



PROGRAM POLICY	
Policy #3	Case Management and Clinical Services
	Effective Date: January 1,2011

Policy:

Transitions to Home provides a housing first program that assists long term shelter users and individuals experiencing homelessness to find and maintain stable housing. Once “housed” people are supported to create a successful tenancy and make changes in their lives to improve their health according to the social determinants of health. A team of Case Managers delivers these services. A Clinical Services program serves to integrate therapy with case management support to enhance the ability to meet the goals of the program.

Case Management

The Case Management program has seven functions that are based on the stages of change associated with motivational interviewing.

Program Function	Participant Stage
Shelter - At risk	Pre contemplation
Engagement	Contemplation
Case Planning	Commitment
Active Participation	Action
Program Exit	Maintenance
Relapse ¹	Renew Commitment

The Case Management team provides a range of formalized supports that provide engagement, assessments and supports for housing and other life needs based on the social determinants of health. Case managers develop a trust based relationship with the individual participant to create a formal case plan (action plan) that the participant is helped to actualize. The Case Manager and Participant develop case plans together to achieve the goal of maintaining stable housing and other chosen life goals they determine are important to their health and well being. T2H program participation requires that a case plan is developed and that the participant agrees to case management visits. On average 1 case management visits per week will occur for each participant. Throughout a term of participation in the program participants can experience as many as 2 or 3 visits per week at critical times such as a move-in and as few as one visit per

¹ Relapse can occur at any stage or point in the program

month as they are winding down their participation with the program having established a stable successful tenancy.

Case Management responsibilities are coordinated, shared and combined with the services of other program partners. In many cases this will be, but not limited to, Ontario Works, the Housing Help Centre, the Mental Health Street Outreach Team, Claremont House, Good Shepherd HOMES, Elizabeth Fry and the emergency shelters. In these situations Transitions to Home will work to identify and clarify each organizations role and work collaboratively with each partner to serve the better interests of the client. In addition to conducting home visits, Case Management services will also use neutral locations such as libraries, coffee shops etc. in the community to meet with individual participants.

Clinical Services

Clinical Services consist of consultation, assessment, therapeutic interventions, addictions counselling and recreation therapy. There are four stages to clinical services.

Clinical Stage
Clinical Engagement
Persuasion/Preparation
Active Treatment
Relapse Prevention

Life Transitions Therapists are registered social workers (Ontario College of Social Workers and Social Service Workers) who provide consultation, assessment and therapeutic interventions, (solution focused and cognitive behavioural therapies) to individuals, dyads and groups. Certified Addictions counsellors provide addictions focused assessment and counselling to individuals. Certified Recreation Therapists provide individual and group therapeutic recreation activities.

Current Application:

Standards (see Appendix) define the delivery of both program components.

Services are delivered between 8:30am and 7pm weekdays and from 9am to 5pm on weekends with the flexibility to extend or modified these hours based on the needs of the partner agencies and the resources of T2H. Program staff are accessible 24 hours, 7 days a week through an after hours call service for urgent matters. Service delivery is mobile within the community with the ability to meet with participants in various community settings. Therapy sessions, have a defined therapeutic setting in various offices and meeting rooms within the community.

Service Agreements and protocols determine the interactions with the Transitions to Home emergency shelter partners. Service agreements determine how referrals are made, the role of the case manager and clinical therapist when visiting the emergency shelters, the role of the

emergency shelter staffs and define how Transitions to Home and other partners coordinate services and collaborate in regards to mutual clients.

Clinical services engage with incarcerated individuals held at the Hamilton-Wentworth Detention Centre in collaboration with the Housing Help Centre. Clinical Engagement in this context begins prior to T2H case management which commences upon the individual's release if they intend to reside in Hamilton, are in need of housing or are released to a hostel, and are interested in the program.

Approval:

Signature & Title	Date Approved

APPENDIX

Transitions to Home Case Management Standards

Program Function	Participant Stage	Case Management Standards
Shelter At risk	Pre contemplation	<ul style="list-style-type: none"> • Written protocols determine process of participant identification within the emergency shelter system • Shelter staff will conduct a primary, common assessment and refer to T2H if appropriate • Long Term shelter use is defined as: <ul style="list-style-type: none"> ○ 42 days/nights in a shelter in the past 12 months ○ Repeated and long term use of drop-in programs ○ Shelter staff inform Case Managers regarding individuals at risk • Elizabeth Fry Society identifies individuals at risk and in need of housing • Mental Health Outreach Team and T2H coordinate involvement with individuals in shelter system • Housing Help Centre refers to T2H according to established criteria • Life Transitions Therapists engage in Hamilton-Wentworth Correctional Institution • Wesley Community Homes contacts program to inform of new tenant (new tenant not a current participant) • Community programs identifies individuals at risk and in need of housing
Engagement	Contemplation	<ul style="list-style-type: none"> • Written protocols determine process of initial contact in shelters, other programs and in the community • Case Managers engage individuals on their terms: in the shelter, in jail, on the street, in hospital, in residential program • Where possible engagement takes place in the individual's place of choice, considering the safety of the individual and Case Manager • Services are offered in the least intrusive manner possible ensuring participant choice • A trusting relationship based on good rapport is established before asking for a lot of details • Case managers explain the program expectations, roles and responsibilities to ensure the individual is aware of commitment to case management, choices and expectations • An anti racist, anti oppressive approach based on different life stage needs, cultural needs and linguistic needs is used; alternative and varied approaches are used to service these needs

Program Function	Participant Stage	Case Management Standards
Active Case Management		
Case Planning	Commitment	<ul style="list-style-type: none"> • To find and maintain stable housing is a mandatory goal required on every case plan • A mutually agreed upon, individualized, case plan-service plan is viewed as the determinant of housing ready status • Consistent, documented format for <i>Case Plan</i> is used with a signed document on file and signed copy given to participant • Comprehensive information about the participants housing history and relevant aspects of their life situation are collected by T2H • Participant needs are determined; Participant housing readiness determined • Housing readiness is measured through agreement to participate in case management • A range of stable housing options are developed by the program that include self-contained apartments, single occupancy rooms, rent-geared to income, subsidized and low cost options • A choice of stable housing is offered to all participants, where necessary a housing allowance is provided to improve affordability • Stable housing is offered as primary intervention to get long term shelter users out of hostels • Stable housing is offered as primary intervention to reintegrate individuals released from correctional facility • Stable housing is offered as primary intervention to continue treatment progress of program graduates • Social housing (Wesley Non-Profit Housing) rent geared to income is obtained through vacancies • Participants are re-housed in various situations in order to keep long term shelter users out of hostels
Active Participation	Action	<ul style="list-style-type: none"> • Case Manager assists participants in successful independent living through home and community visits as determined by case plan and the needs of the tenancy conditions • Case Managers assists participants in improving their lifestyles through the chosen goals on the case plan and a strengths based approach • Case Managers, life transitions therapists and addictions workers assist participants in contacting suitable social services, rehabilitative and other clinical programs • Participants participate in recreation therapy programs • Internal referrals are generated by participants through the Case Manager for clinical social work, therapeutic programs, – an assessment is completed by the therapist - a therapy case plan is developed • Participants may contact addictions counsellor – an assessment is completed - an addictions treatment plan is developed • Written protocols determine 24/7 program operation • Program is available 8:30 am. to 7pm. Weekdays, 9am to 5pm Weekends • Program is available to participants and superintendents, landlords after hours through an on-call, 24/7 by telephone service • Case Management supports slowly back out as tenancy successes increase and case plan goals are attained
Program Exit	Maintenance	<ul style="list-style-type: none"> • Former participant living independently without active case management supports • Former participant cases have follow-up reviews at least every six months • Participant gains are consolidated, participant actions focus on preventing relapse • Participant can contact program at any time to renew case management services
Relapse	Renew Commitment	<ul style="list-style-type: none"> • Relapse is viewed as learning, service plan mutually reviewed with amendments as necessary • Commitment and participation can be renewed by former participants upon request

Transitions to Home Clinical Standards – “Strategies Match the Person’s Stage of Change”

Clinical Stage	Clinical Standards
<p>Clinical Engagement</p>	<ul style="list-style-type: none"> • Written protocols determine process of client identification and referral • Attend and organize case conferences as part of client identification and referral process • Where possible engagement takes place in the participant’s place of choice, considering the safety of the participant and clinician • Clinical engagement is a series of irregular meetings –clinician uses these times to develop a working alliance with the prospective client • Engage with incarcerated males and females at Hamilton –Wentworth Correctional facility • Engage with T2H participants at any Case Management program stage • Engage with referrals from Housing Help Centre who participate in housing case management • Engage with referrals from Claremont House • Clinical notes are kept that describe the purpose, process and outcome of engagement • Goal is to provide psycho-social rehabilitation, advocacy and clinical coordination
<p>Persuasion/Preparation</p>	<ul style="list-style-type: none"> • Conduct assessments, provide therapeutic services according to written protocols and client needs • Researched best practises are used to determine the use of formal assessment tools • Develops motivation for active treatment by mutual exploration of the effects of the client situation • Develops motivation for active treatment by mutual exploration of the effects of substance abuse • Assist client’s in assessing current social leisure and recreational activities • Small change strategies are used • Discrepancy between individuals goals and behaviours is used to elicit change thought • Substance use is not viewed from a problem perspective but from the impact of substance use on individual’s life • Offering of choices, clarifying of goals, building of self-efficacy is used to negotiate a plan for change • Consistent, documented format for a Therapeutic Plan, a signed document on file and copy given to participant • End goal: participant has developed hope that her/his life can be improved by participating in therapy, reducing substance use and/or reconnecting to recreational and social leisure activities
<p>Active Treatment</p>	<ul style="list-style-type: none"> • Provide therapeutic services according to written protocols and client needs • A course of regular contact with the participant has been negotiated and mutually agreed too • Identify high risk behaviours and develop coping skills • Provide single session counselling • Provide Cognitive Behavioural Therapy • Provide Solutions Focused Therapy • Provide Addictions therapy, referral, placement and follow-up to external treatment • Provide therapeutic recreation • Activities to fill void left by less substance use are identified • Natural and informal support networks are identified and contacted where appropriate • Crisis planning, and strategies are developed • Help participants to access those rehabilitative and therapeutic services they are entitled too • Develop skills to negotiate with medical, social and community services providers

Clinical Stage	Clinical Standards
Relapse Prevention	<ul style="list-style-type: none">• Allow participants to learn from own mistakes• Participants learn to advocate for themselves• Skills to predict and prevent future crisis are developed• Facilitate self-management of crises• Sustaining change achieved during active treatment• Natural and informal support networks are maximized• Set backs are placed in the context of recovery• A re-referral process is used for necessary re-contact and reactivation of clinical services