RESEARCH REPORT

Dimensions of Promising Practice

For Case Managed Supports in Ending Homelessness

July 2011

Acknowledgements

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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.

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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.
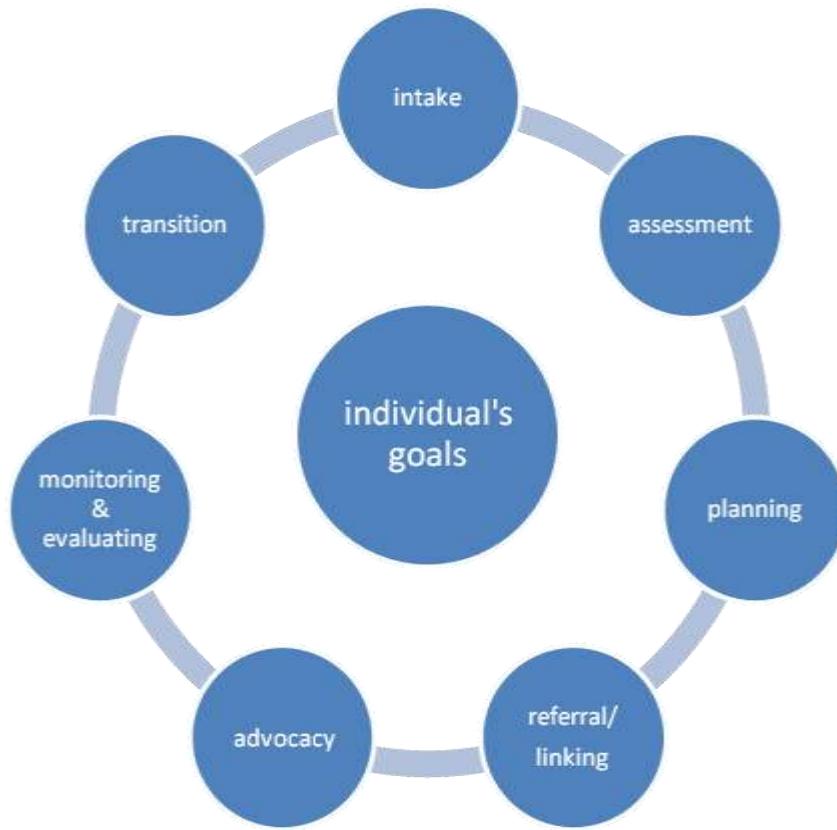
Processes of Case Management

"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).

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.

<u>*Homeless Management Information System (HMIS)*</u>

"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.

"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.

Appendix A: 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 contexts.

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: Sample 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.

Appendix C: 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.

Appendix D: 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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