team Lead or CORE Support will review the schedule with the program's contact person. The team will try to work to the schedule and not keep interviewees (particularly clients) waiting.

Team Requirements

While on-site, the team requires:

- A private space (i.e. board room or enclosed dining room) to meet and discuss their findings
- Other spaces to interview staff and clients
- Access to telephones
- A designated staff person available to:
  - ✓ Explain how files are ordered
  - ✓ Respond to questions
  - ✓ Co-ordinate interviews
  - ✓ Locate file documents
  - ✓ Direct the team to find any missing pieces of documentation

Introductory Meeting

The on-site review begins with the team meeting with the senior management, personnel and others invited in by the program. The purpose of this meeting is to:

- Introduce the team and staff
- Ensure that the lines of communication are clear
- Ensure that everyone is using the same language and terms
- Receive a brief overview of the program
- Understand any particular issues that may influence the team or the review
- Ensure the program is aware of the review process
  - ✓ The team will interview, review files and make observations within the program
  - ✓ The team records the evidence and the CORE Support compiles the results into final ratings within the On-Site Report
  - ✓ Updates on the progress of the team will be shared with the program throughoutthe day
  - ✓ Detailed comments/explanations are provided for all Non-Compliant (N) ratings. Ratings where consensus was not attained will be noted

The team will keep all information gathered confidential unless the team makes a judgment that clients are at risk. The team in those situations may:

- Inform senior management
- Notify the guardian (if applicable)
- Notify other legislated bodies (i.e. Intervention Services, police, funders, etc.)

Interviews

Senior management, Supervisors and Direct Service staff Interviews

Selected senior management, supervisors and direct service staff will be interviewed. The review team will select the staff to be interviewed.

- The questions may not be asked exactly as they are written. The intent is to examine practice and the team member may vary the wording of the question to gather greater understanding or greater detail
- As the intent is to address practice, memorization or rote reiteration of the standard is not required
- Interviewees are asked to provide examples from their experience to illustrate their understanding and practice
- The interviews will be:
  - ✓ In person (at least 80% of the sample size)
  - ✓ By telephone to accommodate staff not scheduled to work on the days of the on-site review (up to a maximum of 20% of the sample size)
  - ✓ In groups of 2-3 or individually (at the discretion of the review team)
- If the team feels that a larger sample size of interviewees is required, a random sample of staff, over and above those selected, may be interviewed

Client Interviews

The experience of people using the program is critical to the accreditation process as it provides the final link between standards and practice.

Program will select the clients to be interviewed. If the number of clients currently served in the program is too small for a representative sample size, the team may request to interview past clients. This would be negotiated with the program.

Client interviews may be:

- In groups of 2-3 or individually, in person or by telephone
- Clients with cognitive impairments will be interviewed using a modified format to accommodate the age or impairment of the client

The interviews involving clients focus upon the relationship between the client, the program and direct service staff. (refer to CAC Review Process)

Clients need to be informed that the interviewer will only be asking questions about their experience with the program NOT about their personal history or current issues. The only personal questions being asked will be:

- Their first name (which does not have to be real)
- The length of time they have been accessing program services
- Their experience with the program and staff

File Reviews

The team will randomly select supervisor and direct service staff files to be reviewed. The team will be looking for specific documents on file. During the on-site, **staff are required to assist the team** in order to find any required materials from the files. If materials are kept on computer, the team will need to have someone show them the required documents.

Only current files will be reviewed, if the program is undergoing accreditation for the first time. If a program is under-going re-accreditation, current and past files will be reviewed.

If issues are identified that precede the previous accreditation, they will be discussed with the team and the program staff. If the finding is reflective of a historical or practice issue that is not representative of current practice, the team may choose to not report it on the final On-Site Report.

Staff Files

Current staff files will be reviewed. If a program is undergoing re-accreditation, personnel files will be evaluated on practices implemented and/or maintained since the last date of accreditation.

Client Files

The team will randomly select and review current and closed client files.

Sample Size

The following are the required number of interviews and file reviews to be completed during the review.

The team may increase the number of interviews or file reviews if the team believes that additional data and representation would be beneficial to the process. It is advantageous to the program to have a larger sample size (i.e. 1 of 10 staff not knowing something is less of an issue than 1 of 2 staff not knowing the issue).

The sample sizes are based on the total number of staff and clients within the program being reviewed. Sample sizes for closed client file reviews will be half the sample size of open client file reviews.

Number Within Program Staff/Clients	Sample Size
3 or less	all
4 – 10	50% or up to 4
10 – 25	50% or up to 8
25 – 50	10
50 – 75	12
75 – 100	14
100 – 150	16
150 – 200	18
Over 200	20

Rating Scale

The Review Team rates program policy and practice to the standards, using the following ratings:

Compliance(C)

Compliance indicates that:

- Program policy and procedures are congruent with the standard
- Senior management, supervisor and direct service staff practice is congruent with program policy
- Clients are able to affirm that the practice within the program is congruent to program policy and standards

Where the indicator is quantifiable (i.e. having a training certificate on file), compliance means that the pattern of practice of the program is congruent with the standards. Where the indicator is not totally quantifiable, compliance means that the program is deemed to conform to the meaning and intent of all aspects of the standard.

Compliance requires no discussion among the team members and does not require a response to be forwarded to the Accreditation Panel.

Partial Compliance (P)

A rating of Partial Compliance is only used by the review team during the pre-site meeting and indicates that additional information is required on-site to formulate a final rating.

All Partially Compliant findings are compiled on the Pre-Site Report and are accompanied by comments from the review team. Partially Compliant findings will be reviewed during the on-site to evaluate additional information and to determine whether the finding is representative of practice or an aberration.

- A ruling of Compliant would result from the review of additional information and/or the review team concluding that the Partially Compliant finding was not reflective of a pattern of practice within the program
- A ruling of Non-Compliant would result from the review team finding
  - ✓ Insufficient information
  - ✓ Concluding that the Partially Compliant finding reflected practice that was not consistent with the meaning and intent of the standard
  - ✓ The practice creates a potentially harmful situation for clients or personnel

Non-Compliance (N)

Non-Compliance means that some aspect in the program (policy/documentation, practice or client experience) has been found to be incongruent with the meaning and intent of the standard.

All Non-Compliant findings are discussed among the team members and documented on the On-Site Report, along with comments and explanations of the rationale.

A written Program Response to the Accreditation Panel is required for all Non-Compliant findings.

Team Decision Making

All team members record their individual findings from the interviews, document reviews and on-site observations on the tools we provide for them.

All questions and findings of non-compliant are brought back to the team and are recorded by the CORE Support onto the On-Site Report. Throughout the time the team is on-site, there will be a number of short meetings (often between other pieces of work) to discuss what is being found by the other Reviewers. If there are concerns or questions, all team members are informed and will remain diligent in their search for information that would lead to a team finding of either compliant or non-compliant.

The team's role is to identify "patterns of practice" and differentiate between what is the practice of the program from the occasional aberration from practice. It is the team's role to identify the areas that are non-compliant to standards. They, as a collective, have the authority to make decisions on a case-by-case basis as to the consistency of practice within a program. They have the authority to gather further information, speak to program staff about a particular finding, and come to a decision whether the program has operated in the parameters of practice and is compliant to the standards or not. If there is a reasonable explanation or documentation to support a change, a particular finding of non-compliant may be found to be compliant.

If there has been a change in practice (i.e. use of a new form, change in staff, practice of informing clients of their rights at all planning sessions, etc.), it is important for the team to be aware of the timeframe and to know when the practice changed. If there has been enough time for the new pattern of practice to be observed and there is evidence that the practice is regularly being implemented, the team has the option of finding the practice compliant. If the new practice has only recently been implemented, the team may come to a finding of non-compliant as there has not yet been enough time to ensure that the new practice is firmly entrenched.

It is the team as a whole who finalizes the findings and decides which standards have been found to be non-compliant. The team's role in decision making is to find the balance between maintaining the integrity of the accreditation process and sorting through the patterns of practice within the program (those that are compliant and non-compliant to the standards).

Review Team Reports

There are two separate reports that are provided to the program: the Pre-Site Report is emailed to the program once the pre-site meeting has concluded and the On-Site Report is presented to the program at the exit interview.

Pre-Site Report: This report is completed following the pre-site meeting and provides the findings of the team in regard to the policies and procedures that were submitted.

On-Site Report: This report creates the framework for the findings of the review and includes a separate document for the program to provide a response to the findings.

The On-Site Report is divided in to the following sections:

- Overview of the Program(s) under review:
  - ✓ The program reference number (i.e. Reference # N4605 – 1)
  - ✓ The type of program being reviewed (i.e. Case Management)
  - ✓ Dates in the review process
  - ✓ The sample size and overall size of the program
  - ✓ Team Leader and CORE Support signature
- Observational Summary:
  - ✓ Identification of Excellence in Practices observed by the team
  - ✓ Identification of practices to be addressed in the areas of:
    - Bring Forward System
    - Staff Training
    - Client Rights
    - Documentation
    - Incongruent Practices
    - Other
  - ✓ Overall summary of the review to establish the context in which the review was carried out

- Statement of Findings:
  - ✓ The total number of standards applying to each section
  - ✓ The number of compliant findings
  - ✓ The number of non-compliant findings, including the standard number and a brief description
  - ✓ The team comments identify the number within the sample size that were found not to be compliant and why the team came to that decision (i.e. 2/3 staff were unaware of the process to report incidents or 1/3 client files did not have the required documentation)
- Program's Response (provided in a separate document):
  - ✓ The standard number and a brief description are identified
  - ✓ A space for the program's Short Term Plan
  - ✓ A space for the program's Long Term Plan

As the team interviews, reviews documents and observes practice within the program, the initial results are compiled by the CAC CORE Support into the On-Site Report.

All comments and findings will be discussed with the team as a whole before they become part of the final report.

Exit Meeting

The exit meeting will occur after all the interviews, file reviews, and observations have been completed and the data has been compiled into the On-Site Report.

If, due to exceptional circumstances, the exit meeting cannot be held at the end of the last scheduled day, it will be re-scheduled within 2 working days.

The exit meeting team will minimally consist of the Team Lead, the CAC CORE Support and the program senior management (or designate). The program may invite other individuals to be present.

The Team Lead will reaffirm that the purpose of the exit meeting is to present the On-Site Report, share positive information and not debate any of the findings. A rationale is given for all non-compliant findings.

At the conclusion of the exit meeting the Team Lead and Program's Senior Management (or designate) initial all pages of the On-Site Report. This is to ensure that there is no misunderstanding as to what was found to be noncompliant and require a response.

A copy of the On-Site Report is left with the program representative and is to be used as the basis for developing the response for the Accreditation Panel.

An electronic copy of the report is presented to the Accreditation Panel along with the Program's Response. All findings identified on the On-Site Report are the final findings of the review team.

Feedback on Process

Everyone involved with the review process, including the Program's Senior Management and the review team members, are requested to complete written evaluations of their experience with the process.

PROGRAM'S RESPONSE

Timelines

The program has 30 days from the exit meeting to respond, in writing, to the On-Site Report. The program's request for accreditation will be presented at the first scheduled meeting of the Accreditation Panel after the expiration of the 30 day period.

A program may choose to waive the 30 day response time and ask that the Accreditation Panel review their On-Site Report at the next scheduled meeting.

The response is required to be submitted to the CAC office a **minimum of 5 working days** prior to the scheduled Accreditation Panel meeting.

Required Copies

The program's response may be submitted electronically or in hard copy.

An electronic copy of the On-Site Report will be provided to the program during the exit interview as well as an electronic copy of the Program's Response. The program will input their plan to respond to non-compliant findings in the Program Response document. The Program Response will be as follows:

- **Standard to be Addressed** – The CORE Support will input the findings from the On-Site Report
- **Short Term Plan** – The plan will identify immediate actions taken to correct the non-compliant findings or will provide additional information relating to the review team's findings
- **Long Term Plan** – The plan to ensure structures, systems and strategies are put in place to correct and maintain compliance

Anonymity

To ensure anonymity, each program is reviewed separately and anonymously by the Accreditation Panel. It is the responsibility of the program to ensure that the Program Response sent to the Accreditation Panel is anonymous.

Programs are identified with the program reference number (i.e. Reference # N4605 – 1) not the program's name.

- All identifying information (i.e. name of the program, names of staff or clients and logos) that could identify the program is to be obscured to ensure that the Accreditation Panel is not able to identify the program or individuals

Clear Presentation

The response needs to be presented in a manner that is clear, concise and easily understood. The Accreditation Panel has requested that unclear responses be returned to the program to be re-assembled or re-ordered.

Guidelines for the Response

The response is to define the program's plan to address the non-compliant findings. Supporting documents and forms (training certificates, etc.) are not to be sent as the Accreditation Panel is evaluating the content of the review findings and the plan that the program has submitted. If the Accreditation Panel requires further information to confirm that the plan submitted has been implemented, the review team will conduct a second on-site visit to review documentation and practice at that time.

The response needs to address what the program has done to demonstrate compliance to the standards and how compliance will be maintained in the future. The Accreditation Panel wants to see evidence of a shift in practice or evidence that a new process has been implemented.

The two most common areas found to be non-compliant are Staff Training and Management of Information. The following are specific guidelines for responding to these non-compliant pieces.

Issues in Core Competencies

If the non-compliant finding relates to staff training (example - number of staff who have completed Aboriginal Awareness training), the response needs to include:

- A detailed description of the efforts made to ensure staff are trained
- A plan outlining future training opportunities and strategies to meet the standard
- Evidence that a training issue is being addressed in an ongoing manner

Issues in Management of Information – "Bring-Forward System"

If the non-compliant finding is related to management of information (outdated certificates, missing documentation), the response needs to include:

- A plan or evidence of change that ensures that information will be addressed within the timeframes identified in the standards
- Reference to missing documents having been found or out-of-date certificates now being current verification of these documents will occur during the follow-up review if required

Checklist

Once the response has been completed, it is the program's responsibility to re-check it to ensure that:

- **All identifying information has been removed from the Program Response**
- If there has been a slight oversight and there is minor identifying information, CAC staff will remove it prior to submission to the Accreditation Panel
- If the program submits a response with identifying information throughout the document the program contact person will be requested to resubmit the response prior to the Accreditation Panel meeting
- All of the non-compliant findings have been addressed
- One electronic copy or one hard copy of the Program Response is forwarded to the CAC office

If the response is incomplete or unclear, the Accreditation Panel may choose not to proceed and have the response returned to the program with instructions to reorganize it. In that case, the request for accreditation will be delayed.

ACCREDITATION PANEL

The Accreditation Panel provides an "arms-length" review of the team's findings and the Program's Response, which results in one of the following decisions:

- Accreditation granted for 3 years and requires an annual Declaration of Compliance to standards
- Accreditation deferred up to 4 months and a follow-up on-site may be required to ensure that practice has been adjusted to comply to the standards
- Accreditation denied (Non-Accreditation Status)

Presentation to Accreditation Panel

The Accreditation Panel will consider the request for accreditation at the next scheduled meeting following the expiration of the 30-day response time.

The Panel is presented with the following documents:

- The On-Site Report which provides background information, including type and nature of the program reviewed and sample sizes used, observations made by the review team and the review team's findings as to the program's compliance to the standards
- The Program Response to the On-Site Report

The program's name or location of the program are not shared with the members of the panel to ensure objectivity and avoid any real or perceived bias affecting the decision to grant, defer or deny accreditation.

Accreditation Panel Decisions

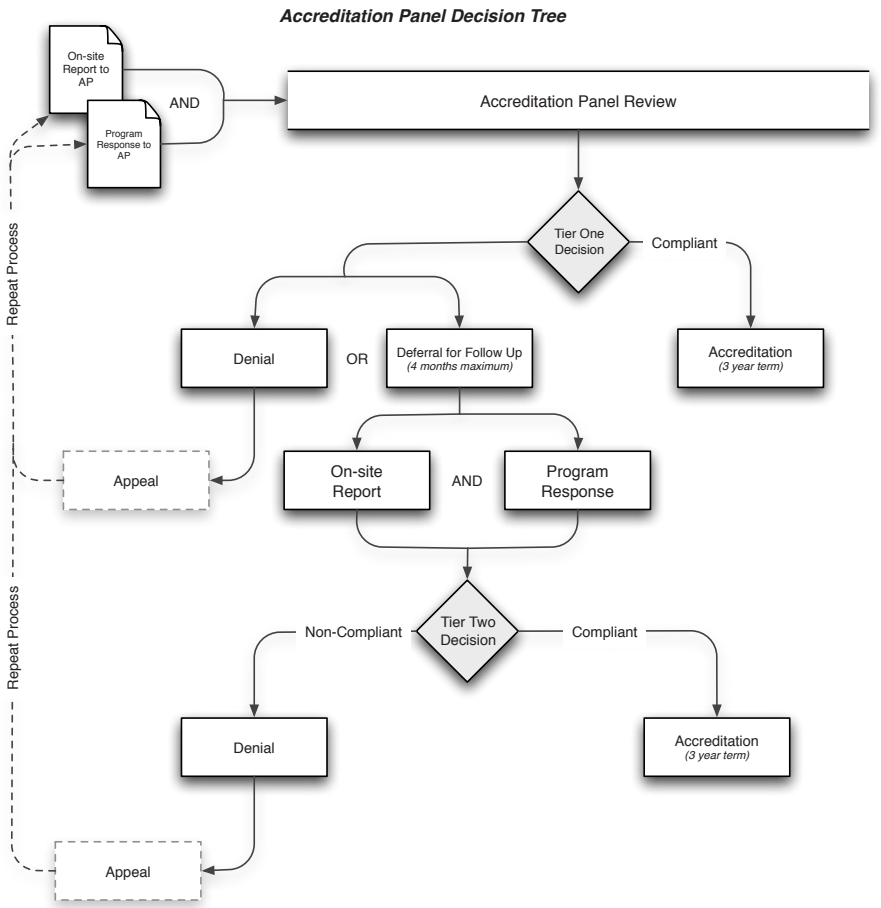
If a program has demonstrated compliance to standards, accreditation status will be granted.

All non-compliant findings need to be addressed and the decision as to accreditation status is made based upon a consideration of:

- Findings of the On-Site Report
- The Program's Response

Non-compliant findings addressing safety, rights of clients and processes to ensure consistency of practice are more heavily weighted than results reflecting an inadvertent oversight due to staff turnover, a single staff person being unaware of some expectations or a misunderstanding of the intent or meaning of a standard. Patterns of practice and the intent to have practice compliant to standards is the measure of decision making, not a narrower interpretation of compliance.

Accreditation Panel Decision Making Tree



Tabling a Request for Accreditation

Review of a program may be tabled to the next meeting due to:

- The Accreditation Panel deciding, after deliberation, that clarification or additional information is needed to make the decision as to a particular finding.

Granting Accreditation

The Accreditation Panel will grant accreditation for 3 years, based upon the program's level of demonstrated compliance to the standards:

A 3-year accreditation is granted to programs that have demonstrated a high level of compliance to the standards and have addressed any areas requiring attention. The Accreditation Panel is assured that the program is operating in compliance to standards on a consistent basis. A 3 year accreditation can be given to programs as part of a Tier One or Tier Two Decision (please refer to the Accreditation Panel Decision Tree).

Policy manuals, self-study materials and on-site tools are shredded 40 days after the Accreditation Panel decision, unless an appeal request has been submitted by the program. One copy of the On-Site Report and Program's Response is kept on file.

The program will be notified of the Accreditation Panel's decision in writing. A plaque and certificate are prepared and forwarded to the program following the written notification.

Deferral Accreditation

Deferral of accreditation is an option the Panel has at its discretion and is used when a program has not provided enough evidence to grant accreditation. The Panel may choose to defer accreditation for 1 to 4 months from the meeting date to allow the program the opportunity to submit documentation or for the team to return to the program to interview staffclients or review files.

If the Accreditation Panel decides to defer accreditation, it will advise the program in writing, outlining what must be done in order to achieve accreditation and indicate when the program needs to be re-presented to the Accreditation Panel.

A deferral may vary in length up to 4 months. The length of time of the deferral is dependent upon the amount of work required to address the issues and the seriousness of the non-compliant findings.

A deferred program may choose to have the follow-up review completed earlier than the time allotted, if the program has been able to address the issues and the team is available.

If, on the other hand, follow-up arrangements have not been made by the program prior to the date the deferral expires, the accreditation status of the program lapses and the program has a Non-Accreditation status. If a program requires more than the allotted time to make the changes, it may make a request for an extension, in writing, to the chairperson of the Accreditation Panel.

Follow-Up Review

When a program has been deferred and requires a follow-up review, the CAC CORE Support will contact the program and make the arrangements.

The Accreditation Panel may request the follow-up review to:

- Address only those non-compliant findings on the initial On-Site Report
- Be a complete re-review of the on-site portion of the accreditation process

The sample sizes used may be the same as used for the initial review or may be larger than originally sampled, if a larger number is necessary to establish compliance. The Follow-up review and presentation to the Accreditation Panel will follow the same process as the On-Site review.

When the follow-up is complete and has been reviewed by the Accreditation Panel, the decision will be to either grant a 3 year accreditation or to deny accreditation to the program.

If the follow-up is not completed within the designated timelines, the Accreditation Panel will be informed and the status of the program will be changed to Non-Accreditation.

Sending an "Extraordinary Circumstance" Letter

In addition to making a decision to defer or deny accreditation, the Accreditation Panel may send out an "Extraordinary Circumstance" letter directed to the Board of Directors, the owner of the organization responsible for the program and/or the funder. The factors considered in determining whether a program warrants an Extraordinary Circumstance Letter would include:

- A significant number of non-compliant findings
- Non-compliant findings that are directly related to the safety of clients or staff
- A Program Response that does not assume responsibility for the shortcomings and fails to include a viable plan for correcting them
- A Program Response that places blame elsewhere or is not prepared to comply with the standards

Non-Accreditation Status

The Accreditation Panel may make a decision to deny accreditation (non-accreditation status) upon an initial review or after a follow-up review based on the nature of the issues identified on the On-Site Report and the Program Response.

Non-Accreditation may be decided by the Accreditation Panel if there are outstanding issues or the issues identified are of such a nature that the Panel is not assured that the program is operating or has the capacity to operate within the parameters of compliance to standards on a consistent basis.

In the event that a program has not adequately complied with the intent or meaning of the standards the program will be informed, in writing, that it has not met the requirements for accreditation, resulting in the program having a Non-Accreditation status. Detailed reasons for the decision will be given.

A program may choose to appeal this decision. If the program does not appeal the decision of the Accreditation Panel, it may re-apply for accreditation whenever it has made the necessary adjustments to be in compliance with the standards.

CONFLICT RESOLUTION

On-Site Conflict Resolution - Between Review Team Members

Where issues arise that are related to standards, discussion with the review team occurs. The Team Lead facilitates the discussion and agreement is reached on the direction the team will take in regard to compliance to the standards.

Where interpretation of standards is an issue, CAC CORE Support provides direction, understanding of the intent of the standards that are perceived as problematic and provides examples of how other review teams have approached the issue. The Team Lead makes the final decision.

On-Site Conflict Resolution - Between the Program and Review Team

If, after discussion with the Team Lead, the program continues to have concerns about:

- A particular team member's approach, attitude or presentation
- The team's objectivity
- The impartiality or fairness of the process

the program has **14 calendar days from the date of the exit meeting** to initiate a conflict resolution process by outlining the concerns, in writing, and forwarding them to:

CEO
Canadian Accreditation Council of Human Services
#203, 10446 - 122 Street
Edmonton, Alberta T5N 1M3

The CEO has 7 calendar days to hear the concern and to respond to the program.

The CEO has the option to:

- Agree with the program that the review was not handled appropriately and order a new review with a new review team
- Find that the program's concern was not substantiated and have the process proceed on to the Accreditation Panel

Following the CEO's decision if the program still feels that their concern was not fairly dealt with, the Program can initiate an Appeal the by following the Appeal Process outlined below.

This process must be completed before the Accreditation Panel will consider the request for accreditation.

APPEAL OF ACCCREDITATION PROCESS

Upon receipt of a letter of notification of the decision of the CEO, the program has 7 calendar days to initiate an appeal of the accreditation process.

The program will, in writing, submit a request for an appeal hearing based upon the appeal criteria listed below, which are the only basis upon which an appeal of process will be heard:

- A particular team member's approach, attitude or presentation
- The team's objectivity
- The impartiality or fairness of the process

The letter requesting an appeal will be sent to:

Chairperson of the Appeal Committee
Canadian Accreditation Council
#203, 10446 - 122 Street
Edmonton, Alberta T5N 1M3

The chairperson of the Appeal Committee will decide whether or not the program has presented grounds for an appeal as outlined in the appeal criteria:

- If the chairperson finds the program has no basis for an appeal, the program will be informed of the decision and the CEO's ruling will remain in effect
- If the program has presented grounds for an appeal, a hearing date will be set

The Appeal Committee has 30 calendar days from receipt of the letter requesting the appeal within which to hear the appeal and an additional 14 calendar days to convey the decision to the program.

The Appeal Committee will take into consideration the following written documents.

- The program request for an appeal citing the reason(s) for the appeal
- The letter from the CEO to the program, outlining the reasons for the decision
- The On-Site Report and Program Response
- A brief written chronology of events compiled by the CAC CORE Support

The written documentation will be submitted to the Appeal Committee members at least 7 days prior to the scheduled hearing.

In addition to considering the written submissions, the Appeal Committee may request the following:

- A briefing from the CEO as to the decision. This briefing may be prior to the hearing
- The program senior management to attend the appeal hearing to present the reasons for the appeal and to respond to questions from the appeal panel
- The CAC CORE Support and CEO to attend the hearing and respond to any questions

After consideration of the written and verbal submissions, the Appeal Committee may choose to recommend that:

- The decision of the CEO is to be upheld
- The program is to be re-reviewed by another review team:
  - ✓ A different team (CORE Support, Team Lead and team members) will conduct a new review, as soon as possible - from within 2 weeks of the decision to a maximum of 2 months
  - ✓ The new review will be a complete review and be treated as if the first review had not been undertaken. If a re-review of the program is the decision of the Appeal Committee, the costs associated with the re-review will be assumed by CAC

The Appeal Committee will notify, in writing, the program senior management, the CEO and the Team Lead of the decision.

APPEAL OF ACCREDITATION PANEL DECISION

Upon receipt of the letter of notification of the decision of the Accreditation Panel, a program has 30 calendar days to initiate the Appeal Process.

If an accredited program appeals the decision of the Accreditation Panel, the program's accreditation status immediately preceding the appealed decision remains in effect until the appeal process is completed.

The program will, in writing, submit a request for an appeal hearing based upon the appeal criteria listed below, which are the only basis upon which appeals will be heard:

- Accreditation Panel did not follow the established procedures
- Based upon the Program Response, the Accreditation Panel's conclusions are not valid

The letter requesting an appeal will be sent to:

Chairperson of the Appeal Committee
Canadian Accreditation Council
#203, 10446 - 122 Street
Edmonton, Alberta T5N 1M3

The appeal will be based upon the information and documentation presented to the Accreditation Panel. The program has the opportunity to explain or clarify the information or materials that had been submitted to the Accreditation Panel.

The Appeal Committee **will not** consider new submissions of materials or documents.

The Appeal Committee has 30 calendar days from receipt of the letter requesting the appeal within which to hear the appeal and an additional 14 calendar days to convey the decision to the program.

The Appeal Committee will decide whether or not the program has presented grounds for an appeal as outlined in the appeal criteria:

- If the committee finds the program has no basis for an appeal, the program will be informed of the decision and the Accreditation Panel's ruling will remain in effect
- If the program has presented grounds for an appeal, a hearing date will be set

The Appeal Committee will take into consideration the following written documents.

- The program request for an appeal citing the reason(s) for the appeal
- The letter from the Accreditation Panel to the program, outlining the reasons for the decision
- The On-Site Report and Program's Response presented to the Accreditation Panel
- A brief written chronology of events compiled by the CAC CORE Support

The written documentation will be submitted to the Appeal Committee members at least 7 days prior to the scheduled hearing.

In addition to considering the written submissions, the Appeal Committee may request the following:

- A briefing from the chairperson of the Accreditation Panel as to the decision. This briefing may be prior to the hearing
- The program senior management to attend the appeal hearing to present the reasons for the appeal and to respond to questions from the appeal panel
- The CAC CORE Support and CEO to attend the hearing and respond to any questions

After consideration of the written and verbal submissions, the Appeal Committee may choose to recommend that:

- Accreditation be granted based upon the Appeal Committee's deliberations
- The decision of the Accreditation Panel is to be upheld:
  - ✓ If a program is granted non-accreditation status, the program may re-apply for accreditation with CAC whenever it thinks it has made the necessary adjustments to be in compliance with the standards
- The program is to be re-reviewed by another review team:
  - ✓ A different team (CORE Support, Team Lead and team members) will conduct a new review, as soon as possible - from within 2 weeks of the decision to a maximum of 2 months
  - ✓ The new review will be a complete review and be treated as if the first review had not been undertaken. If a re-review of the program is the decision of the Appeal Committee, the costs associated with the re-review will be assumed by CAC

The Appeal Committee will notify, in writing, the program senior management, the Chairperson of the Accreditation Panel and the Team Lead of the decision.

SUSPENSION/REVOCATION OF ACCREDITATION

Accreditation is granted for a period of 3 years and is conditional upon the processes identified within this manual.

SUSPENSION OR REVOCATION OF ACCREDITATION STATUS

CAC accreditation status may be suspended or revoked if any of the following occur:

- The program allows accreditation to lapse, meaning the program has not been re-accredited within the period of accreditation and the program has not sought an extension
- The Accreditation has expired and the program has not completed the accreditation process
- The program did not submit the Annual Declaration of Compliance to standards within 60 days of receiving the Annual Declaration of Compliance to Standards
- The program did not notify the CAC within 30 days of the following:
  - ✓ Serious incidents involving the death or major injury to a client or staff
  - ✓ Change of ownership of the program
  - ✓ Location change for the program
  - ✓ Program closure
  - ✓ Program re-opening
  - ✓ The program is found to be negligent by the courts or a judicial inquiry
  - ✓ Allegations made against program staff or the program which are investigated and are substantiated
- The program denies access to information or the facility to a review team ordered to investigate a complaint or allegation
- A program under review offers employment to a review team member during the review or prior to the conclusion of accreditation process

If there are extenuating circumstances, it is the responsibility of the program to explain them and put forward the arguments as to why accreditation should not be suspended or revoked.

RESPONSE TO COMPLAINTS

All allegations are initially presented to the CAC CEO. The process to suspend or revoke accreditation based upon complaints or allegations are taken seriously. Anonymous complaints, either verbal or in writing, are not considered and will be destroyed without further action.

Verbal complaints or allegations from persons willing to identify themselves are heard and counsel is given as to how to proceed. The options may include the following:

- If the complaint is related to the professional practice of an individual, referring the complainant to the appropriate professional college that governs professional practice and disciplinary action of its membership
- If the complaint is in contravention of provincial or federal legislation, standards or policies, referring the complainant to the appropriate provincial or federal body
- If legal or quasi-judicial (e.g. Human Rights Board, Workers' Compensation Board, legal proceedings) action has already been initiated, CAC will not become involved until it has been resolved
- If the complaint/allegation is considered to be within the scope of the standards, a written and signed complaint will be requested and forwarded to the CAC office

If a complainant requires assistance writing or presenting the information, the CAC CEO may provide direction or suggest a non-involved advocate to provide assistance.

The complainant is informed that every effort will be made to keep the identity of the complainant anonymous during the review of the complaint. However, all information and documentation related to the situation may be shared with the organization.

All written complaints received by the office of CAC will be acknowledged in writing within 5 days of receipt and forwarded to the Chairperson of the CAC Board of Directors.

The letter requesting review of a complaint will be sent to:

Chairperson of the CAC Board of Directors
Canadian Accreditation Council
#203, 10446 - 122 Street
Edmonton, Alberta T5N 1M3

The CAC Board of Directors has 30 calendar days from receipt of the letter within which to hear the complaint and an additional 14 calendar days to convey the decision to respond to the complainant.

The CAC Board of Directors will decide whether or not the complaint presented has grounds for further review by CAC as outlined in the following criteria:

- The complaint is related to the professional practice of an individual, and should be referred to the appropriate professional college that governs professional practice and disciplinary action of its membership
- The complaint is in contravention of provincial or federal legislation, standards or policies, and should be referred to the appropriate provincial or federal body

- There is a current legal or quasi-judicial (e.g. Human Rights Board, Workers' Compensation Board, legal proceedings) action been initiated which need to be completed before CAC can become involved
- The complaint is considered to be within the scope of the CAC standards, processes and policies

The CAC Board of Directors will take into consideration the following written documents.

- The written and signed complaint forwarded to the CAC office
- A brief written chronology of events along with any background information related to the complaint compiled by the CAC CEO
- Organization in whom the complaint is been made against will provide a written response

The written documentation will be submitted to the CAC Board of Directors at least 7 days prior to the scheduled hearing.

In addition to considering the written submissions, the CAC Board of Directors may request the following:

- A briefing from the organization in whom the complaint is been made against. This briefing may be prior to the hearing
- The complainant to attend the hearing to present the reasons for the complaint and to respond to questions from the CAC Board of Directors
- The CORE Support staff and CAC CEO to attend the hearing and respond to any questions

After consideration of the written and verbal submissions, the CAC Board of Directors may choose:

- To uphold current accreditation status with:
  - ✓ No action required at this time
  - ✓ Further information as specified by the CAC Board of Directors
- The organization or program is to be re-reviewed:
  - ✓ Accreditation status suspended pending a partial review of the organization or programs as determined by the CAC Board of Directors
  - ✓ Accreditation status suspended pending a complete review of the organization and all programs within 2 weeks of the decision to a maximum of 2 months
- Accreditation Status Revoked:
  - ✓ Accreditation status for the program revoked
  - ✓ Accreditation status for the organization and all programs revoked

The CAC Board of Directors will notify, in writing, the organization director, the complainant, and the CAC CEO of the decision.

If an On-Site Review is Ordered

The organization is informed of the decision, the timelines, the team who will be conducting the On-Site Review and the consequences of not co-operating with the Review Team.

Failure to co-operate with the team, (e.g. not allowing the team access to the facility, files, etc.), will be reported to the CAC Board of Directors and will result in immediate revocation of accreditation status.

If while on-site, the Review Team finds immediate concerns about the safety of person served, this information will be reported to the organization, appropriate ministries, funders or other appropriate bodies and to the CAC Board of Directors within 24 hours.

The program has 10 days to respond in writing to any non-compliant findings by the Review Team.

The On-Site Review Report, along with the Program Response, will be forwarded to the Accreditation Panel. The Accreditation Panel will decide:

- That the issue has been addressed and accreditation status of the program remains in effect until the expiry date or
- To revoke accreditation status

The decision of the Accreditation Panel will be forwarded to the CAC Board of Directors, and the organization, in writing, within 5 calendar days of the decision. If the status of the program has been revoked, the program is requested to return the CAC plaque and certificate.

The organization has the right to appeal the decision of the Accreditation Panel and would follow the process as outlined in the section on Appeals.

CONFIDENTIALITY AND ACCESS OF INFORMATION

Review findings are shared with the CAC office, and the Calgary Homeless Foundation.

Identifying information about clients, staff or the program is not revealed to anyone other than the review team and the program.

CAC will report any issue, event or matter to appropriate authorities should CAC staff or reviewers believe that there is a risk posed to the safety or well-being of clients.

CAC acknowledges that the Government of Canada has passed the Freedom of Information and Protection of Privacy Act. This Act applies to all information obtained, related to, generated by, or collected during the course of a review.

All members of the CAC Board of Directors, CHF Adhoc Committee, Accreditation Panel, reviewers, and CAC staff are bound by an Oath of Confidentiality.

Programs that have been granted accreditation or are in the process of accreditation will be listed on the website: http://www. cacohs.com

USE OF CAC LOGO AND CERTIFICATES

CAC accredited programs are encouraged to indicate this status on their program letterhead and in their promotional materials.

CAC will gladly forward a "print-ready" logo and an "Accredited" seal.

If accreditation status of a program lapses or is revoked, the use of the logo must be discontinued.

Any certificates given to a program remain the property of CAC. These must be surrendered to CAC if requested for reasons such as revocation of accreditation of a program.

Calgary Homeless Foundation

STANDARDS

Standards of Practice

2011 Edition

Canadian Accreditation Council
Since 1974

Table of Contents

1.0 Privacy & Information Management

The collection of information and the use of that information by programs must be in alignment with federal and provincial legislation and regulations and professional guidelines around privacy.[viii]

These include but are not limited to the following:

- *The Privacy Act (federal)*[ix]*: protects the privacy of individuals with respect to personal information about themselves held by a federal government institution and provides individuals with a right of access to that information.*
- *Personal Information Protection and Electronic Documents Act (PIPEDA)* [x]*: establishes rules to govern the collection, use and disclosure of personal information in a manner that:*
  - ✓ *Recognizes the right of privacy of individuals with respect to their personal information,*
  - ✓ *The need of organizations to collect, use or disclose personal information for purposes that a reasonable person would consider appropriate in the circumstances.*
- *Personal Information Protection Act (Alberta) (PIPA)*[xi]*: protects individual privacy by requiring private-sector organizations to obtain consent for the collection, use and disclosure of personal information in most cases, and provides individuals with a right of access to their own personal information.*
- *The Freedom of Information and Protection of Privacy (FOIP) Act*[xii]*: aims to strike a balance between the public's right to know and the individual's right to privacy, as those rights relate to information held by public bodies in Alberta.*
- *The Health Information Act*[xiii]*: sets the privacy and confidentiality standards by which health information is collected, protected, utilized and accessed.*

1.1 DATA MANAGEMENT

*1.1.1 Information Management System**

The program has a system to manage information requirements (i.e. training of staff , scheduled reviews, documentation, forms etc.) and has written procedures to ensure the completeness of its files and data.

1. Staff files
2. Client files
3. Outcome and quality improvement monitoring

INDICATORS

- ❑ Procedure
- ❑ Senior Management interview
- ❑ Supervisor/Direct Service Staff interview
- ❑ On-site observation of the monitoring system used

**CAC Standard used with permission from the Canadian Accreditation Coucil of Human Services*

*1.1.2 Access To Files/Data**

The program has written policies and procedures that define the processes by which it restricts and monitors access to the files/data of staff and clients. These policies include:

1. How staff and clients may access their own records and addresses those documents (if any) that would not be accessible
2. Positions within the program who may access files or other communication mechanisms (i.e. logs, communication books, etc)
3. Addressing the process to:
    a. Add, correct and/or delete information currently on the file
    b. Respond to requests for access by former staff or clients
    c. Respond to requests for the records of deceased clients, and

INDICATORS

- ❑ Policy and procedures
- ❑ Senior Management interview
- ❑ Supervisor/direct service staff interview
- ❑ Client interview

**CAC Standard used with permission from the Canadian Accreditation Coucil of Human Services*

1.1.3 Maintenance Of Data*

The program has written policy and procedures that address files and/or data for current and past staff and clients.

Procedures are congruent with legal and funder's requirements, the program's confidentiality policy and address:

1. Transporting of information
2. Sharing and reporting of information
3. Timelines for storage for records
4. Means of storage for open/closed files
5. Destruction of records or data

INDICATORS

- ❏ Policy and procedures
- ❏ Senior Management interview
- ❏ Supervisor/direct service staff interview

**CAC Standard used with permission from the Canadian Accreditation Coucil of Human Services*

1.1.4 Protection Of Confidential Information*

The program has written procedures to protect its electronic and physical information files and data from unauthorized access, theft, and destruction by fire, water, loss, corruption, power failure and/or other damage. Procedures may include, but are not limited to, the following measures:

1. Locked storage for paper files containing personal information
2. All computers have up-to-date anti-virus protection
3. Secure protocols, including the use of passwords and firewalls which govern the electronic collection and transfer of sensitive data
4. Regular backup of all electronic records, which are preferably stored off-site

INDICATORS

- ❏ Narrative and documentation submitted
- ❏ On-site observation of procedures to store and protect its electronic and physical information files and data

**CAC Standard used with permission from the Canadian Accreditation Coucil of Human Services*

1.1.5 Electronic Technologies*

The program has written policies and procedures that address the use and security of electronic and wireless technologies as it pertains to information regarding clients (i.e. cellular telephones, personal digital assistants (PDA), E-mail, computers, portable methods of electronic storage, internet, digital imaging, recording devices, pagers, etc.)

INDICATORS

- ❑ Policy and procedure
- ❑ Senior Management interview
- ❑ Supervisor/direct service staff interview

**CAC Standard used with permission from the Canadian Accreditation Coucil of Human Services*

1.1.6 Consent For Services

The program has written consent forms in plain language that discuss the protection of privacy and confidentiality of client information. Forms are signed by the client before initiation of services, and a copy is kept in client files.

Consent forms should include:

- Purpose of the information being collected
- Reason for collection of information
- Use of information
- Access to information
- Secure storage of information
- Length of time information will be stored

INDICATORS

- ❑ Policy and procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ Client file

2.0 Activities Of Case Management

Case management specifically for ending homelessness should follow the activities of case management outlined below and should ensure that rigorous processes of engagement and avoidance of unplanned or premature discharges are in place and documented.

2.1 INTAKE

Intake in case management is defined as:

A screening process to identify client needs in order to ensure program fit.[xiv] It is crucial that the family/persons' needs are matched to the organization's eligibility criteria.[xv] Once screened for eligibility, clients go through a more formal intake process.

During this process the case manager will outline the scope of services that will be provided, conduct a process of informed consent to receive these services, review a grievance and appeals process, and the criteria/process for planned and unplanned discharge from the case management relationship.

Appropriate referrals and follow-up should be documented for people assessed as not eligible for the program. If the client was referred from another program, and they are not eligible they should be referred back to the original referral for follow up with the reason for ineligibility. If it was a self-referral and the person is not eligible, the person should be provided with 3 additional program referrals. These should be documented.

At intake, clients are to be explained their rights and understand:

- *grievance procedures*
- *involvement in service planning*
- *involvements in future planning*
- *advocacy*
- *cultural connection*
- *confidentially*
- *consent and sharing of information*

2.1.1 Referrals

Within 5 working days of the receipt of a referral, the program must respond to the referred person to acknowledge whether or not the referral meets the program's eligibility criteria and to provide information regarding anticipated wait times. This information is to be documented.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ On-site observation

2.1.2 Inappropriate Referrals

Should the referred person not meet the eligibility criteria for the program, the program will provide three (3) alternate resources. If there are not 3 programs available, (i.e. inappropriate client/program eligibility match) this should be documented including what the case manager did to facilitate the referrals.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ On-site observation

2.1.3 Information And Sharing Agreements

Information and sharing agreements must include an expiry date up to a maximum of one year and be signed by the client, witnessed and maintained in the primary client file with copies to the client.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ Client file

2.1.4 Discharge Processes

Discharge processes and procedures should be discussed and documented during intake. Specific criteria for planned and unplanned discharge should be discussed and copies signed and given to the client (note: samples of discharge forms are attached).

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ Client file

2.1.5 Client Rights

Client rights are explained, including grievance and appeals procedures which include the Calgary Homeless Foundation as a contact, if the program is funded by the CHF. This should be signed and witnessed, and a copy provided to clients for accountability purposes.[xvi] As well, client involvement, access to services and confidentiality and consents should be explained. These should be reviewed with clients minimally every three (3) months.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ Client file

2.1.6 Serious Incidents*

The program has a written policy defining what is considered a reportable incident. Reportable incidents include:

- Unanticipated or unauthorized absence from the program
- A medical or other kind of emergency, serious illness or accident
- A dangerous situation (i.e. threats of violence; weapons, client is a danger to self through self-mutilation; suicidal ideation or attempt; etc.)
- Suspicions and/or allegations of abuse, either within or outside the program
- Use of restrictive procedures (i.e. restraints, unlocked confinement)
- Searches
- Death
- Inappropriate use of strategies to influence behaviour by staff; volunteers, students and/or contractors
- Other events as identified by the program

INDICATORS:

- ❑ Policy
- ❑ Reportable Incident forms submitted

**CAC Standard used with permission from the Canadian Accreditation Coucil of Human Services*

2.1.7 Documentation Required – Serious Incidents*

The program has written policy and procedures that require reportable incidents to be documented and reviewed:

1. Documentation to include:
   - ✓ A history of the events or circumstances leading up to the incident
   - ✓ Behaviour of the client that required intervention, if applicable
   - ✓ Timeline of interventions used
   - ✓ Description of actions taken by staff/volunteer, supervisor and/or others involved (i.e. police, medical personnel, etc.)
   - ✓ Follow-up actions/recommendations
2. Follow-up after the incident to include
   - ✓ Debriefing with clients and others who may have been affected
   - ✓ Client was informed of their rights (i.e. initiate the appeals procedure, contact an advocate etc.)
3. Timelines for reporting to the appropriate authorities (i.e. legal guardian, police, etc.).

INDICATORS:

- ❑ Policy and procedures
- ❑ Senior Management interview
- ❑ Supervisor/direct service staff interview
- ❑ Client file – review of incidents involving clients and documents relating to staff involved with inappropriate use of strategies to influence behaviour

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2.1.8 Review Of Serious Incident Reports*

The program reviews all incident reports on a case by case and semi-annually (at a minimum) on a program basis to:

- Ensure the completeness of the information included
- Identify trends (i.e. number of incidents with a particular client, staff, particular circumstances – time of day/month/season; related issues, etc.)
- Address corrective action required (i.e. training needs identified)
- Ensure reporting requirements are being met (i.e. members of the team, Senior Management, family and /or guardian, police, etc.)

INDICATORS

- ❑ Senior Management interview
- ❑ Supervisor/direct service staff interview
- ❑ Client file review of all incident reports to ensure completeness and reporting requirements are being met
- ❑ Onsite review of program summary of Incident Reports (may be included in the quality improvement materials or a separate document)

**CAC Standard used with permission from the Canadian Accreditation Coucil of Human Services*

2.2 ASSESSMENT

An assessment is the process by which the case manager and client identify the presenting issues, client strengths, and service/support requirements to achieve successful permanent housing and enhanced health and well-being. The assessment should be done with the person using a structured process.[xvii]

The case manager should:

- *identify the person's goals, their strengths and current support systems including both professional and natural supports*
- *further explore their needs, concerns, values and choices*
- *be culturally sensitive, respectful, and courteous*
- *be interactive with them*
- *work collaboratively with others to avoid service duplication*
- *inform the person of their care options*
- *identify and prioritize at risk and/or most vulnerable people*
- *work within a scheduled time frame*
- *discuss the plan of action for achievement of their goals*
- *gain consent from the person to share their information with other care providers when necessary*
- *contact the person in a manner preferred by them*
- *include the person in meetings*
- *document all information confidentially*[xviii]

2.2.1 Initial Assessment - Timeline

Initial assessment should be completed within 30 days of intake

INDICATORS:

- ❏ Policy and Procedures
- ❏ Supervisor/direct service staff interview
- ❏ Client interview
- ❏ Client file

2.2.2 Use Of An Evidence-Based Tool

An evidence-based tool is required for assessment, one that measures quality of life, housing barriers, housing retention and stability

INDICATORS:

- ❏ Policy and Procedures
- ❏ On-site observation of tool

2.2.3 Completed Assessments

A copy of the completed assessment tool should be included in the file

INDICATORS:

- ❏ Policy and Procedures
- ❏ Client file

2.2.4 Identified Needs

Assessments should identify primary, secondary and tertiary service needs as well as additional services not provided by the main case manager but that may be required to support the family/individual in achieving success.

INDICATORS:

- ❏ Policy and Procedures
- ❏ Client file

2.3 PLANNING

A service/support plan is developed over the course of several meetings with the person and works to further identify strengths, goals, and activities to achieve these goals. Service plans are intended to be client driven/person-centered and should reflect the individual/family's goals and needs first and foremost.[xix]

Working with the person/family, and based on assessment results, the case manager determines:

- *health care needs*
- *formal and informal support systems*
- *financial, education and employment needs*
- *cultural and religious preferences*[xx]
- *issues or trigger points, and, strategies for dealing with them when they emerge*

The person's goals and priorities should be documented to help the case manager identify the progress as well as determine resources that are available. The service plan should include the activities to be conducted by both the client and the case manager and other service providers that will support goal attainment. Finally, a review and an end date should be attached to each individual service goal to support a process of mindful and continuing reflection and adjustment of goals over time.

2.3.1 Initial Service Plan - Timelines

The initial service plan should be completed within 45 days of intake

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ Client file

2.3.2 Person-Centred Planning

Plan should be person-centered and reflect the needs, goals, etc appropriate to the client (e.g.: youth, harm-reduction, etc).

INDICATORS:

- ❑ Policy and Procedures
- ❑ Client interview
- ❑ Client file

2.3.3 Plan Involvement

Plan should be signed by case manager and client, as well (if possible) as any additional service providers who may be or become engaged in providing services to support housing and health retention.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Client file

2.3.4 Plan Review

The plan should be reviewed with the client at least every 90 days thereafter, up to and including discharge, to ensure its continued relevance and to identify goals achieved and/or goals and timelines to be adjusted.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ Client file

2.4 REFERRAL AND LINKING

A holistic, wrap-around approach to services is best indicated to support families/individuals in achieving permanent housing and increased well-being. This often includes the need for multiple services and service providers to work in a coordinated manner and together with the person. For this reason, the case manager needs to ensure that resources are available to the person to effectively carry out their plan of action to help them achieve their goals. The case manager is expected to:

- *collaborate and build relationships with other care providers about the mutually agreed-upon plan*
- *outline and gain agreement of the roles and responsibilities of all care providers*
- *help facilitate and develop the person's self management skills*
- *promote independence*
- *maintain open communication channels*
- *coordinate and facilitate regular meetings to advocate on the client's behalf, and to discuss or alter changes in the care plan when necessary*[xxi]

2.4.1 Support To Access Referrals

If referral to outside services is a part of the case management plan and the individual/family agrees or requires it, the case manager should accompany the person to the needed service the first time to help ensure successful engagement.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ On-site observation

2.4.2 Efforts To Connect Clients

Efforts to connect clients to services/resources including cultural, spiritual, and/or religious resources must be documented.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Client file

2.5 MONITORING AND EVALUATION OF THE SERVICE/SUPPORT PLAN

As stated previously, a period review of the service goals and plan should be conducted by the case manager in collaboration with the client. Documentation of progress is important to understanding the next steps that should be taken to help the person continue to be efficient in achieving their goals.

When clients are engaged in a plan with at least 6 months timeline, 90 days is the minimum time period between reviews, the case manager and client should determine:

- *the frequency and depth of when reassessments are needed based on each individual*
- *if the identified goals are current*
- *if the plan is satisfactory to the person and care providers*
- *if the person's environment has changed*
- *if decision making has helped towards identified goals, and the impact of goal achievements*
- *the areas of improvement and address any issues any of the providers may be having*[xxii]

2.5.1 Plan Review

The plan will need to be reviewed and updated with the person, minimum every 90 days until the file is closed, unless the case manager and client determine a more frequent review is appropriate.

INDICATORS:

- ❏ Policy and Procedures
- ❏ Supervisor/direct service staff interview
- ❏ Client interview
- ❏ Client file

2.5.2 Ongoing Needs Assessment

An evidence based tool is utilized in conjunction with service planning to assess client needs at intake and once every three months following up to and including 30 days prior to discharge. This will allow for an assessment of extension of services if required. The period of time for goal assessment can be reduced if the case manager or client deems it necessary.

INDICATORS:

- ❏ Policy and Procedures
- ❏ Supervisor/direct service staff interview
- ❏ Client interview
- ❏ Client file

2.5.3 Goal Outcomes

Goal outcomes through case notes and assessments should be reviewed with the client and team members and a copy kept in the file.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ Client file

2.6 DISCHARGE PLANNING

The case management relationship may end upon successful completion of the identified goals (planned), or conclude with the goals unfulfilled if the family/individual decides not to continue with the service and/or if the service is unable to meet the family/individual's service needs (unplanned). Case managers are expected to facilitate the transfer to the appropriate service if their program is unable to meet the needs of the individual/family.

During assessment and planning, the case manager is expected to:

- *discuss the criteria for the end of the case management relationship*
- *determine whether or not the person understands the criteria*
- *provide them with information or links to other available services*
- *support them in securing such resources*
- *obtain written confirmation from the client that they have understood this communication*

To prepare for discharge out of the program, the case manager is expected to:

- *support people to develop self-advocacy skills to maximize independence*
- *collaborate information with other providers upon the person's transition out of case management*
- *provide contact information for re-accessing services or support*
- *address any concerns the person may have about the ending of the relationship prior to ending it*

Processes specific to discharge are undertaken at the beginning of engagement in a program. Discussion of criteria for planned and unplanned discharge is done when first engaging with people and is included in intake and assessment processes. This process is specifically designed before service provision begins, revisited during the case management relationship if issues emerge, and before, during and after planned or unplanned discharge occurs.[xxiii] *All efforts should be made to keep individuals/families engaged in services until final assessments show readiness to disengage (planned discharge).*

Planned Discharge

Planned discharge is the process whereby client's transition out of the formal case managed relationship because goals have been reached and assessments show readiness to disengage. Clients should be provided with contact information for follow up questions and/or for re-engagement with the program if necessary. Extension beyond the original agreed upon completion date can be negotiated if assessment shows additional supports or time is needed.

Unplanned Discharge

Several steps should be in place and documented to ensure all available means were utilized to avoid unplanned discharge from a program. There are two kinds of unplanned discharge, foreseen and unforeseen.

Criteria for unplanned discharge include but are not exclusive to:

1. *Habitual non-compliance with the terms of case management agreement*
2. *Threaten to assault another individual in the program or program staff*
3. *Physically assault another individual in the program or program staff*
4. *Endanger the safety of others*

Foreseen unplanned discharge can occur over several weeks for behavioural issues (I) or over 24 hours for safety/dangerous situations that threaten harm (II, III,IV). Unforeseen discharge can occur at any time, (client leaves program without prior discussion with the case manager). However, unplanned discharge occurs only as a last resort and must be documented within very standardized processes.

Case managers are expected to reduce the likelihood of foreseen and unforeseen unplanned discharge by:

- *regular meetings to address issues*
- *flexible options for payment of arrears*
- *advocating with landlords/building operators on client's behalf, or,*
- *liaising with 'housing locators' to advocate with landlords/building operators if this service is provided through formal partnership with another program*
- *mediation and conflict resolution*
- *supporting clients to transfer to different housing if negotiations and accommodations cannot be made with existing landlords/building operators*
- *these activities should be documented by the case manager*

In the event of a foreseen unplanned discharge, the case manager must make every effort to ensure the successful transition to another program by ensuring:

- *appropriate referral to a minimum of three (3) programs that the client could enrol in, with client consent. The focus of these referrals should be housing stability. If there are not 3 programs available, (i.e. inappropriate client/ program eligibility match) this should be documented including what the case manager did to facilitate the referrals*
- *Only when no reasonable alternative is available should a return to emergency shelter be an option, for example, if a woman/family fleeing violence requires the additional security of a women's shelter while alternate housing plans are made. This should be documented in the case file*
- *acknowledgment from receiving program of referral and date of screening/ intake*
- *the agency receiving the referral, should consider program fit. Wait list, and capacity to accept client. If referral is not appropriate, the agency should communicate to referring agency with the reason for refusal*
- *transfer of client information if appropriate and with consent can include plan, referral history and case notes*
- *if client is unwilling to take transfer it is important that s/he be supported in their right to choose. Once presented with 3 appropriate options, and they refuse all, the agency may discharge the client from the program*
- *provision of contact information for re-engagement in the discharging program NOTE: if discharge occurred due to threats of violence against program staff, program can use discretion for allowing re-entry, if the program decides not to accept the client back, this should be documented including the reasons why not, e.g. staff still felt as though they were still under threat*
- *provision of program grievance and appeals procedures*

All efforts should be documented and kept in the client file.

2.6.1 Final Plan Review

A final review of the service/support plan should occur 30 days before the end of the formal relationship for planned discharge

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ Client file

2.6.2 Post-Measurement

Using the same evidence-based measurement tool as at intake, a post-measurement should be completed within 10 days before or 10 days after planned discharge

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client file

2.6.3 Further Supports

If further supports are needed a continuation of the service can be negotiated or referrals made to other services. Consents and agreements should be re-signed; this should be documented in the client file.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ Client file

2.6.4 Unplanned Discharge

Before unplanned discharge from a case management program the case manager will ensure all efforts have been made to address behavioural issues and rental arrears. Mediation, conflict resolution, landlord/building operator negotiations, and options for housing transfer. All efforts should be documented and kept in the client file. Copies should be given to clients.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ Client file

2.6.5 Unforeseen, Unplanned Discharge – Discharge Summary

In the case of unforeseen, unplanned discharge, that is immediate and cannot be predicted (client leaves without prior discussion with the case manager), the case manager must complete a discharge summary that contains information related to efforts to resolve issues and keep clients engaged. This should be documented in the client file.

INDICATORS:

- ❏ Policy and Procedures
- ❏ Supervisor/direct service staff interview
- ❏ Client file

2.6.6 Unforeseen, Unplanned Discharge – Transfer Efforts

In the event of foreseen, unplanned discharge the case manager will ensure all efforts have been made to facilitate transfer to another case management program. This includes transfer program contact information, acknowledgment of receipt of referral from receiving agency, proposed date of screening/intake, transfer of client information (with consent) contact information for re-engagement in the discharging program. A minimum of 3 appropriate referrals should be made. Only when no alternative is available should emergency shelter be a referral option. If a client is unwilling to take transfer it is important that s/he be supported in their right to choose. Once presented with 3 appropriate options, and they refuse all, the agency may discharge the client from the program. This should be documented in the case file.

INDICATORS:

- ❏ Policy and procedures
- ❏ Supervisor/direct service staff interview
- ❏ Client file

2.6.7 Reinforming of Grievance And Appeals Procedures

Clients should be reminded of the grievance and appeals procedures which include the Calgary Homeless Foundation as a contact for clients if the program is funded by the CHF, and a copy provided to the client.[xxiv]

INDICATORS:

- ❏ Policy and Procedures
- ❏ Supervisor/direct service staff interview
- ❏ Client interview
- ❏ Client file

2.6.8 Re-Accessing Services

At discharge the client is advised how to re-access the service if necessary in the future. If re-access occurs within 12 months of discharge, the client file can be re-opened and an updated plan developed. If re-access occurs after 12 months, the case management process begins with a new intake.

INDICATORS:

- ❏ Policy and Procedures
- ❏ Supervisor/direct service staff interview

3.0 Training & Core Competencies

Training

It is critical for case managers to have an understanding of the populations they are serving and to demonstrate qualifications specific to their clientele and program criteria. Case managers and the organizations they work for need adequate training and support, for professional development, unique needs of client populations, cultural competency, and to ensure standards, ethics, and codes of conduct are understood and used .

Aboriginal people are over-represented in the population of those at-risk of and experiencing homelessness. Newly emerging research indicates that attention to cultural competency and cultural re-connection can be an important success factor leading to positive outcomes. Some additional research suggests that for some populations experiencing homelessness, more successful engagement occurs when the person receiving the services is able to identify via shared cultural background, cultural understanding with their service provider (Government of Canada, 2005).[xxvi] Organizations serving Aboriginal individuals and families should work to ensure Aboriginal staff are included in their case management staffing models.

Attendance at all annual training should be documented in the employee's file.

Core Competencies

Henning & Cohen, (2008) argue that applying core competencies to the work of case managers is an important aspect of orientation and training for those new to the job, for professional development of existing case managers, to align competencies with standards of practice and to create standardization within case management practice. The competencies are added to job descriptions and performance evaluations primarily because case managers come from a variety of professions and academic backgrounds, some of which are rooted in clinical practice and not necessarily rooted in community based care.

Competency was defined as "the knowledge, skills, abilities, and behaviours needed to contribute to the mission, vision and values of our organization" (Henning & Cohen, 2008, p. 131).

Morse (1998) further describes competencies in the context of homelessness.

Specifically, agencies should recruit, hire, and/or train, and supervise staff to develop skills and knowledge in the following areas:

- *homelessness*
- *specializations based on agency mandates and culturally appropriate interventions, e.g. mental health, addictions, and/or sub-populations. As well, it is recommended that case managers receive training on dealing with multiple issues and heterogeneity*
- *engaging homeless people and developing trusting relationships*
- *administer and analyze a variety of assessment tools*
- *activities, and processes of case management*

- *crisis intervention including suicide assessment and prevention*
- *a strong working knowledge of the existing services and supports and how to access them (systems navigation)*
- *the specific model or method of case management the agency adheres to*
- *disease education and prevention e.g. HIV/AIDS*
- *work-life balance and stress management including burnout avoidance*

3.1 TRAINING AND CORE COMPETENCIES

*3.1.1 Aboriginal Awareness Teachings**

Staff, who are engaged to work solely with a client that is non-Aboriginal, may be exempt from this standard. Staff file will indicate that they will not work with Aboriginal persons until training has been completed.

1. All direct service staff, who work with Aboriginal clients (members of First Nations, Métis, or Inuit communities), receive a minimum of eight (8) hours of Aboriginal Awareness within nine (9) months of initial work with the program. This learning may be individualized to accommodate program needs and staff's previous experience, current knowledge and/or involvement within the Aboriginal community

   Learning may include a combination of:

   - ✓ attendance at cultural and/or educational events
   - ✓ learning from historical interpretive centres
   - ✓ attending lectures, workshops
   - ✓ experiential learning
   - ✓ meeting with an elder or other knowledge-keeper
   - ✓ having guest speakers address staff functions etc

2. Direct Service Staff new to the field or who are not aware of Aboriginal history have training that addresses some or all of the following issues:
   - ✓ history of Aboriginal people
   - ✓ definitions of who is Aboriginal
   - ✓ effects of colonization and government policies (i.e. residential schools, 60's Scoop, Jordan's Principle)
   - ✓ current issues and realities of Aboriginal peoples on and off reserve;
   - ✓ impact of the Indian Act
   - ✓ systemic racism and its impact on individuals and communities
3. Documentation on an annual basis, a minimum of eight (8) hours of on-going learning.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Supervisor/direct service staff file

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3.1.2 Safety Procedures

The agency has staff safety procedures in place and all staff are trained in these.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Supervisor/direct service staff file

3.1.3 Core Training

Direct service staff will have (or receive within the first 3 months of employment) training in basic interviewing and client engagement techniques, non-violent crisis intervention, suicide training, and disease education and prevention e.g. HIV/AIDS. Orientation will include, the agency's agreed upon ethical code of conduct, (see Appendix B for sample code of conduct), and case management standards of practice (e.g.: conducted in-house by experienced case management leads or clinical staff; or as provided by the Calgary Homeless Foundation).

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Supervisor/direct service staff file

3.1.4 Network Of Services

Case manager should be knowledgeable about the network of services and have up-to date information. Activities that ensure this continuing knowledge update should be documented regularly throughout the year in the employee's supervision notes or program training file.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Supervisor/direct service staff file/training file

4.0 Case Management Processes

4.1 CASE LOADS

Case loads should be determined by the family/individual's level of acuity/need and the capacity of the organization. Time issues of case managers should be continually reviewed

By taking into account clients' individual mental health needs, physical health needs, and, if present, substance misuse or addiction concerns, services should be selected and tailored specific to their needs and goals as people experiencing, or at risk of homelessness should not be treated as a homogenous group.[xxviii]

4.1.1 Case Load Determination

Case loads will be determined based on complexity of client issues but a guideline range would be 1:10 to 1:25 or higher dependent upon agency capacity and client acuity/need. For example: case managers who work with people with high needs/acuity the case load ratio should not exceed 1:10/15, while those who work with people with moderate acuity needs the case loads should not exceed 1:20. Lower acuity needs caseloads generally should not exceed 1:25.[xxix]

INDICATORS:

- ❑ Policy and Procedures
- ❑ Senior management interview
- ❑ Supervisor/direct service staff interview

4.2 MODELS

Existing models such as ACT (Assertive Community Treatment) or ICM (Intensive Case Management) are proven successful but need to be adapted for people experiencing or at risk of homelessness to ensure complex and multiple individual needs are being met, there is a strengths focus and client choice is forefront.[xxx] *The provision of 24/7 crisis support should be included in all models of case management service delivery. It is also important to note here that while not a standard, best practise literature and emerging promising practises in case management indicate that inclusion of a peer support model may lead to successful client engagement and housing retention outcomes.*

Model should be determined by:

- *duration of services*
- *intensity of services*
- *focus of services (from specific services to a comprehensive holistic bundle of services)*
- *resource responsibility (who will deliver services, advocate and coordinate the services)*
- *office hours*
- *location of services (in home, and/or out in community)*
- *staffing pattern (building interdisciplinary teams with shared caseloads and determining roles)*[xxxi]

4.2.1 Model

The model or approach used should be based on the needs of people and the mandates of the organization and/or experience and specific role of the case manager.[xxxii]

INDICATORS:

- ❏ Policy and Procedure
- ❏ Senior management interview
- ❏ Supervisor/direct service staff interview

4.2.2 Primary Case Manager

A team based collaborative approach with one primary case manager is essential.[xxxiii] The primary case manager should be identified on the client file.

INDICATORS:

- ❏ Policy and Procedure
- ❏ Supervisor/direct service staff interview
- ❏ Client interview
- ❏ Client file

5.0 Service Delivery

The following section highlights key competencies specific to delivery of case management activities. Organizations must ensure processes to address the unique support needs of the homeless population/s they are serving.

5.1 SERVICE DELIVERY

5.1.1 Direct Clinical Services - Qualifications

Agencies providing case management services that include direct clinical services such as counselling in regards to mental illness (including Post Traumatic Stress Disorder), and chronic health concerns will ensure that these services are provided by qualified clinicians (either via partnerships with other agencies/services or internal to the program) who are registered and/or regulated by their specific professional body. Clinical designations include: physicians, nurse practitioners, mental health therapists (MSW, Clinical Psychologist, Psychiatrist, Mental health/Psychiatric nurses, etc).

INDICATORS:

- ❏ Policy and Procedures
- ❏ Senior management interview
- ❏ Clinician file

5.1.2 Specialized Training

Should the person require it, the case management team should include service providers with experience/training in complex individual/family concerns, e.g. domestic violence interventions, and substance abuse/addictions related issues. These should be provided by qualified staff with specialized training or accreditation/education in these interventions. (e.g.: Addictions Counselling Certificate, College/University degree which included this training, other specialized training).

INDICATORS:

- ❏ Policy and Procedures
- ❏ Senior management interview
- ❏ Supervisor/direct service staff file

5.1.3 Direct Service Provision - Partnerships

Any partnerships and/or processes to provide direct services via other organizations should be documented within the program's protocols along with copies of any partnership agreements or MOUs (Memorandum of Understanding).

INDICATORS:

- ❑ Policy and Procedures
- ❑ Senior management interview
- ❑ On-site observation of documentation (agreements/MOUs)

*5.1.4 Recruitment Reflective Of Clients**

Recruitment is reflective of clients.

If the program recruits and selects staff with regard to specific characteristics, it does so in accordance with exemptions in the law(s) governing equal opportunity in employment (Human Rights Commission – provincial and federal).

The program has written policy and procedures (practices) in place to recruit and retain staff that are reflective of the diversity of clients.

INDICATORS

- ❑ Narrative submitted as to the diversity of the clients (% within program over the last year) and the program's ability to recruit and retain staff that is reflective of the diversity (how many were recruited and left the program)
- ❑ Senior Management interview
- ❑ On-site observation of recruitment materials

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5.1.5 Aboriginal Staff*

Aboriginal peoples are often overly-represented in accessing programs and services. Historically and currently the number of Aboriginal people providing services has been under represented. This is an especially important issue in those programs working with Aboriginal children, youth and families.

Programs which serve Aboriginal children and families recruit and retain Aboriginal workers at a similar ratio to its Aboriginal children and/or families.

Minimally, programs serving 15% of Aboriginal persons served (of total persons served within the last year) retain a minimum of 10% complement of full time equivalent Aboriginal workers (FTE).

INDICATOR

- ❏ Narrative submitted to address:
  - The percentage of Aboriginal persons served;
  - Listing of all staff (full-time, part-time and casual) employed in the program;
  - The number of full time equivalent positions;
  - Listing of staff who identify as Aboriginal (% of FTEs)
  - Documented attempts to meet this standard (i.e. copies of recruitment advertisements, evidence of contacts with Aboriginal programs, internal practices that accommodate the needs of Aboriginal personnel, etc.)
- ❏ Senior Management interviews

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5.1.6 Crisis Support

24/7 crisis support available by telephone or in-person should be provided by the main service agency if possible, or alternately a list of crisis resources (including 24/7 response) should be provided to the family/individual. This should be included in the intake process.

INDICATORS:

- ❏ Policy and Procedures
- ❏ Supervisor/direct service staff interview
- ❏ Client interview
- ❏ Client file

5.1.7 Serious Incident Reporting

Serious Incidents involving clients and/or staff in a Calgary Homeless Foundation funded program are documented, signed (or electronically acknowledged) by a senior agency personnel, and forwarded to the Calgary Homeless Foundation within 24 hours of occurring. *See attachments for a sample Incident Reporting Form

INDICATORS:

- ❑ Policy and Procedures
- ❑ Senior management interview
- ❑ Supervisor/direct service staff interview
- ❑ Client file

5.1.8 Move In/Moving Support – Basics And Necessities

Comprehensive, cost-effective move-in/moving support provided by the case management service or via appropriate referral. The case manager should work with the family/individual to ensure that they have all the basic furniture and necessities in place upon move in or relocation (rehousing), or, have a plan in place to ensure acquisition of necessities as quickly as possible. Examples of minimum necessities include a bed & related items for each tenant (maximum time within 2 weeks); basic cookware and dishes (within 2 days), a telephone/cell phone (within 2 days); 1 week of groceries and toiletries (upon move in). If this cannot be accommodated the efforts made and reasons why not must be documented.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ Client file

5.1.9 Relocation/Rehousing

Prior to relocation and/or rehousing, the case manager will support the client in accessing moving services and ensuring that minimum necessities required are available to ensure loss is minimized. These should be documented in the service/support plan.

INDICATORS:

- ❑ Policy and Procedures
- ❑ Supervisor/direct service staff interview
- ❑ Client interview
- ❑ Client file

5.1.10 Code Of Ethics

The program/agency has a clearly outlined code of ethics/ethical conduct in place.

INDICATORS:

- ❏ Policy and Procedures
- ❏ Supervisor/direct service staff interview
- ❏ Supervisor/direct service staff file

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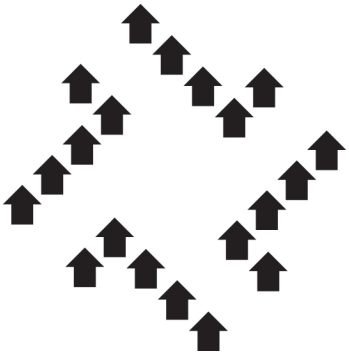

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SAMPLE DOCUMENTS

Sample Documents

2011 Edition

Table of Contents

DISCHARGE REPORT PRIOR TO UNPLANNED DISCHARGE (FORESEEN)

I _____(name of case manager) _____ provided the following services prior to client discharge:

Action	Services	Date	Number of Times
	Mediation		
	Conflict resolution		
	Landlord/building operator negotiations		
	Liaised with 'Housing Locator' staff to ensure Landlord/building operator negotiations		
	Name of housing locator staff and Agency		
	Transfer to new housing		
	Facilitated transfer to another case management programs		
	Provided referral contact information		
	Provided contact information for re-engaging in same program		
	Provided program grievance and appeals procedures		

With (Client Name) _____

Client was notified of this report by:

Action	Communication	Date
	Voice mail	
	Personally handling a copy to _____	
	Mailing a copy to his/her place of residence	

AND: _____ adding a copy to the client file on (date): _____

Signature: _____

DISCHARGE REPORT FOLLOWING UNPLANNED DISCHARGE (UNFORESEEN)

I ____(name of case manager)_____ am reporting that on or about (date) _____the following client (client name) _____ disengaged from services.

The following actions were taken by me to determine disengagement:

Action	Communication	Date	Number of Attempts
	Phone calls with voice mail messages		
	Phone calls without voice mail messages		
	Visits to residence		
	Emails		
	Written letters		

INCIDENT REPORT

Safety		Safety	
Health		Med Error	
Other (Please describe)			

Name of individual:	
Incident date:	
Incident time:	
Report date:	
Staff name:	
Place of incident:	

What happened just before the incident? Describe the setting, name of who was present, list of the events leading up to the incident.
Describe early situational indications of the impending incident. Describe any preventative measures used.

Give a precise description of the actual incident including the individual served, observer and (if applicable) victim behaviour.Please answer all of the following, including time references and complete descriptions:
1. Were Restrictive Procedures used? _____ If no, proceed to question 3
2. If yes, describe what restrictive procedures were used, for how long, and who used them.
3. Were there any consequences for the individual?

4. Is there any history of the action of concern and have previous strategies been employed to address it?

5. Who was notified of the incident? When?

6. What procedures do you believe need to be implemented to prevent reoccurrences?

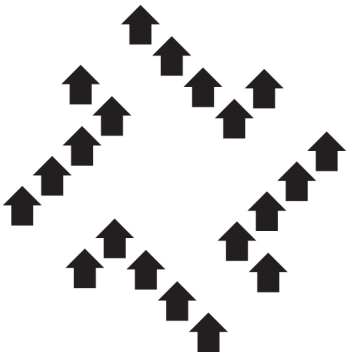
7. As a staff member, do you believe you require further training to deal with possible reoccurrences?	Yes	No

8. What follow-up plans have been made? May include further individual training, in services or change to Policy and Procedure.

Staff Signature:	
Date:	

Has the Parent/Guardian been notified?	Yes	No

By Whom?	
Date:	
Program Manager:	
Date:	
Signature:	



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SUPPORTING RESEARCH

Supporting Research

2011 Edition

DIMENSIONS OF PROMISING PRACTICE

For Case Managed Supports in Ending Homelessness

July, 2011

ACKNOWLEDGEMENTS

Thank you to the members of the advisory committee in the development of this background paper. Their expertise, feedback and support added strength and rigor to this project. Many thanks also to our community partners for their open, honest feedback, and to the men, women and youth whose experiences guided this project.

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EXECUTIVE SUMMARY

"Ending homelessness" is a complex and multifaceted endeavor. Case management has been identified as a critical aspect to successfully ending a person's or family's homelessness. Several months of consultation and research facilitated by the Calgary Homeless Foundation led to the development of this report. Its purpose is to gain clarity on and to set dimensions around the promising practices essential for case managed supports to end homelessness.

The research revealed several key findings:

- Defining case management is a difficult process. Existing research and information from service providers indicated variety and sometimes confusion in how it is described and administered.
- Clarity in language and definitions is critical to a coordinated community of care. The variance and confusion has led to different approaches, and therefore different outcomes, for people accessing services.
- Effective case management is potentially one of the best interventions for a sustained end to homelessness. Research shows that case management works. It has been documented to reduce homelessness between 97% and 100% when done in a holistic and comprehensive way.
- Existing definitions for case management are often done by identifying its key activities, processes and principles, and the roles and core competencies of case managers.
- Local barriers to effective case management include: a complex, fragmented system that leads to staff burnout, rigid and complex resource accessibility, politics, and scarcity approaches to service delivery.
- Promising practices for case management include: collaboration and cooperation, right matching of services, ethical conduct, a coordinated and well managed system and continued professional and sector development.
- Overwhelmingly, peer support was identified by service recipients as a key factor in their success.
- Providing case managers with support to develop and maintain identified core competencies can help reduce staff burnout, ensure adherence to ethical codes and behaviors, increase consistency in practices across the continuum of care, and improve the likelihood of success for service recipients.

Implications and recommendations:

- By following the advice and input of people experiencing homelessness in our community, we can ensure the interventions or actions we put into place directly reflect lived experiences. Continuous consultation with our homeless community will ensure that practices aimed at ending homelessness reflect individual needs including cultural supports, complex or multiple issues, and/or past histories of unsuccessful systems interactions.
- There are many solutions for the multitude of barriers we face to effective case management. This includes inter-sector collaboration through team

based intervention, participation on advisory committees and consistent information sharing on best practices.

- The use of evidence-based practices for case managed supports, in addition to processes and tools for coordinating, adequately resourcing and managing a case management system, is important and achievable. The critical aspect is ensuring the processes address both individual and systemic factors, and are as guided by and done with community.
- There is a need for ongoing research about case management and how it relates specifically to ending homelessness. This includes research specific to sub-populations, models of case management for ending homelessness, and client complexity and concurrent disorders. Given the heterogeneity of peoples' experiences, further research will also help indicate whether or not dimensions of practice are applicable, adaptable and continually relevant.
- Providing case managers with adequate support for training and professional development will help ensure that promising practices continue.

BACKGROUND

"We need constant consultation with people who experience homelessness. Their input is real; ours is borrowed" (Service Provider #6, SP6).

Several months of consultation with people experiencing homelessness in 2008 and 2009 overwhelmingly identified that if people are to be truly successful in ending their homelessness, they must have adequate and appropriate supports as well as housing. It was also discovered that there are varied and diverse approaches to supportive housing, which creates barriers to community collaboration and limits effective service delivery. In the end, this causes varied levels of success for people trying to end their homelessness.

Calgary's 10 Year Plan to End Homelessness identifies case management as a support system that has been successfully used to ensure people have what they need to succeed. The 10 Year Plan and information from community consultations led to a research project to discover how service providers are actively defining case management. The end goal is to design a document that outlines key definitions, key concepts, best practices, and over-arching principles for providing meaningful and evidence-based case managed supports for overcoming homelessness.

Prioritizing the development of evidence-based practices to aid in a sustainable end to people's homelessness was rooted in certain assumptions:

- We need to understand the complexity of people's experiences. This includes individual factors such as childhood trauma and abuse, intergenerational trauma for Aboriginal people, addictions, family breakdown and mental health concerns. Structural factors such as lack of affordable housing, the role of the economy and discrimination, as well as complex, often unmanageable, systems must also be considered.
- Individual and structural factors are significant pathways into homelessness.
- The ways in which people are marginalized by these factors can be exacerbated in their dealings with a system that can create further issues of mistrust and isolation.
- People experiencing homelessness are the foremost experts in their experiences and therefore their perspectives are the driving force in the development and implementation of solutions.

To set the framework and the context, this report begins with a narrative account of the experiences of 10 men, women and youth either experiencing homelessness or having a recent history of homelessness. This report has been written based on quotes and summarizations of the accounts collected in interviews with these individuals.

About homelessness...

Living on the street is hard. There is always a reason that someone is there. Maybe they had a hard life at home and had to get out, maybe they were forced out or maybe they made bad choices that piled up so high they couldn't get out from under them.

*Sure I've have made bad decisions, but I have also had some pretty sh*tty things happen to me too. Ending up on the street is scary and lots of times you do things to cope with that. You feel hopeless and helpless and you want to give up. You don't know where to go or what to do.*

Getting assistance is hard, especially if you are a youth. You are told, "You're young and healthy; go get a job." The recession has made it harder to find work. I used to work three jobs so I could pay my rent, [but] now I can't find one job. If you are homeless and a youth, people think you are untrustworthy so they won't hire you. I even offered to work for half the salary and wasn't hired.

Shelters should be an absolute last resort, not the place you have to go to because there is no other place… We need something positive and constructive to do especially on weekends. If there is no place constructive to go you end up getting into trouble.

One of the hardest parts is when people don't understand what you are going through and assume things. Or, they treat you like a third class citizen because of the way you look.

Regarding case managers...

I have had case managers who supported me in the wrong way. [They] treated me like a child – like I didn't know anything. I ended up feeling judged and stupid. It felt like supports were forced on me because they knew what was best.

Good case managers are open, good listeners and make me feel comfortable and understood. Not being judged, but just being accepted and supported in my decisions. They need to like their jobs and have a 'don't worry about it; I'll take care of it' attitude.

The best case manager I had, had personal experience with homelessness. He didn't have the most education, but he had been there. He almost never got frustrated and if he couldn't help me he knew who could and he got me there. He treated me with respect, like a real human being because he knew what I was going through.

Youth on the street have had to grow up fast just to survive, so we are smart. We should be able to sign our own leases. If you need roommates, each person should be able to sign their own lease with the landlord. That way if my roommate doesn't pay rent, we don't all get kicked out – just that one person. Case managers could work with landlords to make this happen.

Everyone needs something different, so a good worker is someone who knows all the systems and how to get what you need. It is better to have one person who knows all the systems than to have three or four. They went with me everywhere to help me do it and didn't leave me on my own to

do it for a while. But [they] didn't do it for me; they taught me how to do it for myself. Everybody should have this.

Having a case manager helped to fast-track me through everything. They helped me get to appointments, and access bus tickets and food when I needed it. They helped me get into housing in three days but not just housing – furniture, food and the right supports. Services and people are hard to find; they taught me where to go for help and how to find help if I needed it, so I could access a bunch of services at the same time.

My case manager worked behind the scenes, and was beside me all the time. This was one person I knew I could contact. Long-term connections, any time I could call. This helped me feel wanted.

She did good referrals and knew the good offices to go to get financial support, including help getting AISH. She provided me with all the information I needed and explained everything, stayed with me from the start right through to the end – stable housing with access to money and support if I needed it. She still calls me once a week to see how I am doing.

Having housing was great but also, having someone talking with the landlord to help me keep it. Weekly appointments are good but phone calls anytime and long-term supports and crisis intervention are good too. It has been important to stay connected to my case worker even after I moved into housing. If something happens, I have someone to turn to.

The key aspects of case management that were important to the men, women and youth emerged in discussions about what makes good case manager. This included being heard and understood, not being judged, and having open, honest communications. It also required a patient and engaged case manager, and access to flexible programs and support for systems navigation. The most important aspect of successful case management was overwhelmingly described as having peer support or working with someone who had personal experience with homelessness.

SETTING THE CONTEXT

Case management works!

Case management is an effective and important intervention when well coordinated and adaptive (Melaville, 1991). According to Nelson, Aubry & LaFrance (2007), a combination of case management and housing supports is the most successful approach because to end homelessness, individuals or families must be able to find stable, permanent and affordable housing, accompanied by the appropriate services and support systems (National Alliance to End Homelessness, 1999; Tull, 2006). For those in stable housing, case-managed supports should be provided in the home (Tull, 2006). According to Flowers-Dortch (2008) and the National Alliance to End Homelessness (1999), providing case managed supports over a period of time reduces both the length of time homeless and the reoccurrence of homelessness. In one study, those with complex needs showed a 100% increase in the

number of days successfully housed when their case managed supports were balanced with appropriate housing (Clark & Rich, 2003). In another study in Fayette County in the US, only 3% of people accessing case managed supports returned to a homeless state following completion of service (Veghts, 1990).

Effective 'full service' (multidisciplinary and collaborative) case management is expensive and a complex process to implement (Rosenheck, Kasprow, Frisman & Liu-Mares, 2003), but has been shown to increase treatment retention, housing retention, reduce hospitalizations, reduce emergency related costs, reduce symptoms and increase satisfaction rates (Bedell, Cohen & Sullivan, 2000; Bond, Drake, Mueser & Latimer, 2001; Cheng & Kelly, 2008; Sadowski, Romina, Vanderweele, & Buchanan, 2009; Medina, 2000). The result is reduced service use and therefore cost savings (Phillips, Burns, Edgar, Mueser, Linkins, Rosenheck, Drake & McDonel & Herr, 2001; Bond, Drake, Mueser & Latimer, 2001). The case manager plays a critical role in successfully supporting people with multiple and varying needs (Zlotnick & Marks, 2002).

Two of the strongest indicators of success in case management are building a plan based on the individual needs of the person (Clark & Rich, 2003; Brody, 1997) and the relationship between the case manager and the person (Chinman, Rosenheck & Lam, 2000; Lee, 2007).

Key findings from the research revealed that there is a need for dimensions of promising practice to reduce systems barriers, increase collaborative community resources and, ultimately, provide the best supports for people.

What are Dimensions of Practice?

According to McCollom & Allison (2004), standards of practice or 'practice guidelines' are "statements that are systematically developed to assist practitioner and client decisions. They are intended to be flexible; deviations are expected, accepted and justified depending on individual characteristics and circumstances" (p. 50).

The authors argue for the importance of practice guidelines to ensure an evidence based framework for service delivery and to establish a way for evaluating outcomes and successful care. Given that practice guidelines are meant for working with people with varying and individualized needs, the authors caution their use as a 'be-all-end-all' tool, and argue they be used primarily as a foundation for care and treatment (McCollom & Allison, 2004).

The following discusses the research processes and key findings. The purpose is to highlight the background evidence for development of 'dimensions of practice' for homelessness-focused case management work.

Research Processes

The primary research question for this project was: what are the most promising practices to ensure people trying to end their homelessness have the right supports in place? In order to answer this question several secondary questions emerged:

1. What does the existing research tell us about gaps and promising practices?
2. How are agencies defining and engaging in case management?
3. What promising practices already exist in our community?
4. What barriers or difficulties are service providers experiencing, and what are their suggestions for improvements?
5. What advice can individuals experiencing homelessness offer to service providers for greater success?

In order to answer the above questions, multiple methods of data collection were necessary. Included in the literature review were 81 original sources. After examination for relevancy, 61 resources were referenced, including academic/peer reviewed articles, text books, reports by service providers working in homelessness case management and summarized standards of practice developed by other organizations.

Telephone interviews were conducted with nine case management organizations in the United States working in ending homelessness initiatives. Rationale for including their perspectives was based on the fact that they have been engaged in rehousing programs for several years and could add experiential knowledge of issues and best practices. Following this, a survey was developed and distributed to over 100 local service providers and 39 completed surveys were collected. Forty-four local professionals participated in individual or group interviews, and men, women and youth were interviewed as well.

The 14 member advisory committee was selected to provide a 'bird's eye view' of the research project to ensure access to important and appropriate resources, to review potential questions on the survey and in interviews, to give feedback on key findings as they emerged, and to review the reports and dimensions. In addition, two community consultations were held and attended by key stakeholders in Calgary and across Alberta.

Findings

"Case management services need to be considered within a broad perspective that recognizes the multiple and serious needs of people who are homeless, the varying subgroups, the need for multiple interventions at various levels of society, and the crucial importance of adequate housing resources. Undoubtedly, however, case management has become in practice one of the most common services to people who are homeless" (Morse, 1998 p.1).

The following discussion is a summary of the key themes that emerged in data collection:

- Defining case management can be done through identifying its key activities, processes, principles, and the role and core competencies of case managers.
- Local barriers to effective case management include: a complex, fragmented system that leads to staff burnout, rigid and complex resource accessibility, politics, resistance and scarcity approaches to service delivery.

- Promising practices for case management include: collaboration and cooperation, right matching of services, ethical conduct, a coordinated and well managed system, and continued professional and sector development

What is case management?

"Housing first has been totally misrepresented. It is trickier than people think. It's not just about one type of housing. It is really about the right type of housing for this person or family. Some people need more support and more connections, others need less. What people need is a housing plan and a support plan that is appropriate for them. Time and the right assessments for the level of need are key" (Service Provider (SP) 14).

Defining case management is an onerous task. There is such variety in methods, approaches, models, issues and sub-populations that landing on one definition that fits all contexts is difficult (Morse, 1998). Twenty-three percent of respondents to the survey said their organization either did not have a formal case management definition or if they did, they were not aware of it.

The Canadian National Case Management Network (NCMN) has defined case management as a "collaborative, client-driven process for the provision of quality health and support services through the effective and efficient use of resources. Case management supports the client's achievement of safe, realistic, and reasonable goals within a complex health, social, and fiscal environment" (NCMN, 2009, p.8).

The Case Management Society of America uses the Commission for Case Manager Certification (CCMC) definition, a "collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes." (CCMC, n.d.) The case manager is a functioning link between the service recipient, the healthcare team, the funder, and the community. Case management provision serves to identify care options most beneficial to the person while collaborating with care providers and utilizing resources effectively.

While both definitions have been developed through national organizations and share common elements, they were developed primarily with clinical health care workers in mind. Given the community based nature of case management for ending homelessness specifically, it seems appropriate to include those definitions from the literature that fall outside of the above purviews.

According to Beyond Shelter in Los Angeles (Tull, 2006), there are four key components that define case management in ending homelessness.

1. Crisis intervention and stabilization includes emergency shelter services and short-term transitional housing to address specific needs such as domestic violence, substance abuse, treatment, etc.
2. Intake, screening, and needs assessment produces an action plan for both short and long term goals and objectives, and identifies specific action steps.
3. Housing search assistance and relocation to permanent, affordable housing means addressing barriers to accessing affordable rental housing, and applying for housing assistance, rent subsidies, etc. It also involves tenant education, and helping in the housing search and negotiations with property owners.
4. Home-based case management is provided within the first 90 days, but can intensify in the event of a crisis. It includes connecting people to community services and resources, and possibly even longer-term support for vulnerable and at-risk families or individuals.

According to Morse (1998), in a review of the literature specific to case management in ending homelessness, a definition can be determined based on the services of case management. Seven primary and consistent services that characterize case management were articulated:

1. Identification and outreach: attempting to enroll people, some of whom are not already engaged in services
2. Assessment: determining a person's existing and potential strengths, wants and needs
3. Planning: develop a specific, holistic, individualized treatment and service plan
4. Linkage: refer people to necessary services, treatments and informal support systems
5. Monitoring: conduct ongoing evaluations of progress, needs and adapt if necessary
6. Advocacy: negotiate on behalf of a person or a group of people to ensure timely access to services
7. Discharge planning: supporting people to transition between and from services

Four additional services were identified as common but variable across service providers depending on agency mandate and/or individual need:

1. Direct service provision
2. Crisis intervention
3. System advocacy: to reduce barriers across services
4. Resource development: accessing additional sources and resources

ACTIVITIES OF CASE MANAGEMENT

Often much time has been spent building a relationship and gaining trust before the formal case management relationship begins. Tull (2006) argues that several immediate interventions or crises may also have to be dealt with before formal case management activities begin.

To build on Morse's discussions above, the activities of case management, or what case managers do, are fairly consistent across the literature, survey and qualitative data. The following are summarized from existing standards of practice, many of them developed within health or clinical contexts. It is important to note that community-based case management may utilize different language and slightly different processes, though the activities are consistent. Working with people from varying backgrounds may affect the ways in which these activities are 'taken up' due to the philosophies people may be rooted in. For example, the establishment of a healing relationship for Aboriginal people and their case workers may acknowledge the importance of a shared journey through case management, possibly affecting the goals, processes and methods for achieving success.

Case Management Activities include:

Intake

If a relationship has not already been established, often a case manager's first interaction with a person is during the intake evaluation. The agency screens people to identify his or her needs in order to direct them to the appropriate services (Council on Accreditation [COA], 2008). It is crucial that the persons' needs are matched to the organization's eligibility requirement(s) (NCMN, 2009). Often during this process the case manager will outline the complaints and appeals process, explain the criteria to end the case management relationship and provide options for people should they not be eligible for services.

Assessment

The intake and assessment processes are distinctly different. The City of Toronto (2005) argues that the assessment not only collect vital information but also help with the development of the therapeutic relationship. The assessment should be done with the person using a structured process (NCMN, 2009).

The case manager at this stage should (COA, 2008; NCMN, 2009):

- identify the person's goals, and further explore their needs, concerns, values and choices;
- be culturally sensitive, respectful, courteous and interactive;
- discuss informed consent and when it might arise;
- work collaboratively with others to avoid assessment duplication;
- inform the person of their care options and identify at risk people;

- work within a scheduled time frame;
- discuss the plan of action for achievement of their goals;
- gain consent from the person to share their information with other care providers when necessary;
- contact the person in the manner he or she prefers; and
- document all information confidentially.

Planning

Each person will have a case plan. "A case plan is developed over a series of meetings with the person to identify their strengths, wants and needs. The case manager assesses the components of service by looking at the person's health care needs, their informal support system, involvement with other agencies, economic and employment status, and other relevant cultural and religious influences" (City of Toronto, 2005; p. 15). It is also important to identify issues or trigger points in order to develop strategies for when they emerge. The person's short-term and long-term goals and priorities should be documented to help the case manager identify the progress as well as any unforeseen issues they may have, as well as determine resources that are available.

The case manager should develop a plan of care that is optimal for the person's benefit in achieving their goals. The case manager should (NCMN, 2009):

- take into account the person's own assessment of their needs and explore with them comprehensive options so they are an informed decision making participant;
- identify obstacles that may hinder progress towards their goals;
- determine any safety/risk factors to the person;
- determine the financial resources available;
- determine the timeline that the plan of action will follow and how to implement the plan;
- know the requirements for communication about personal information;
- maximize the person's independence to meet their care needs;
- document measurable criteria such as clinical stability, adherence factors, and effectiveness of care strategies; and
- ensure the person and necessary care providers have unhindered access to documentation.

Engaging people in the planning process helps them to discover their options not just by being asked. Through ongoing dialogue, other options emerge that the case manager or person did not think of in the beginning. This dialogue is key to helping people process their realities and set goals for where they want to be, for example, in two days, two weeks or two months. Through this engagement process people will be able to take ownership and move forward.

Within the plan, the distinction needs to be made of who is providing the individualized supports and services (COA, 2008). In other words, 'who is responsible for what,' including the person receiving services.

Referral and linking

Referral and system navigation are a major activity within case management. The case manager needs to ensure that resources are available to the person to effectively carry out their plan of action to help them achieve their goals. The case manager is expected to (NCMN, 2009):

- collaborate and build relationships with other care providers about the mutually agreed-upon plan;
- outline and gain agreement of the roles and responsibilities of all care providers;
- help facilitate and develop the person's self-management skills;
- promote independence;
- maintain open communication channels;
- have regular meetings to discuss or alter changes in the care plan when necessary;
- monitor the person's needs and preferences;
- evaluate areas of improvement and provide opportunities to do so; and
- address any issues any of the partners may be having.

People, whose needs cannot be met by the intake organization need to be connected to appropriate resources in the community (COA, 2008). The referrals need to be developed with the person (Province of Ontario, 2005). This activity could include accompanying the person to the services and/or having the service provider come to the person.

Advocacy

The case manager needs to be knowledgeable about what services the person is eligible for and what is accessible because an important part of their role is to provide up-to-date information (Province of Ontario, 2005). While case managers advocate on behalf of people, they need to keep in mind the people's right to self-determination, "as it relates to the ethical principle of autonomy, including the client / family's right to make informed choices that may not promote the best outcomes" (Case Management Society of America [CMSA], 2002, p 9).

Monitoring and evaluation of case plan

Periodically, the case manager should reassess the progress towards the person's goals and identify current needs. However, consensus on how often to review the case plan was left up to the case manager in most existing standards (Streets to Homes, n.d; CMSA, 2002; Minnesota Interagency Task Force on Homelessness, 2009).

There were two sources that indicated a specific time frame. COA (2008) argued that service monitoring should occur every three months and that formal reassessment should occur at least annually with the person and case manager present. The City of Toronto (2005) calls for a review every two months. What was not clearly articulated within these standards was if the person receiving services is able to determine when a review should occur.

Documentation of progress is important to understanding the next steps that should be taken to help the person continue to be efficient in achieving their goals, as the plan of action may need to be adjusted over time. The case manager should (NCMN, 2009):

- determine the frequency and depth of when reassessments are needed based on each individual;
- evaluate if the identified goals are current;
- evaluate if the plan is satisfactory to the person and care providers;
- determine if the person's environment has changed;
- review if decision making has helped towards identified goals; and
- review the impact of goal achievements.

Transition/discharge

A case manager needs to discuss the transition process very early in the relationship (NCMN, 2009), as this stage of case management needs to be planned (COA, 2008).

The case management relationship may end upon successful completion of the identified goals, or conclude with the goals unfulfilled. During assessment and planning, the case manager is expected to (NCMN, 2009):

- discuss the criteria for the end of the case management relationship;
- determine whether or not the person understands the criteria;
- provide them with information or links to other available services and support them in securing such resources if desired;
- support them in developing self-advocacy skills to maximize independence;
- collaborate information with other providers upon the person's transition out of case management;
- provide contact information for re-accessing services or support; and
- address any concerns the person may have about the ending of the relationship prior to the end.

Figure 1: Activities of case management

PROCESSES OF CASE MANAGEMENT

"When we start talking about programs a lot of times we hear the word 'OR' – that's when we start eliminating choices. For example a shelter might have a policy of single female OR family, what happens if a male engages this agency? What are his options? This is where 'AND' conversations happen, a case manager should think, here's what we can do for folks that fall into our parameters AND here is who we partner with for folks who fall outside our scope of practice" (SP17).

The processes of case management or how the case manager operates are different than the activities or what they will do.

Morse (1998) describes seven process variables to distinguish the types of case management services as key questions for the case manager:

1. Duration of services: length of time
2. Intensity of services: how often they meet and caseloads
3. Focus of services: from specific services to a comprehensive holistic bundle of services
4. Resource responsibility: determining who will deliver services and advocating and coordinating the services
5. Availability: determining office hours, scheduled or 24/7
6. Location of services: in office, in home, and/or out in community
7. Staffing pattern: interdisciplinary teams with shared caseloads and determining roles

In addition to these seven variables related to how case management operates, it is useful to consider who specifically needs to be involved in the case management team:

- Who is the service recipient's sub-population? Does there need to be inclusion of someone from a cultural group, gender, religion etc?
- What are the disciplinary backgrounds of the team members? Do you need addictions specialists, housing specialists, parenting specialists, etc, if you're service does not include these?

Caseloads

There is no magic number of exactly how many people to support, but more likely a range. The key is to match the intensity and types of services to the needs of the person. The other important consideration is to balance the service an agency provides with the supplementation of other service providers to fill the gaps. If for example, you primarily work with people with complex needs you will have smaller case loads. If you provide services in addition to case management work, you will have to balance caseloads based on the time you can give to each piece.

One service provider in an interview descried their system to determine case loads by the level of support a person will need. After the initial assessment the person is assigned a number that illustrates the level of need. A person with a score of '1' means they have complex needs and will require a lot of time (9hrs per week). If they have a '4' assigned to them they need a one hour phone call per week. Each case manager takes on 29 hours of direct support per week; this allows approximately 6 hours per week for paperwork and other activities. The case loads or 'weighting' system is managed by the supervisor.

Several service providers set a more specific range of case loads. The number ranged from 10 to 25 for those who balance service provision with systems navigation, advocacy etc. For those only working as systems navigators (broker model), the case loads were much higher (25 and up).

Time issues of case managers should be continually reviewed (Cesta & Hussein, 2003). Streets to Homes (nd) argues that for case managers who work specifically with high needs people the case load ratio should not exceed 1:10, while those who work with people with moderate needs the case loads should not exceed 1:20.

Models

Survey respondents were asked if their organization used a particular model, and 49% said there was no formal model, or if there was, they were not aware of it.

There is no 'one right model' for effective case management in ending homelessness (Patterson, Somers, McIntosh, Shiell & Frankish, 2008; Morse, 1998; Zlotnick & Marks, 2002). The model or approach used should be based on the needs of people and the mandates of the organization, and/or experience and specific role of the case manager (Bedell, Cohen & Sullivan, 2000; Morse, 1998; Zlotnick & Marks, 2002). The more complex the issues, the higher the rate of 'failure.' Therefore, a team based collaborative approach with one primary case manager is essential (Clark & Rich, 2003; Morse, 1998; Zlotnick & Marks, 2002).

Assertive Community Treatment (ACT), Intensive Case Management (ICM) and Clinical Case Management (to name a few) are being used successfully in this work (Salyers & Tsemberis, 2007). Existing models such as these may need to be adapted for homeless individuals to ensure complex and multiple individual needs are being met, there is a strengths focus, and personal choice is forefront (Coldwell & Bender, 2007; Hackman & Stowell, 2009; Matejkowski & Draine, 2009; Morse, 1998; Mueser, Bond, Drake & Resnick, 1998).

Many local service providers who do not follow a particular model instead adopt important principles and activities, such as those outlined above, and adapt them into their own 'model'. The 'model' used depends on the particular agency, the population or issue the agency typically addresses and their role in the community.

An overarching theme was that rather than choosing one model for all situations, case management across the system should be leveled and layered, from basic to intensive, and our community as a whole should have the capacity to address all the levels and layers of homelessness experiences with a team approach.

An example of an effective model that works for people with complex needs (multiple barriers including mental health and/or substance issues and homelessness) is described by Kim, Calloway & Selz-Campbell (2004) as: a two-tiered strengths based approach meant to challenge 'clinical approaches' by placing the person at the centre of all planning and decision making and 'wrapping supports' around them. The model of support is called 'Mentor Advocacy.' "Mentor advocacy case management is distinguished from traditional community-based case management by its services approach, intensive intervention, and the facilitation of change and growth through provision of emotional support, practical assistance,

education, mentorship, resource linkage, and advocacy" (p. 108). It is based on the principle that strengths and collaborative processes empower and support people to succeed.

According to Patterson, Somers, McIntosh, Shiell, & Frankish (2008), in their study of case management and supported housing for people with co-morbidity, little agreement has been found in specifying the models of case management across different organizations. Even the terms 'model' and 'case management' can be ambiguous terms, as they vary in definition so frequently. Ways to distinguish case management models can be based on factors such as: "size of case load, team versus individual case management, emphasis on outreach, and… services versus referring clients to other providers" (p. 58). Each different model of case management has unique features and dimensions and they are therefore separate entities.

The authors suggest focusing efforts on "dimensions of care, linkage of services, and outcomes achieved" rather than a specific model of case management (Patterson, Somers, McIntosh, Shiell, & Frankish, 2008, p. 59). Regardless of the model or approach, part of the case manager's role is to determine where on the continuum their agency sits in terms of service provision and system navigation, and build the necessary partners around the person either internally, externally or a combination of both. See Appendix A for more details on models of case management.

Case conferences and meetings

Regular meetings are needed with the team who is supporting this person in the community. Setting up a plan within this team creates open, honest communication from the start. The person is a part of this process. This method works well with people who have complex needs, as it enables more seamless support and makes it easy to see where they are progressing and where they are struggling. It is a lot of work but it is highly successful.

Ongoing support for case managers is essential and monthly internal staff meetings are encouraged. This creates opportunities for staff to review successes and issues on an ongoing basis. A consumer panel that meets regularly and acts as a forum for feedback to the team can also provide an important avenue for information sharing (Kim, Calloway & Selz-Campbell, 2004).

An example of an important meeting was provided by one service provider working with Aboriginal people. Once per month, often on the day after rent is due, the agency hosts a meeting for all people receiving housing support. The purpose of the meeting is to provide an open group dialogue about issues and experiences with re-housing. Elders with similar life experiences are present to provide both peer support and cultural support. The meetings ensure people are successfully managing financial and treatment commitments, allow for connections with peers and elders, and provide opportunity for any issues to be brought up and discussed in a problem-solving context.

Timelines

"Relapse happens, this is a part of the process, be ready for it… and try to normalize it to reduce stigma and shame and help to build on the previous progress" (SP11).

The appropriate length of time for engagement varies from agency to agency and person to person. It could be a few months or it could be two to three years. The most important decision making criteria is ensuring people have supports for the length of time that matches their level of need, while building skills for increased independence.

The need for somewhere a person can go or call anytime during the day or night was also discussed by numerous service providers. This does not have to be every service provider, or even the primary case manager, but at least one agency with which a person is engaged.

"For people with complex needs, it is essential to spend the first 90 days just securing housing and basic needs… don't expect too much in that first bit. After there has been some stabilization, you can re-assess goals and progress and set new goals for the next phase. People move forward in incremental ways and at different times. And supports must be collaborative and non-intrusive. It is important to differentiate between crisis and stabilization so we don't have the same responses for each. Focus on building strengths, supports and skills, not on self-sufficiency – no one is self-sufficient" (SP14).

Flexibility

"This is not a homogenous population…the process is not linear – it has to be flexible. The standards need to be flexible…case managers and workers need to be flexible. You have to go the extra mile, you have to be a dog with a bone, relentless and never give up" (SP9).

Case managers or case workers who can go into community with people are very important, particularly when working with people who have been homeless for extended periods. Case managers need to be mobile to go to appointments and other agencies with people. This practice bridges connections both for the person and for the service providers. It allows agencies to work together and balance limited resources more effectively.

In-home support is critical. Having case managers that go into people's homes and provide supports in that context helps create sustainability and increased independence.

"We sort of have the philosophy of, "if we don't do it, no one will." In other words, if we don't take them to the doctor appointment, they might not go, and going is essential to success. We can't just operate from the phone or office setting; we are out in community and in people's homes" (SP19).

PRINCIPLES OF CASE MANAGEMENT

Of equal importance are the underlying principles and assumptions of case management, or why we do what we do. The following is adapted from the Canadian National Case Management Network (NCMN, 2009), and provides some insights.

1. *Support people's rights*: Case managers need to build a successful relationship with people to be able to support their choices and decisions based on their identified goals.
2. *Specific, purposeful treatment*: Case managers need to work with each person individually with specific care plans based on that individual, not necessarily by following a cookie-cutter plan. When working towards the person's goals, the case manager should provide them with the highest calibre of services available to help their individual needs.
3. *Collaboration with others*: Service provision is not the job of one individual, but of a community. Case managers engage several different kinds of care providers to help people achieve their goals. The person accessing services therefore has a group of people supporting them, and all of these people must work together and communicate effectively as a team.
4. *Ethical and accountable work*: Case managers need to provide effective, organized and individualized care to meet the needs of the people they work with. They need to promote self-care and independence, and keep up to date with changes in the goals or needs of the person. Case managers need to use care and resources ethically and within the financial means allotted.
5. *Culturally competent*: Case managers need to provide services that work with the person's beliefs, values, and practices. Case managers should be sensitive to the differing needs of different people and become aware of cultural knowledge to aid them in being culturally conscious and effective in supporting people.

Again from Morse (1998), principles in case management specific to ending homelessness must include:

- assertive and persistent outreach to engage people on their terms and comfort zone;
- active support to help people access needed resources;
- person-centered and focused support, based on what the person wants;
- respect for person's autonomy; and
- trust and strong relationships.

A final principle as identified by service providers is the 'right kind of engagement.'

"People are messy and sometime beaten down, we need to be professional and engage with people where they are at" (SP9).

Several service providers mentioned the importance of consistent contact with the person, either while engaged or while waiting for engagement, or even contemplating engagement.

It is important to also ensure the same consistencies in contact amongst the internal and external teams. Without this engagement throughout the case management relationship, people are at risk of slipping through the cracks and being lost.

"Time frames are short; there is a difference between out-right homeless people and couch surfing. If I can't engage and support them and make something happen, within two weeks I will lose them" (SP2).

In sustaining engagement it was suggested to focus on the strengths and the positives. Managing one crisis after another for people does not create a positive environment to move forward. Including long-term goals like employment and education training, as well as celebrating successes helps with long-term stability.

"You don't have to 'earn your housing' and then get help. Our goal is to get them stable housing first then build supports around people. We all need to shift to this model" (SP6)

A final aspect regarding engagement was described as modeling positive behaviors. That is, behaving in non-judgmental ways that show positive decision making, critical thinking and problem solving.

IMPORTANT COMPETENCIES OF CASE MANAGERS

'Competency' can be defined as "the knowledge, skills, abilities, and behaviors needed to contribute to the mission, vision and values of our organization" (Henning & Cohen, 2008, p. 131).

Henning & Cohen (2008) argue that applying core competences to the work of case managers is an important aspect of orientation and training for those new to the job and for professional development of existing case managers, in order to create standardization within case management practice. Competencies are added to case manager job descriptions and performance evaluations, primarily because case managers come from a variety of professions and academic backgrounds, some of which are rooted in clinical practice and not necessarily rooted in community based care.

The authors conducted a review of the literature and best practices in conjunction with consultation with individuals from different professions (e.g. nursing and social work). Information was also channeled through clinical focus groups. This resulted in the development of key competencies meant to incorporate self and supervisory assessments that have tangible and measurable goals and outcomes.

Morse (1998) further describes competencies in the context of homelessness. Morse argues that more research is needed in this area, but there is a body of work that discusses recommendations for ensuring recruitment of successful case management staff.

Specifically, agencies need to recruit, hire, and/or train, and supervise staff to develop skills and knowledge in the following areas:

- homelessness;
- specializations based on agency mandates and culturally appropriate interventions (e.g. mental health, addictions, and/or sub-populations);
- training on dealing with multiple issues and heterogeneity;
- engaging homeless people and developing trusting relationships;
- administering and analyzing a variety of assessment tools;
- activities, processes and principles of case management;
- crisis intervention including suicide assessment and prevention;
- a strong working knowledge of the existing services and supports and how to access them (systems navigation);
- the specific model or method of case management the agency adheres to;
- disease education and prevention including HIV/AIDS; and
- work-life balance and stress management including burnout avoidance.

WHAT THEN IS CASE MANAGEMENT IN ENDING HOMELESSNESS?

Using the information above, the following *definition* is proposed:

"Case management for ending homelessness is a collaborative community based intervention that places the person at the centre of a holistic model of support necessary to secure housing and provide supports to sustain this housing while building independence."

For case management in this context to be successful in accessing the appropriate housing and supports to end homelessness in a sustainable way, it must be:

- focused on the right- matching of services;
- person-centered;
- adaptive;
- individualized;
- culturally appropriate;
- flexible;
- holistic;
- long-term;
- multi-disciplinary;
- include advocacy that leads to self-advocacy;
- focused on establishing networks and relationships;
- include coordination and engagement; and
- ensure that the activities, processes and principles of case management are in place.

The case manager

"The work of the case manager is often surprisingly practical, from showing people how to grocery shop to running a dishwasher" (SP 11). But also… *"Being innovative and imaginative, thinking outside the box, but working within it. Politically savvy, we need to be comfortable stretching the envelope and pushing the system while working within it" (SP1).*

Differences in case management approaches and agency mandates have led to complexity in the system, and in the opinion of many services providers, can affect the outcomes for service recipients.

For example: people experiencing complex issues may engage a particular service provider for addictions support, but also need other supports like housing, counseling, financial support, medical care, etc… Depending on where that person is engaged affects the 'model' of case management they receive. This can cause conflict in deciding who plays the role of the case manager.

Another conflict occurs when a case manager is trying to build holistic wrap-around supports for a person, but due to high case loads, limited resources and time constraints, ends up managing crises or being stuck providing for basic needs, without being able to guide the person into stability and reduced dependency.

The case manager is a navigator, an advocate, a coordinator a collaborator and a communicator who balances service provision and systems navigation with short term and long term strategies to break the cycle of homelessness with individuals and families in a sustainable way.

According to respondents, the role of the case manager is to 'manage the process' so that there is an individualized plan for each person's needs and wants. They lead, build and facilitate the team based on the needs of the person. They can also 'translate' information from other service providers.

"A case manager needs to know the service providers, but they also need to know the policies and loopholes of the agencies they are working with and be able to interpret them for the client" (SP13).

LESSONS LEARNED/BARRIERS

In addition to descriptions specific to providing case managed supports, service providers were asked to discuss barriers they have experienced in doing case management work.

"The client isn't the problem; the system is the problem. Huge service providers often think about their programs but not about the bigger picture. A good case manager can bridge this" (SP1).

The System

The 'system' would be defined as the network of all available programs, services and supports, including but not exclusive to, health care, addictions supports, legal systems, housing, financial benefits and other basic needs, education, counseling and family support, etc.

Complex and fragmented

Coordinating the complex web of government and non-governmental resources that are available to people takes a lot of time, skill, resources and patience. There are gaps within and between the service community. Examples were given of wait times and complex assessments for accessing government benefits for disability supports, emergency rent and other emergency funds.

"Our case manager's work is in an uncoordinated system and we ask them to coordinate it. Setting up relationships and maintaining them takes an overwhelming amount of time. Calgary systems are very fractured and boundaries are always being negotiated between programs" (SP9).

Burnout and high staff turnover rates

There is a need for constant new learning and relationship building. Staff often work in highly stressful situations with little support or inadequate resources. Managing staff morale and stress levels is a constant challenge.

"People's experiences are based on individual workers. If you get a 'bad worker,' or one that does not know the system, this will affect the persons' success and experiences" (SP12).

Silos

"Organizations operate in isolation with one another because of the service they provide, this creates barriers" (SP5).

Overwhelmingly respondents believed that we cannot change anything without consistent and holistic collaboration. Having government, justice and the health care system participating in community consultations, meetings and on case management teams is critical to reducing silos and systems barriers. It is also important to work outside of our sectors. For example, youth will be transitioning into adult services so it is important to build strong relationships between youth and adult sectors.

Resources

"Wait lists are too long – people can die while on a wait list" (SP7).

Rigidity

Accessing flexible funds for emergency needs is difficult. There is a need for flexible money with little or no paperwork attached and case managers who have access to the money to be able to pay off fines, provide damage deposits and utilities arrears, or whatever else each person needs.

"If people have outstanding debts like rental arrears or utilities, or the only barrier is a damage deposit, why are community based agencies having to step in with dollars to pay these off? This is a duplication of services and unnecessary. It creates confusion in the sector and for people trying to access this type of support. It should be available in one place to all people who legitimately need it" (SP2.)

FOIP laws, or confusion about privacy requirements can create barriers to accessing important information. Agencies may have internal privacy processes in place in addition to government requirements creating confusion about how to access people's information in a timely manner.

Complexity

There are different requirements from different funders. Having different outcomes measures and short term funding is problematic. A solution would be to have three-year funding agreements and ensuring funding is based on doing best practices, not on the numbers of cases.

"If funders can't agree on the same types of reporting they should at least be very open and honest with agencies on what they require – more time spent working the process through together (SP7)".

Resistance/entrenchment/politics

"There is often resistance to change. What would happen if we actually ended homelessness? What would that mean to the field of social work? How would it change? Some of those jobs would actually be gone… Many of us get into this field because we are passionate people and we want to help. Because of this dynamic it becomes hard to balance our personal beliefs with the actual needs of the community. This is maybe one meaning behind why there is resistance to change" (SP17).

There was a general consensus from most respondents that attitudes are shifting and sector and community collaboration is improving. Examples were given of how agencies sit on different committees and try to work together. It was argued that some groups will "fall off" (SP22) if they don't collaborate, as this is the way to work smarter.

"It is an evolution, there are still some old school people in our sector but it is shifting" (SP22).

"In other cities shelters lead the charge in housing first. They have the closest and easiest access to people who need housing. I think it is getting better in our city, and…some shelters are starting to do this. It makes it easy for the people and they can balance emergency supports with case managed re-housing in one place" (SP10).

Scarcity

Although there has been an influx in funds for appropriate, affordable housing, it was argued that there are not enough options in housing to choose from. Private market rent may not be the best option for everyone. Housing options should be varied, from group living with on-site cultural supports, to shared accommodation and single residency apartments.

"Rents are still too high and accessing supplements is very difficult. The economy and market fluctuations impact you if you are low income or homeless regardless of if they are boom or bust - how can we house people and keep them housed if we can't support them to sustain rent?"(SP2).

PROMISING PRACTICES IN CASE MANAGEMENT

The following section highlights key themes that emerged during data collection regarding best and promising practices.

Right matching of services and person-centered case management

"To really treat someone the right way…the plan needs to be built around them based on their exact needs and wants… The case manager's role is to find out what this is and make it happen"(SP15).

"Right matching of services can be accomplished by truly being person-centered and having consistent and relevant assessment processes in place. This will ensure a balance between what we think people need with what they say they need… remembering that we are working for them" (SP22).

According to several service providers, a problem exists currently when funding is attached to case loads and not to 'right matching of services' or, levels of support based on individualized planning. Several service providers indicated the importance of being person-centered, or in other words, building appropriate support around people with their choices and decisions guiding all of the supporting team's work. There was some discussion of the difficulties of ensuring this given time constraints and resource issues.

Another consideration in being person-centered was recognition of the complexity of people's experiences that lead them to a homeless state. Individual factors as well as structural factors can contribute to this complexity. There was discussion of the ways in which people who are already marginalized by the individual factors, become even more marginalized in their dealings with a system that often does not always work in their favor, but instead creates further issues of mistrust and isolation. The solutions to dealing with the

many layers of complexity as a result of these individual and structural issues were specific to the right matching of services and/or being truly person-centered.

"Being homeless does not happen overnight. People's lives are complicated and difficult, and many times their situations are not completely their fault. All homeless people are not the same and we should not treat them the same. This means assuming we know nothing about their life or their situation until they tell us… Our job then is to work with them to figure out the ways to deal with all the layers" (SP22).

"If you truly start with the person at the centre and build supports around them based on what they say they need, it does not matter how old they are, what background they have or their gender. It is our job to build the right supports around them by including the right people and services to meet those needs" (SP22).

People with complex needs, particularly concurrent disorders that include mental health issues and/or addictions, continue to be the hardest to support (Cheng & Kelly, 2008; Clark & Rich, 2003; Zlotnick & Marks, 2002). Approaches to supporting them are often haphazard and uncoordinated. There is also a lack of gender and cultural appropriate supports and evidence based research and practices (Cheng & Kelly, 2008; Gone & Alcantara, 2007; Morse, 1998).

CONTEXTUAL CASE MANAGEMENT

Services need to be 'contextual." This means supports should balance basic needs provision with broader personal and structural issues, such as a history of victimization, poverty, abuse and substance abuse (Cheng & Kelly, 2008).

The effects of colonization in particular must be contextualized within Aboriginal peoples' homelessness (United Native Nations Society, 2001). Specifically, the role of inter-generational trauma specific to the effects of colonization must be addressed to ensure adequate cultural connectedness and healing for Aboriginal people (Menzies, 2006). It is essential to ensure that models of support or treatment options align with cultural/spiritual beliefs, as there are often distinct differences in how Aboriginal communities engage in healing practices. As well, this allows people to build connections to broader communities and supports outside of immediate crisis interventions (Samson, 2009; Kral & Idlout, 2009).

Though context is important to consider for all people, below are two examples from the literature.

Contextual Approach – Aboriginal Male

According to Menzies (2006), Aboriginal people experienced intergenerational trauma due to the Canadian governments' implementation of public policies that eradicated Aboriginal value systems in the following four domains; individual, family, community and nation. Aboriginal people have been forced to be integrated into an outside, unfamiliar society. An

estimated 100,000 Aboriginal children were forcibly placed into residential schools between 1840 and 1983. After the schools began to close, and Aboriginal parents were impacted by their residential school experience, an "overwhelming number" (p. 4) of their children were taken from their homes by child welfare authorities and permanently placed into foster care or made Crown wards.

The children were required to assume a new culture that failed to recognize their past Aboriginal culture, leaving them disconnected from both cultures. Many Aboriginal children lost their family and community ties, leaving them unable to cope.

Specifically, it is argued that historical social policies by the Canadian government correlate to the cause of Aboriginal homelessness today (this includes policies such as child welfare legislation which took children out of their homes at early ages, the residential school system, and the Indian Act of 1876). These policies also contribute to social anomie amongst Aboriginal people and the isolation of individual, family, community, and nation in relation to one another.

Menzies proposes a new definition for homelessness among the Aboriginal population: "homelessness is a condition that results from individuals being displaced from critical community social structures and lacking stable housing" (p. 15).

The author further proposes "The Intergenerational Trauma Model" which uses a holistic approach in considering how individual, family, community and the nation contribute to homelessness.

Support services that are culturally appropriate should be considered by provincial and municipal authorities in urban settings. Housing, health and social programs need to be provided long-term, as well as programs that promote positive self-image and community well-being should be available to Aboriginals living in city centers. To end Aboriginal homelessness, holistic public policies and programs should be undertaken to strengthen and rebuild Aboriginal peoples' link to the individual, family, community, and Aboriginal nation (Menzies, 2006).

Contextual approach – Female Lone-parent Family (fleeing violence)

According to Tull (2006), case management is a permanent solution for families and individuals in need of housing. As such, case management is divided into two stages to address their changing needs over time: case management before the move into permanent housing, and case management after the move into permanent housing.

The primary activities of case management, intake, assessment, planning, linking, monitoring, advocacy and transition, are applied to both stages.

Before the move into permanent housing:

Part of the process to help a family address both their short and long-term needs is the development of a family action plan. This plan can be developed either before or after stabilization in emergency services. It serves as a plan of action for ongoing case management, including the time following a move into permanent housing. General questions that must be asked during the development of this action plan include:

1. What does the family need?
2. What should the priorities be?
3. How will they achieve these goals?
4. What are the barriers they are confronting?
5. How will they attain permanent housing?
6. How could their income situation be improved?
7. What are the issues for the children?
8. Are there mental health or recovery issues that should be addressed?

In developing such an action plan the time period for achieving the objectives must be set, followed by the identification of those objectives. Subsequently, the family must then identify specific tasks/responsibilities which they must carry out in order to meet their objectives.

Further assistance through case management in accessing and moving into permanent housing is provided through the development of a housing plan. The objective of this plan is to assist the family to obtain decent, affordable, permanent housing in which they can stabilize and rebuild their lives. In order to carry this out, a match must be found between the family's needs, the community resources and the housing unit. Although the case manager can work with the family to resolve issues related to securing housing, it is preferable to have a housing specialist, who can work alongside the family to identify appropriate and reasonable housing goals (Tull, 2006).

Following the move into permanent housing:

In this stage, case management is home-based, and therefore, has several goals which differ from the prior stage. The primary goals of this stage are to: integrate stable living patterns into the daily lives of formerly homeless families, and to develop a community network from which the family can draw support in times of crisis.

The primary functions of home-based case management are to assist families in making the transition from homelessness to stability, while at the same time, linking them with community services/resources that they may need. Further assistance for some families may include helping them develop basic life skills.

The experiences from Beyond Shelter suggest that formerly homeless families are most at risk during the initial three months following their move into permanent housing (Tull, 2006). As

such, provision must be made to provide home-based case management for the first 90 days. In some cases this time can be extended. During these 90 days, the case manager provides the core level of services (household and money management, problem solving/survival skills, advocacy, referrals, monitoring and crisis intervention) and links families with existing community programs to address their specific needs. Although all of these services can be provided, many families just need assistance in identifying the community resources, and occasional monitoring to insure a smooth transition (Tull, 2006).

Collaboration and cooperation – the "TEAM Approach"

Service providers overwhelmingly believed that a team approach to case management is a critical aspect in ending people's homelessness. Because of the diversity in service providers' approaches, people's lives and needs and in accessible resources, the best way to ensure we balance individual needs with ending homelessness on a grand scale is to build a multi-disciplinary team around each person. There must be clarity of the role of the case manager and the role of the rest of the team. Several examples of how to make this work were offered, most notably: each person needs one case worker and everyone in the community needs to know who that person is and how to reach them. The lead case manager must have good relationships with other service providers and a solid knowledge of systems navigation. This means having a solid network both internally and externally.

The role of the primary case manager in this approach is to ensure the activities and processes of case management are followed and the principles of case management are maintained. The case manager will reduce barriers to effective service provision by advocating based on particular needs. The key is to balance basic needs service provision with long-term supports meant to address root causes of homelessness. This approach, because of its collaborative nature, can also work to change systems and policy barriers as it requires a team that includes government, academics, employment training groups, community service providers housing and health services.

The lead case manager will coordinate the team and communications and will also hold the team accountable to their roles. Reaching outside of the 'usual suspects' in the network is important. This may include employers, educators, and not-for-profit legal support for help accessing identification and negotiating rights with landlords.

Diversity

Including diverse team members that represent both genders, age groups and same cultural backgrounds, allows the person opportunity to develop relationships with people who reflect the community at large, but also opportunity for them to seek out team members they have a particular connection with. For example, this can be particularly important for Aboriginal people, providing opportunity for culturally appropriate experiences and healing approaches (Fiske, 2008). Building and extending a social support network will help ensure sustainability once formal case management has ceased (Mueser, Bond, Drake and Resnick, 1998; Coughey, 1998).

Peer Support

Each of the men, women and youth who were interviewed for this project suggested that the most important aspect of effective team-based case management was mentorship and peer support. Being able to connect with someone who has previous experience with homelessness was discussed as a critical aspect to building trust, feeling heard and understood, and giving people hope that ending homelessness was possible for them. The literature supports this, though very few service providers specifically articulated this (Gates & Akabas, 2007; Salyers & Tsemberis, 2007; Weissman, Covell, Kushner, Irwin & Essock, 2005; Veghts, 1990).

Inclusion of peer support has been shown to reduce hospitalizations, substance abuse, crises interventions, improved employment outcomes and quality of life (Gates & Akabas, 2007; Coughey, 1998; Felton, Stastny, Shern, Blanch, Donahue, Knight and Brown, 1995). The peer worker also reports benefits related to being part of the team. However proper support is important for success, including clarity of roles, policies specific to confidentiality and ethical conduct (Gates & Akabas, 2007; Weissman, Covell, Kushner, Irwin & Essock, 2005). Advice for ensuring success with peer workers includes ensuring agency buy-in for the importance of this team member.

Roles and Boundaries

Clarity of roles, boundaries and common goals are essential for true collaboration (Medina, 2000; Reina, 1999). Conflict arises when agencies compete for resources and/or have differing mandates and expectations. Ensuring the needs of the person are at the forefront and clarifying team members' support roles are essential at the outset. Given the heterogeneous nature of people's life experiences, goals and needs/wants for success, the role an agency plays may change from person to person.

Clear communication and standardized language and reporting methods and outcomes can help reduce these barriers/conflicts (Medina, 2000: Hallett & Birchall, 92; Stevenson, 1989). It is also very important that people do not become overwhelmed by multiple team members (Salyers & Tsemberis, 2007) and have consistent access to their primary case manager to balance any issues that arise.

Need for a Coordinated and Well Managed System

Communication

Open, honest and consistent communication was argued to be one of the most important aspects of effective case management work (Krafft, 2009).

Consider the following example: the case management team includes a psychiatrist, doctor, nurse, psychologist, substance abuse specialist, housing team, vocational specialist, justice and diversion specialist, financial advisor, and/or occupational therapist. Each person has

opportunity to see each specialist but they focus their work with the people they need at that time. This team meets with the person three to four times per week. They interact regularly with government income benefits providers and each team could work with multiple people. This team would go to people's homes and could also run targeted group sessions for people based on their specialized role. Team members also have opportunities to learn about the roles the others play because of the amount of time spent together.

Sharing all documentation with the person and ensuring an honest and transparent process was another consideration to ensure seamless communication. The file should be open and accessible and should not contain anything that the person cannot see. This is also a good tool to enable revisiting of the case management plan and revising as needed. The plan should be a living document.

Many service providers believed that sharing information and resources openly and freely, as well as sharing best practices not only improves communication but is also in the best interests of the people we serve.

Training and Support for Case Managers

Case managers come from a variety of backgrounds, experiences and education; they also come with different ethical supports or beliefs (Cooper & Roberts, 2006; Powell, 2000; Zlotnick & Marks, 2002). Case managers often have to balance highly skilled work with low skilled work and must work quickly, depending on the situation. Training should include care for the caregiver, use of standards and ethical conduct, avoiding burnout, available community resources and how to access them, diversity, and other practices to enhance professional development. Weekly staff meetings with the whole team are also important part of staff support. There must be adequate funding to support this long term.

Case managers often work in stressful conditions, so they must be adequately supported to balance the many demands on their time, reduce burnout and increase work satisfaction (Cousins, Mackay, Clarke, Kelly, Kelly, & McCaig 2004). Several criteria for identifying stress in human service employees include:

- *demands* (the work environment, workloads and work patterns);
- *control* (how much 'say' the worker has in how the work gets done);
- *support* (receiving encouragement and having adequate resources to do the work);
- *relationships* (ability to handle conflict and address unacceptable behavior across the organization);
- *role* (the organization understands and makes clear the roles of all team members); and
- *change* (the organization communicates changes well).

Cousins et al (2004) argue that if the above conditions are present and processes for supporting these conditions are transparent, this will facilitate a healthy organization with satisfied employees.

Homeless Management Information System (HMIS)

"We are getting good at preventing homelessness and re-housing. Things are starting to flow with the city and provincial 10 Year Plan and the HMIS database. But we are not getting to the point of sustainability yet" (SP9).

An HMIS system is an electronic system that collects consistent information about homeless populations throughout the community of care. It is argued to be absolutely essential to the effective implementation of any 10 year plan to end homelessness (National Alliance to End Homelessness, 2005).

It allows communities to:

- collect standard data system wide for accurate, real-time data on the total number of homeless, length and causes of homelessness, and demographic characteristics and needs;
- better understand people's experiences being homeless and the services they use;
- enable agencies to better meet clients' needs by improving service co-ordination, determining client outcomes, providing more informed program referrals and reducing the administrative burden; and
- improve research for evidence based decision making, such as program design and policy proposals.

Through this, the end goal is to help shorten the length of time people are homeless and to direct them through the system of care more efficiently and with more understanding.

Service providers argued that implementation of a Homeless Management Information System (HMIS) is an excellent way to manage data, but also can potentially reduce 'over-assessment.' Implementing this would give a holistic picture of a person, where things have broken down before and how new solutions can be created. Streamlined and consistent data entry, assessments, reporting, and information sharing would allow for more time for creative problem solving and collaboration.

Having quality data, perhaps even on a national system, was seen as critical. It can show past goals and future plans. This is also an opportunity to find out who the central case manager is for a person and how to contact them. It would include all of the service providers working with the person, emergency contact information, and what connecting work other agencies are doing. Service providers believed that HMIS could save time and resources and facilitate a more seamless service delivery. There would be less need for repetitive new relationship building, and could therefore enhance trust.

There were several suggestions for enhancements, such as adding the contact information for government benefits the person has worked with and ensuring a centralized intake and assessment process.

There were concerns raised in the development process of the HMIS. It was suggested that to implement this new systems, community consultation is needed for wants/needs and early buy-in. This included collaboration amongst different funders. It was also suggested that there be adequate and sustainable funding to build in time and resources for training and support after implementation, and to keep the processes and the tools themselves as clear and simple as possible. A final concern was specific to balancing the need for good, effective and useable information with managing privacy and confidentiality issues.

Professionalization and Ethics

Several service providers discussed the importance of increasing the professionalization and credibility of case management work. Suggestions included consistent and transparent evaluation strategies that ensure accountability. Incorporating a code of ethical conduct was also suggested.

Evaluate for Success

"If someone is not moving forward it is important to assess our role and our work to see if we are contributing to the issue…if we are, we admit it and fix it. Internal support and communication and support from the executive director is critical to maintaining this" (SP22).

Several service providers indicated the importance of doing internal assessments of their work, even if this process is fairly informal and done as part of weekly or monthly staff meetings. Included would be questions such as: "Are we inadvertently creating barriers for this person?" and "Are we being as effective as we can be?"

"Be a part of the solution. If you are too critical of the system you will not be able to work within it or reduce barriers. You will get stuck in the negative and unable to move forward" (SP1).

Case managers need clear job descriptions and expectations, as well as performance measures and evaluations. These should include tangible and measurable goals and be standardized to ensure consistency of supports (Powell, 2000; Powell & Tahan, 2008). Case managers and the organizations they work for need adequate training and support for professional development and organizational culture, and to ensure standards and codes of conduct are understood and used. There also needs to be clear expectations and guidelines made available for all staff (Cesta & Hussein, 2003; Medina, 2000; Melaville, 1991).

Effective case management needs to be well financed and well managed (Bond, Drake, Mueser & Latimer, 2001; Medina, 2000). Given their frontline experience and relationships with people case managers should be supported and encouraged to influence outcomes,

practices and programs. Extending their role to include organizational effectiveness enhances the vitality and dynamics of the role of the case manager (White, 2004; Austin, 1993).

Outcomes should be system wide and the same language used in an HMIS or other database and centralized intake system (Carling & Curtis, 1997; Nelson, Aubry & Lafrance, 2007; Brody, 1987).

Outcomes should be applied in an evaluation framework and include the following elements:

- effectiveness of peer support;
- importance of right matching of services (acuity);
- the impact of case management on different sub-populations;
- the effect of combined housing and case managed supports and particular models with mandated caseloads; and
- housing retention and satisfaction rates.

Evaluations should not be limited to statistical accounts of housing retention, but should include qualitative descriptions of people's experiences, successes and setbacks. Evaluations should include the perspectives of people accessing services, and should be flexible enough to capture instances of innovation and creativity.

Ethics

Given that case managers come from a variety of backgrounds in education and experience, ethics are important to, but largely absent from, case management practice.

According to Powell (2000), case managers are constantly faced with ethical issues and dilemmas in their daily work experiences. Each case manager has unique values and beliefs, and their professional training is often particular to the field they work in, shaping the decisions they make when ethical problems arise.

Ethics and law are both concerned with maintaining social order and right behavior. While the law regulates conduct, ethics tries to promote the best decision in each situation. Codes of ethics for human service providers try to provide guidance on ethical behaviour and conduct, in order to protect public interest and the best interests of the people they serve (Powell & Tahan, 2008).

Case managers can apply ethical decision making to their practice during assessment, planning, implementation, and evaluation. For example, during implementation of the case plan, a case manager helps to collaborate with the person(s) involved to maximize ethical and lawful outcomes. Case managers may have to mediate between the patient and service providers (in ethical situations), as well as handle potential conflicts of interest, unethical behavior by other service providers or breaches of conduct, privacy or confidentiality (Powell, 2000).

Different organizations have developed codes of ethics for their certified professionals. For example, the National Case Management Network of Canada is currently developing a code of ethics for Canadian case managers. The Canadian Association of Social Workers has a code of ethics for registered social workers in Canada. The code of ethics that American certified case managers must comply with is called the Code of Professional Conduct for Case Managers. However all case managers, whether certified or not, must follow the Statement of Ethical Case Management Practice, and follow specific organizational policies where they work. Principles of the code include "autonomy, beneficence, non-malfeasance, justice, veracity and distributive justice" (p. 311).

Consistency across the different codes dictates that case managers must always: promote the best interests of the person, do no harm to others, be fair and reasonable in the treatment of others, be respectful and ensure confidentiality, and be socially just in their decision making.

According to Powell & Tahan (2008), ethical concerns for case managers are on the rise due to demands for service provision to be cost effective, safe, and high quality. The essential role of a case manager as an advocate has evolved to include preventing or addressing ethical issues while advancing service recipients' civil liberties. According to these authors, regardless of the 'code' that case managers use, organizational support is needed to ensure case managers receive training on how to apply the code appropriately amongst diverse people with complex needs. See Appendix B for a sample of an ethical code of conduct.

SUMMARY AND DISCUSSION

The results from the literature, survey and interviews indicate several things. First, defining case management is a difficult process given the variance in agency mandates, approaches to ending homelessness and backgrounds of service recipients and case managers. Several barriers were identified that make effective and efficient case management work difficult, including navigating complex and fragmented systems and accessing needed resources. However, the promising practices highlighted by service providers indicated that improvements in collaboration, communication, individual and community engagement, flexibility, and effective and meaningful work processes are being made.

There were common themes and discrepancies which emerged during data collection, beginning with the activities, processes and principles of case management. Although there were differences in application, there was consistency in the importance and applicability of activities, processes and principles for effective case management. These commonalities led to the working definition of case management for ending homelessness described earlier in this report.

There were also similarities in discussions on appropriate case management models. Both the literature and the interviews indicated that ACT and ICM were very common approaches. Yet they also argued for adaptations to these models that build on people's strengths, provide a holistic team approach and allow for flexibility. These were important in the homelessness

context due to the complexity and heterogeneity of people's experiences. Key questions for developing adaptations to traditional approaches were based on each agency or case manager's processes, mandates and priorities. Developing specific processes first required determining the length of service, case loads, the key manager and supporting partners, and forms of communication patterns (e.g. meetings, assessments and conferences).

Underlying principles for case management clearly emerged from the literature. They included relationship building and "meeting people where they're at," and being individually focused, person-centered, collaborative, ethical, accountable and culturally competent. These themes emerged in the interviews as well, but as promising practices rather than specific principles.

Right matching of services emerged as a key promising practice in the literature, interviews and survey. In the literature this was expanded upon to include using and adapting the right models or approach, as well as detailing the importance of 'contextual case management.' In the interviews and survey, the descriptions of being person-centered were very similar to the literature's description of contextual case management. All sources saw the importance of building a supportive plan with and around people based on the complexities of their experiences.

Communication was a key theme in the literature, interviews and survey. In the literature review, communication emerged as a critical part of increasing community collaboration. In the interviews and survey this was a key theme that included, open, honest consistent communication amongst the team of supporters but also with the person accessing supports. The research also supported developing and sharing documentation.

The need for a coordinated and well managed system, including common language, assessments and outcomes, was clear from the literature. This theme emerged in the interviews and survey as something that needed strengthening in the homeless serving sector. Respondents indicated that implementing an HMIS system would help facilitate this. However there were concerns about ensuring confidentiality, community consultation, funding and funder input, and cost effectiveness, as well as the resources and time needed for adequate training and supervision.

Flexibility, internal assessment and evaluation were the promising practices that emerged clearly in the interviews and focus groups. Though less prominent in the literature, these practices are important considerations as they were articulated in our local context.

The literature discussed the importance of processes and procedures for ensuring ethical practices, including examples of codes of conduct developed for general case managers. This theme emerged as important in our local context, though not as clearly or in as much detail in terms of how to practice it. While local service providers articulated a need for job descriptions, performance evaluations and core competencies, the literature provided more specific examples.

Finally, peer support was indicated as the number one aspect for success in case management by the men, women and youth interviewed for this project. Though service providers acknowledged the importance of non-judgmental support, formal peer support was not prioritized to the same degree.

There is a need for ongoing research about case management and how it relates specifically to ending homelessness. This includes research specific to sub-populations, models of case management for ending homelessness, and client complexity and concurrent disorders. Given the heterogeneity of peoples' experiences, further research will indicate whether or not dimensions of practice are applicable, adaptable and continually relevant.

CONCLUSIONS

Several things can be concluded given the above findings and discussions. First, by following the advice and input of people experiencing homelessness in our community, we can ensure the interventions or actions we put into place are directly reflective of real lived experiences.

Second, commonalities emerged in all of the data collection methods regarding key themes and arguments, though they often were expressed different ways.

There are many barriers to doing consistently successful case management work. Though defining, coordinating and collaborating amongst the homeless serving sector is difficult, it is critical if we are to successfully end peoples' homelessness, both for individuals and across our communities.

Fourth, though there are many promising practices identified in the literature and already occurring in our community, there were also many solutions offered for addressing the multitude of barriers we face.

Finally, it is important and achievable to develop dimensions of evidence-based practices, in addition to determining processes and tools for coordinating, adequately resourcing and managing a case management system. The critical aspect for success is ensuring the processes address both individual and systemic factors and are guided by and done with community.

Information in this report will be used to guide the development of promising dimensions of practices for case managed supports to end homelessness.

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Appendix A

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MODELS MATRICES

MATRIX A

Copied from Mueser, et al (1998)

NOTE: For illustration purposes only, this matrix was developed based on case management studies specific to persons with severe mental illness. Homelessness was not specifically discussed as a factor in service provision.

Program feature	Broker Model	Clinical Case Management	Strengths Model	Rehabilitation Model	Assertive Community Treatment	Intensive Case Management
Staff to client ratio	1:50	1:30+	1:20-30	1:20-30	1:10	1:10
Outreach	low	low	moderate	moderate	high	high
Shared caseloads	no	no	no	no	yes	no
24 hour access	no	no	no	no	often	often
Consumer input	no	low	high	high	low	low
Emphasis on skills training	no	low	moderate	high	moderate	moderate
Frequency of contact	low	moderate	moderate	moderate	high	high
Place of contact	clinic	clinic	community	community/ clinic	community	community
Direct service provision	low	moderate	moderate	moderate	high	high

MATRIX B

Copied from Morse (1998)

NOTE: For illustration purposes only, this matrix was developed specifically with homeless individuals in mind but does not address issues of co-morbidity, culture, gender, or other social context

CASE MANAGEMENT MODELS	SERVICE INTENSITY	SERVICE DURATION	STAFF/CLIENT RATIO	SERVICE LOCATION	SERVICE EMPHASIS
Persons with mental illness					
Intensive Case Management. ICM	Extensive	Ongoing	10:1 or 15:1	Community	Emphasis on outreach assisting clients to access needed services and providing advocacy as needed
Assertive Community Treatment ACT	Some	Ongoing	10:1	Community	Emphasis on providing intensive treatment and support services in vivo, for an ongoing, open-ended period of time. Staffing is intensive, utilizing an inter-disciplinary team that includes psychiatrist and nurse and a shared caseload.
Broker Case Management	Minimal	Moderate to ongoing	50:1 to 85:1	Office based	Emphasis placed on assessing, planning, referring and helping clients to access needed services and resources delivered by other providers elsewhere in the community, and monitoring ongoing needs. Contact tends to be office-based and less intensive.
Persons with Substance Use					
ICM	Moderate to extensive	9 months or may be open ended but decreasing in intensity	15:1 to 30:1	Community and office	CMs link clients to service, monitor involvement, and assist (ICM) clients in problem-solving and recovery strategies. Aggressive outreach, develop trusting relationship, counseling, practical assistance.
Families					
ICM	Some	Open ended	20:1	In home and in office	Intended as ICM, with frequent open-ended service. In practice an average of 15 contacts and 15 hours direct service per first year.

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Appendix B

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CODE OF ETHICAL CONDUCT

Code of Ethical Conduct for Case Managers in Ending Homelessness

Preamble

The Code of Conduct below is an adaption of the *Discovery House Family Violence Prevention Society (Discovery House) Code of Ethics*. The original code was developed by Discovery House employees to assist them with ethically carrying out professional employment responsibilities, and work through ethical challenges that arise when working with individuals, families and related stakeholders. The adapted Code of Conduct is a statement of an employee's commitments to supporting individuals and families in ending their homelessness. This adaptation is intended for case managers at all levels in housing work.

The internal and external contexts in which employees carry out their work are constantly changing. This can be a significant influence on the ability of an employee to carry out their work ethically. The Code should be revised periodically to ensure that it is attuned to the needs of employees. Periodic revisions also promote lively dialogue and create greater awareness and engagement with ethical issues among employees.

Purpose Of The Code

The Code serves as a foundational document intended to assist case managers in maintaining a professionally and ethically exemplary standard. It provides general guidance for ethical relationships, responsibilities, behaviors and decision-making based on the fundamental ethical principles identified by Discovery House employees. It cannot deal with all possible situations that arise. It must be considered in conjunction with agency policies, goals, visions and missions. Codes of conduct should augment, not replace, independent ethical reasoning.

The Code serves as a means of self-evaluation and self-reflection for ethical practice and provides the basis for feedback and peer review. It also serves as an ethical basis from which employees can advocate for quality work environments that support the delivery of safe, compassionate, competent and professional service. The Code also serves to bridge gaps in ethical processes and decision making processes amongst and across service providers.

Employee Values And Ethical Responsibilities

Employees in all areas of all agencies bear the ethical responsibilities identified under each of the six (6) values. These responsibilities apply to employee interactions with clients, co-workers and community stakeholders including, but not limited to, external service providers, other professionals, volunteers and members of the public. The responsibilities are those identified by Discovery House employees and are intended to help agency employees apply the Code. They also serve to articulate organizational values to other professionals and

members of the public. Employees help each other implement the Code, and they ensure that students and volunteers are acquainted with the Code.

1. Right to housing and supports

Case managers in believe that everyone has the right to housing and individualized supports to live in their community of choice.

Ethical Responsibilities:

a) Case managers engage in practices that support and empower the physical, emotional, psychological, cultural and spiritual choices of the people who receive services as well as the people employed to provide services.

2. Respect

Case managers believe that all people deserve to be treated with respect.

Ethical responsibilities:

a) Case managers acknowledge, without judgment, the right of clients to make choices and decisions about their life within the parameters of agency mandates, policies and the law.

b) Case managers engage in direct, honest and empathic communication that acknowledges the worth and dignity of the other person.

c) Case managers recognize the intrinsic value of the other person, whether client, co-worker or stakeholder, by seeking their input into decisions that impact their life.

d) Case managers follow through with commitments and expectations.

e) Case managers are inclusive in their practice and recognize the value of individual differences and unique skills everyone brings including, but not limited to: culture, religion, ethnicity, race, language, ancestry, ability, family status, education, vocation, personality, mental or physical, gender, sexual identity, political and social views.

3. Professionalism

Case managers are advocates for their agency and committed to engaging in professional practices that add value and credibility.

Ethical responsibilities:

a) Case managers lead by example.

b) Case managers accurately present and apply their professional qualifications, experiences and knowledge.

c) Case managers recognize that objectivity, professional judgment and client needs may be compromised by the existence of dual relationships with clients, (romantic, sexual or other) and take steps to maintain appropriate boundaries by avoiding or terminating such relationships.

d) Case managers will not engage in behavior with clients that results in any perceived or actual personal or financial gain.

e) Case managers believe that appropriate workplace dress, language and behavior are important to role model for clients, fellow employees and other stakeholders.

f) Case managers carry out their employment responsibilities in a way that builds respect and credibility within their agency, the homelessness serving sector, and the community at large.

g) Case managers treat clients and all other persons with whom they interact with courtesy, compassion, respect, honesty and fairness.

h) Case managers are punctual and demonstrate an appreciation and respect of other people's time.

i) Case managers hold themselves accountable for their actions and take initiative to ask questions and seek clarification about any issues that impact their working experience.

4. Competence

Case managers are committed to quality service and pursue excellence in a lifelong commitment to optimize their professional competence, as embodied in the qualities of knowledge, ability, experience and judgment.

Ethical responsibilities:

a) Case managers recognize the boundaries of their competence and only provide services for which they are qualified by training or experience.

b) Case managers recognize when and if their personal issues are interfering with their ability to provide their particular service within the agency. Under these conditions employees take appropriate steps and seek assistance and support internal and/or external to the agency.

c) Case managers are committed to recruiting members to the case management team, who have abilities and competencies that meet and exceed the standard of excellence in their agency.

d) Case managers take responsibility for sharing and developing their expertise.

e) Case managers engage in self-care and strive to achieve work-life balance

5. Confidentiality

Case managers recognize the importance of privacy and confidentiality and safeguard personal information obtained in the context of a professional relationship.

Ethical Responsibilities:

a) Case managers recognize the right of people to have control over the collection, use, access and disclosure of personal information.

b) When discussing personal information, case managers take reasonable measures to prevent confidential information from being overheard.

c) Case managers collect, use and disclose personal information on a need-to-know basis with the highest degree of anonymity possible in the circumstances and in accordance with relevant federal and provincial laws.

d) When case managers are required to disclose personal information for a particular purpose, they disclose only the amount of information necessary for that purpose and inform only those necessary. They attempt to do so in ways that minimize any potential harm while meeting professional and legal requirements.

e) Case managers advocate for clients to receive access to their records through the appropriate channels and in a timely process when such access is requested.

f) Case managers respect policies and laws that protect and preserve people's privacy including agency information and security safeguards in information technology.

g) Case managers intervene if others inappropriately access or disclose personal information.

6. Collaboration

Case managers are collaborative in their approach to the provision of services.

Ethical responsibilities:

a) Case managers seek input from all pertinent and available resources in the best interest and achievement of the client's goals.

b) Case managers appropriately share information with external resources as required and in accordance with the principles of confidentiality enumerated within this Code.

c) Case managers provide concrete and emotional support to each other to foster the team work and cooperation necessary to best meet the needs of clients and each other as colleagues.

d) Case managers respond in a timely manner to information and requests from clients, as well as internal and external stakeholders.

e) Case managers invite open and honest feedback from clients, co-workers and supervisors.

Using The Code

Values are related. It is important to work toward keeping in mind all of the values in the Code at all times for all persons in order to uphold the dignity of all. Values may be in conflict. Values conflicts need to be considered carefully.

Maintaining high ethical standards is the responsibility of every employee. The resolution of ethics issues does not occur in a vacuum. Review and resolution may be accomplished

using this document and other relevant agency policies, other professional codes of ethics, employment practices such as performance management and employee relations principles.

If you have an ethical concern:

a) Where possible resolve it directly with the other person or persons involved.

b) If needed, seek coaching and information from a supervisor.

c) If unable to speak with the employee involved or the supervisor, or if efforts to resolve the issue directly are unsuccessful, the employee will seek assistance from an ad hoc ethics committee made up of two internal and two external agency employees. Conflicts of interest around committee composition will be resolved by substitution of a committee member. The director, the executive director, or the chair of the board of directors of the lead agency will determine the composition of the ethics committee.

d) All concerns submitted to the ethics committee must be submitted in writing.

e) Where the concern involves a supervisor, the concern will be taken to the supervisor's manager, and in the case of the executive director, to the chair of the board of directors.

If an ethical concern is brought to you by a colleague:

a) Listen to the concern and use reasonable effort to resolve the issue with that colleague.

b) Seek coaching or assistance with resolution from a supervisor.

The rights and responsibilities of the Ethics Committee are to:

a) Meet with and interview any persons who can provide information germane to the resolution of the ethical issue.

b) Review the facts and make recommendations that will include a plan for resolution in writing to the employees and either the agency Director, the Executive Director, or the Chair of the Board of Directors.

c) Complete this process within forty-five working days of striking the Committee.

Case managers by virtue of adhering to this document acknowledge the importance of maintaining an ethical workplace. Employees who refuse to cooperate with the resolution of ethical issues will be subject to discipline including suspension and termination.

Breach of the Code

Case managers believe it is important to be committed to the standards they identify in this Code, and in recognition of this belief, advocate consequences to employees who breach their commitment to the values in the Code.

A breach of the Code may result in:

Informal (verbal) counselling: A private discussion between the employee and their supervisor regarding the desired course of action to rectify the issue, the supervisor's expectations for improvement, and what might occur if the behavior is not corrected. A summary of the discussion will be placed on the employee's file.

Formal (written) counselling: A private discussion between the employee and their supervisor to emphasize the significance of relatively minor breaches when facts and discussion with the employee demonstrate that verbal counselling has not corrected the problem. The supervisor should identify the issue and the desired course of action for improvement, including the supervisor's expectations and what might occur if the behavior is not corrected. Depending on the breach, it may be used to address first instances of a breach.

Formal counselling must be documented by letter or memorandum. A copy will be given to the employee and a copy kept by the supervisor. No copy will be placed on the employee's personnel file except as necessary to support subsequent formal disciplinary action.

Written Notice: When counselling has failed to correct an issue or when an employee commits a more serious breach of this Code, a Written Notice may be issued. A Written Notice would identify the behavior and could include additional actions such as suspension or termination. A copy of this notice will be kept on the employee's personnel file.

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Appendix C

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GLOSSARY OF TERMS

Case management for ending homelessness

Case management for ending homelessness is a collaborative community based intervention that places the person at the centre of a holistic model of support necessary to secure housing and provide supports to sustain this housing while building independence.

For case management in this context to be successful in accessing the appropriate housing and supports to end homelessness in a sustainable way, it must be:

> *focused on the right- matching of services; person-centered; adaptive; individualized; culturally appropriate; flexible; holistic; long-term; multi-disciplinary; include advocacy that leads to self-advocacy; focused on establishing networks and relationships; include coordination and engagement; and ensure that the activities, processes and principles of case management are in place.*

Case manager for ending homelessness

The case manager is a navigator, an advocate, a coordinator, a collaborator and a communicator that balances service provision with systems navigation with short-term and long-term strategies to break the cycle of homelessness with individuals and families in a sustainable way.

The role of the case manager is to 'manage the process' so that there is an individualized plan for each person's needs and wants. They lead, build and facilitate the team based on the needs of the person and are responsible for ensuring the activities and processes of case management are in place.

Housing first

The definition of housing first consists of two components: as a philosophy and as a programmatic intervention.

Housing First as a philosophy is the belief that managing homelessness through emergency shelter responses or programs designed for 'housing readiness' are not appropriate for ending homelessness.

The philosophy of housing first says that anyone can be supported into housing directly from homelessness and can maintain that housing with supports, regardless of the level or intensity of individual and structural issues that led to their homeless state.

Housing First as a program type refers to interventions that place people experiencing homelessness directly into permanent housing without the requirement of a transition

period or of sobriety or abstinence. While individualized case managed support services are offered, the program does not require participation in these services to remain in housing.

Person–centered

The plan is defined and driven by the person. It is a process of working with people by listening to and learning about their needs and wishes, in order to encourage and support an increase in their independence to sustain their housing. It is focused on what is important to people and acting on this through collaborative planning and implementation of services and system navigation.

Right matching of services

'Right matching of services' or, levels and intensity of support, is based on individualized planning and a thorough, comprehensive and consistent assessment of needs, wants, goals, strengths and barriers. It requires effective and meaningful planning and application of services and referrals to match the assessment.

Best/promising practice

The first five practices in this list have been adapted from the Collaborative Community Health Research Centre at the University of Victoria. The sixth has been added by the Calgary Homeless Foundation.

According to University of Victoria, the first practice would be considered the bare minimum criteria to be considered a "promising practice", the closer the project gets to number five, the more likely it is considered a "best practice."

1. Has the program/project received awards or honors?
2. Has it appeared in non-referenced professional publications?
3. Has it appeared in a peer referenced publication? Have the source documents undergone scrutiny by experts?
4. Has there been either a quantitative or qualitative analysis of the program or principles?
5. Has it been replicated in other contexts with other populations?
6. Can you contact the group or individual who implemented and/or evaluated the model to determine long-term results?

Ethical conduct

"Principles, values, standards, or rules of behavior that guide the decisions, procedures and systems of an organization in a way that (a) contributes to the welfare of its key stakeholders, and (b) respects the rights of all constituents affected by its operations" (2007, International Federation of Accountants).

Dimensions of practice

Dimensions of practice are statements and guidelines developed to assist service providers and individuals accessing services when making decisions. They are intended to be flexible and some deviation is expected as people are individuals with differing and complex needs.

Dimensions should be used for building an evidence based framework for service delivery and establishing a way to evaluate outcomes and successful care. They should build accountability and consistency in service provision, thereby reducing barriers. Their use is not intended as a be-all-end-all tool, but to be used as a foundation for care and treatment.

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Appendix D

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ADDITIONAL INFORMATION

This list represents various websites where pertinent information to case management and/or homelessness can be accessed.

Council on Accreditation

http://www.coastandards.org/

This website includes various standards of practice for social service agencies, including case management standards. This organization is the gold standard for social service agencies in the United States.

The National Case Management Network of Canada

http://www.ncmn.ca/

This organization has developed national standards for clinical case managers in Canada.

Case Management Society of America

http://www.cmsa.org/

This organization has developed nationalized standards for case management. Though not specific to homelessness, there is lots of emphasis on policy and procedures.

American Case Management Association

http://www.acmaweb.org/

This is an interagency and networking website for clinical case managers.

National Alliance to End Homelessness

http://www.endhomelessness.org/content/media/detail/2246

This website has many resources specific to ending homelessness, including the Minnesota Interagency Task Force on Homelessness.

City of Toronto: Shelter, Support and Housing Administration

http://www.toronto.ca/housing/info-agencies-shelters.htm

This website has information specific to emergency shelters and supportive housing, including a case management handbook.

Province of Ontario.

http://www.health.gov.on.ca/english/public/pub/ministry_reports/mentalhealth/intens_cm.pdf

This is a link to Intensive Case Management Service Standards for Mental Health Services and Supports

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Appendix E

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REFERENCES

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Glossary

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Aboriginal - "Aboriginal Peoples of Canada" includes First Nations, Inuit and Métis peoples of Canada who may or may not reside within their cultural community. (Canadian Constitution, Part 1, Section 35, Sub Section 2)

Aboriginal Staff - An Aboriginal person who, in addition to having the educational requirements identified in the program standards, is aware of, respects and knows how to access support to give recognition to the cultural values, beliefs and practices of Aboriginal children, families and communities.

Abuse - May be direct and overt, or disguised and covert and includes:

- Physical actions that are intended to inflict violence or pain on another;
- Emotional or psychological coercion used to manipulate another;
- Inappropriate sexual contact;
- Failure to meet physical (i.e. food, medical attention) or emotional needs;
- Bullying - repeated and systematic physical attacks, threats, humiliation, extortion of money or possessions and/or exclusion perpetrated by individuals or group,
- Administration of medication for an inappropriate purpose and
- Exploitation - taking advantage of others (i.e. using their money or belongings, persuading them to be involved in illegal actions or actions not in their best interest).

Admitting Parent/Guardian - The admitting parent/guardian is responsible for admission to and authorizing of access to services.

Advocacy - The promotion and safeguarding of the rights of a clients by interceding on his/her behalf and assisting the clients to intercede on his/her own behalf.

Anticipated Wait Times – The period of time forecast between a program receiving a referral to provide services to a client and the beginning of service delivery.

Assessment - An evaluation process in which professional expertise and skills are exercised to collect and analyze data in order to understand and describe the nature of the service needs of the clients and to determine priorities of program planning and service development.

Authorization - Authorization is the power to make decisions or the commission to a certain person or body to act on behalf of another person or body.

Behaviour Management - The means used to influence, change or manage the behaviour of a client. The following interventions may not be utilized as a mechanism to alter behaviour:

- Corporal punishment: punishment of a physical nature such as shaking, pushing, slapping or spanking
- Humiliation: engaging in any form of conduct which is intended to ridicule, humiliate, degrade, insult, or otherwise undermine the dignity or self-worth of a client
- Degrading punishment: implementation of a consequence for an undesirable behaviour where the effect, the intent or effect of the consequence is to lower the dignity of the offending individual
- Mechanical restraints: an artificial appliance used to physically restrict the movement of an individual (i.e. handcuffs)
- Group punishment for one individual's behaviour: Group punishment is interpreted from the perspective of intent rather than effect. There are circumstances that will cause Clients to feel punished (effect), though the intent/purpose of the action/consequence was not to punish (e.g. if behaviour of one clients results in not having adequate staffing to take the other Clients on the outing. The cancellation of the outing would not be interpreted as group punishment). In the context of the principles of a positive peer culture, a group privilege or reward may be lost due to the misbehaviour of one clients, provided that such contingencies are established in advance with the group that is affected. An example of unacceptable group punishment would be the cancellation of telephone privileges for all Clients due to the inappropriate use of the telephone by one person
- Medication as punishment
- Intentionally harmful or abusive practices: The use of pain, either physical or psychological, as a method intended to reduce or avoid a particular behaviour or situation
- Locked confinement (with the exception of Intensive Treatment programs, Secure programs and Protective Safe Houses)
- Sleep deprivation
- Withholding of meals
- Withholding spiritual observances, and
- Withholding visits: with family, guardians, advocate or lawyer

Case Load – The number of clients assigned to each direct service staff; should be determined by the client's level of acuity/need and the capacity of the organization. A guideline range for Case Management is 1:10 to 1:25.

Case Management - A process of service coordination and delivery on behalf of Clients which includes assessment of the full range of services needed by the Clients, implementation, provision of support, coordination and monitoring of services, and

termination with appropriate referrals when the organization's direct service is no longer needed.

Child Welfare - Child Welfare is the term used to refer to child protection services and/or organizations that provide child protection services.

Client - Any one person (child, youth or adult) or combination of persons (family) receiving services from a specified service provider.

Clinician - A person trained to a Masters level or higher and currently registered with their College (e.g. College of Social Workers, College of Psychologists, College of Physicians and Surgeons, etc). He/she specializes in the psychological, emotional and/or psycho/social treatment of Clients, as distinct from one specializing in administration, research or academic work.

Competency Based Hiring - Hiring method based upon merit and selecting an individual for the knowledge, skills, and abilities needed to be successful in doing a particular job. Staff, who do not have the educational requirements but are hired bases upon their competencies, will have a written rationale for experience based hiring maintained in the file.

Consent forms – The documentation of a client giving approval or assent to elements of service delivery.

Consultant - A consultant is a person who provides specialized/technical advice or services to a program for specific purposes on a contractual or fee-for-service basis.

Contractor - Professional and/or non-professional person(s) hired on a contractual or fee-for-service basis to provide a specific service (i.e. drivers, foster parents, respite or supported independent living providers, Aboriginal/Cultural Resource Person, etc).

Cultural Competency - The ability to understand, communicate with, and effectively interact with people across cultures.

Cultural Resource Person - A person recognized and endorsed by a specific ethnic community who can provide support, guidance and wisdom regarding the culture and cultural practices, beliefs and issues inherent to the community.

Debriefing - A conversation that takes place after a serious incident with anyone who may have been affected by it. The purpose is to discuss events that took place, feelings that have been incurred and reduce any harmful after-effects.

Disaster - A disaster is any event that:

1. Causes much suffering/loss (i.e. flu pandemic) or
2. Results in great damage/destruction requiring evacuation (i.e. tornado, flood), or
3. Renders a facility uninhabitable either temporarily or permanently

Discharge - The process in which a client is terminated (or terminates) services. This can be planned or unplanned.

Planned Discharge – The process whereby clients transition out of the formal case managed relationship because goals have been reached and assessments show readiness to disengage.

Unplanned Discharge – The process whereby clients leave the formal case management relationship, whether due to habitual non-compliance to the case management agreement, the threat or actual assault of another individual in the program (or program staff) or the endangering of others. Can be foreseen or unforeseen.

Foreseen Unplanned Discharge – A discharge that can occur over several weeks for behavioural issues or over 24 hours for safety/dangerous situation that threaten harm.

Unforeseen Unplanned Discharge – Discharge that may occur at any time, without prior discussion with the Case Manager.

Discrimination - Discrimination means treating people differently, negatively or adversely because of their race, age, religion, sex, etc. As used in human rights laws, discrimination means making a distinction between certain individuals or groups based on a prohibited ground of discrimination.

Duty of Care - An obligation that a sensible person would have in the circumstances when acting toward others and the public. If the actions of a person are not made with care, attention, caution, and prudence, their actions are considered negligent.

Elder - Elders are members of the Aboriginal community who have gained humble authority by displaying wisdom in life. Not all seniors become Elders, and not all Elders are seniors, though the latter is very common as wisdom is gained through experience. Elders, as keepers of knowledge and tradition, have been recognized by their communities and by the Creator, because they hold many important lessons in their hearts that they willingly share with others to make their community a better place. Elders are teachers, philosophers, linguists, historians, healers, judges, counselors - all these things and more. They come from many communities, are of many ages, and have had unique experiences that have shaped their view of the world. Yet, they have one thing in common - the desire to help their people live the right way. (Heritage Community Foundation)

Evidence- based Tool – An object ive measurement tool, which has been tested and conforms to validity and reliability.

File - A file is the formal record of contact with a clients, which may include both paper and electronic components.

Foreseen Unplanned Discharge – A discharge that can occur over several weeks for behavioural issues or over 24 hours for safety/dangerous situation that threaten harm.

FTE - Full time equivalent paid staff position that may be made up from a number of part-time, casual and/or relief positions.

Goal - A goal is a statement of desired performance or behavior, which is specific, qualitatively and quantitatively measurable and attainable.

Good Faith - Good faith is being active and constructive in establishing and maintaining productive relationships. It's about how people and organizations treat one another every day, including being responsive and communicative. At the most basic level, good faith is about telling the truth. It means employers, employees and unions are not allowed to do anything that misleads or deceives one another.

Governance - The procedures associated with the decision making, performance and control of organizations, with providing structures to give overall direction to the organization and to satisfy expectations of accountability to those outside it.

Governing Board - The governing board of a non-profit organization has the legal authority and responsibility to set policy and oversee the operation of an organization.

Grievance - A real or imagined cause for complaint brought to the attention of the organization by a clients, staff, foster parent, volunteer, student and/or any other person having contact with the organization or program.

Guardian (also referred to as a Legal Guardian) - A person who has the legal responsibility for providing care and management of a person who is incapable, due to age or to some other physical, mental or emotional impairment, of administering his or her own affairs.

Guardianship - A legal relationship created by a court between a guardian and his ward - either a minor child or an incapacitated adult.

Harassment - Any unwanted physical or verbal conduct that offends or humiliates and can consist of a single incident or several incidents over a period of time. (Canadian Human Rights Commission) Harassment is discrimination and may include:

- Threats, intimidation, or verbal abuse
- Unwelcome remarks or jokes about race, religion, disability, or age
- Displaying sexist, racist or other offensive pictures, or posters
- Sexually suggestive remarks or gestures
- Inappropriate physical contact, such as touching, patting, pinching, or punching, and
- Physical assault, including sexual assault

Holistic – Addressing all contributing factors which may affect a person's well-being, including (but not limited to) physical, emotional, spiritual, social, cultural and mental.

Human Services - Programs which assist people in meeting their needs to be adequately housed, clothed, and fed, as well as their needs for social, developmental, educational, recreational, and religious opportunities for the maintenance and enhancement of physical, psychological, social, and spiritual well-being.

Incident Report - A report outlining an occurrence or situation happening to the clients during participation in the program. (See *Reportable Incidents* and *Serious Incidents*)

Informed Consent - A legal condition where a person can be said to have given consent based upon an appreciation and understanding of the facts and implications of an action. The person needs to be in possession of relevant facts, his/her reasoning faculties and without an impairment of judgment at the time of consenting. 'Minors' (which may be defined differently in different jurisdictions and/or for different issues) are generally presumed incompetent to consent. Informed consent is usually required from the parent/guardian.

Intake - The initial gathering of information about individuals for the purposes of assessment, the determination of eligibility and the need for services provided by the program or other appropriate resources in the community.

Intervention Record Check - Alberta Children's Services information system checks to determine if there is a record of the person having been involved with the child welfare system.

Liability - Liability is the condition of being responsible for a possible or actual loss, penalty, evil, expense, or burden whether existing, potential or contingent.

MOUs (Memorandums of Understanding) – A document outlining an agreement between parties.

Management Staff (also referred to as Senior Staff) - Management staff is responsible for the overall operational aspects of the program and may include the Chief Executive Officer, Chief Financial Officer, Program Directors, and Volunteer Coordinator etc. Based upon the size of the organization, management staff may or may not be involved in providing direct services to Clients and/or their families.

Organization - Organizations are legal entities that manage themselves in accordance to the Act, laws, policies and regulations that direct them and may include agencies, government run services, proprietorships etc. An organization may provide services through a single program or may offer a large range of services through many programs.

Outcomes - Outcomes may be for a client or a community and are a change in knowledge, behaviour, feelings, thoughts, attitudes, and acquisition of resources and/or characteristics - the difference the provided service will make in the short, intermediate and long term. (Canadian Outcomes Research Institute)

Personnel - Personnel refers to all paid and/or unpaid persons working within the program either directly with Clients or in an administrative role (i.e. staff, contractors, service professionals, practicum students and volunteers).

Planned Discharge – The process whereby clients transition out of the formal case managed relationship because goals have been reached and assessments show readiness to disengage.

Policies - Statements of practice derived from principles and philosophy that guide organization operation and services.

Procedure - When used in the context of "policy and procedure" means the method and manner by which the policy will be implemented.

Professional - Occupations with a unique service orientation whose work is systematically and continuously informed by a growing body of knowledge peculiar to the practitioner; governed by an acknowledged code of ethics and which has a system for maintaining control over its membership.

Program - A planned, structured and organized set of functions and activities designed to achieve specific objectives relative to the behavioral, physical, emotional and/or psychological developmental needs of the individuals served by an organization.

Direct Service staff - Staff involved in providing direct services to and with Clients (e.g. front line child and youth care workers, support workers, youth workers, house parents, home service providers). This definition does not include administrative staff or clinical consultants when their responsibilities are consultative rather than providing direct service.

Psychologist - A chartered professional psychologist meeting the standards set and registered by the Psychologists Association of Alberta.

Public Organization - An organization established by statute, owned and operated by any level of government.

Qualified Trainer - There are many organizations providing training in the areas of first aid, crisis intervention/physical restraints and suicide. It is the responsibility of the program to provide a rational for the trainer selected and the means of training used – i.e. workshop, train the trainer, on-line training etc.

Crisis Intervention/Physical Restraints

The trainer must possess a current training certificate (certified within the last three [3] years) from a recognized body or organization.

All training will incorporate the following elements:

1. Prevention: philosophy of crisis intervention, phases of crisis, conflict resolution and self-evaluation of individual reactions to verbal and physical aggression
2. De-escalation: triggers that a clients responds to re-direction techniques, body language, voice tone, team work and treatment planning
3. Physical Intervention: different levels of intervention that are progressive and painless and allow for the maximum control and safety of the individual and staff
4. Post Intervention Debriefing: processing the incident with the clients and staff, examination of alternative reactions and behaviours and required documentation, and
5. Personal Safety: learning to protect oneself in situations where one is at imminent risk of injury

First Aid

A person who has expertise in the field of first aid will deliver the training program. The trainer must:

1. Possess a current training certificate (certified within the last 3 years) from a recognized body or organization, or
2. Currently works in the area of first aid

Suicide

A person who has expertise in the field of suicide intervention will deliver the training program. The trainer must:

1. Possess a current training certificate (certified within the last 3 years) from a recognized body or organization , or
2. Currently work in the area of suicide prevention, or
3. Have focused on suicide as part of a graduate degree within the last 5 years

Quality Assurance/Quality Improvement - A system using established measures which promotes and confirms consistency of performance to these measures. It helps reduce variance in performance and outcomes.

A continuous cycle with a focus on change directed towards purposeful and future-oriented action including:

1. Setting of improvement goals
2. Evaluating performance of current practice
3. Changing methods to improve service delivery, and
4. Evaluating the impact of such changes

Rights - Entitlements assured by custom, law or property or something to which one has a just claim or the power or privilege to which one is justly entitled to have i.e. natural and legal rights.

Search - The investigation of personal space: bedroom, study area, possessions—a client's backpack, purse or clothing—for a specific purpose (i.e. looking for contraband such as drugs, weapons and/or stolen items).

Serious Incidents - Are situations or circumstances that are mandated to be documented and/or reported to appropriate authorities, both within and outside of the organization. Reportable incidents include:

1. Unanticipated or unauthorized absence from the program
2. A medical or other kind of emergency, serious illness or accident
3. A dangerous situation (i.e. threats of violence; weapons, clients is a danger to self through self-mutilation; suicidal ideation or attempt; etc)
4. Suspicions and/or allegations of abuse, either within or outside the organization
5. Use of restrictive procedures (i.e. restraints, unlocked confinement)
6. Searches
7. Death
8. Inappropriate use of strategies to influence behaviour by staff, volunteers, students and/or contractors and/or
9. Other events as identified by the program

Service/Support Plan - The written assessment of the needs of the clients in a plan developed to address these identified needs and/or issues identifying the goals, strategies (tasks/activities) and timelines. The case plan may be referred to as the, Case Plan, Concurrent Plan, Healing Plan, Individual Program Plan, Care Plan, Transition Plan, Treatment Plan etc.

Service Professional - Professional persons (i.e. Clinicians, Psychologists, Physiotherapists, Teachers etc.) hired by the organization on a contractual or fee-for-service basis to provide a specific professional service(s) i.e. assessments, consultation, clinical treatment, supervision, case management, teaching school board curriculum etc.

Service Provider - Persons contracted by an organization such as foster parents, community workers, consultants, Aboriginal/Cultural Resource Persons. Also may be used at a systems level to refer to the organization that provides services.

Service Team - Staff, contractors, service professionals and volunteers assigned to work with or be involved with the clients and/or their family.

Social Services - Activities designed to assist individuals and families in coping with social and psychological problems which interfere with their functioning.

Staff - Persons employed by the organization for wages or salary on a full-time, part-time, causal or relief basis. Staff does not include contracted persons such as foster parents or service professionals hired on a contractual or fee for service basis (i.e. Clinician, Occupational Therapist, Teacher etc.).

Stakeholders - Individuals, agencies and/or funders who have an interest in the organization.

Supervisor - Staff responsible for providing supervision to direct service staff providing direct services to and with Clients. This definition may include clinical consultants when their responsibilities include consultative and/or supervisory duties.

Termination - The planned or unplanned end of services in a specific program to a clients.

The 60's Scoop - The 60's Scoop refers to the adoption of First Nation/Metis children in Canada between the years of 1960 and the mid 1980's and is so named because the highest numbers of adoptions took place in the decade of the 1960s and because, in many instances, children were literally scooped from their homes and communities without the knowledge or consent of families and bands. Many First Nations people believe that the forced removal of the children was a deliberate act of genocide. (Kimelman, 1985; Sinclair et al., 1991)

Therapy - Activities designed to influence a change in thinking, cognition, behaviour, and/ or relationships.

Training - Training may take many forms and may include classroom training, an one/ many day session devoted to learning a particular skill, conference workshops, distance learning opportunities (i.e. videos, on-line courses), coaching sessions, clinical case conferencing, reading materials, peer training, etc.

Treatment - Services offered to overcome physical, behavioural and/or emotional difficulties that are severe enough to be problematic in a person's served physical, social, emotional and/or familial functioning. In the context of "restrictive procedures", treatment does not include those procedures which are used solely as disciplinary measures to correct isolated or sporadic incidents of clients misbehaviour.

Treatment Team - A multi-disciplinary team which includes people from different disciplines and with different roles in relation to the clients (i.e. direct service staff, foster parents, clinicians, Aboriginal or other cultural resource person(s), education staff, probation worker etc.) and any other people involved in the life of the clients that may be able to provide input into the development and implementation of the individualized care plan.

Unforeseen Unplanned Discharge – Discharge that may occur at any time, without prior discussion with the Case Manager.

Unplanned Discharge – The process whereby clients leave the formal case management relationship, whether due to habitual non-compliance to the case management agreement, the threat or actual assault of another individual in the program (or program staff) or the endangering of others. Can be foreseen or unforeseen.

Calgary Homeless Foundation

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