

city of toronto case management handbook
for city-operated shelters



april 2005

table of contents

page

1 introduction	3
Shelter, Housing and Support Division – Mission Statement	3
Hostel Services Unit – Mission Statement	3
2 what is case management?	5
Why are the city-operated shelters standardizing case management now?	5
How does case management support system effectiveness?	5
How does case management support an improved service delivery?	6
How does the model address the increased needs of shelter users?	6
Shelter Standards	6
Shelter Standards 6.2	7
Guiding Principles	7
3 the case management model for city-operated shelters	9
Case Management Models	10
The Matrix	10
Case Management Model – Matrix (illustration)	11
Components of Service	12
Definitions of the Components of Service	12
Definitions of the Stages of Service	14
4 the role of the caseworker	17
Skills	17
a) Communication	17
b) Organization	18
c) Guidelines for Conducting Interviews	18
d) Documentation	20
e) Cultural Competency	22
5 case management tools	23
Role of Supervision	23
Group Activities	24
Informal Supports	24
Ongoing Training	24
6 conclusion	25
bibliography	26
appendix 1: websites	27
appendix 2: guidelines for conducting interviews	29



1 introduction

This handbook was developed to assist you in your work with clients in the city-operated shelters. You will use the Case Management Model for City-Operated Shelters to provide caseworker services. The model will ensure that client needs are being met while supporting the goals of your organization. It is a balance to fulfill both of these responsibilities. We hope this model assists you in doing your work and encourages both you and your clients.

In order to have a better understanding of the model and its application within the shelter, it is important to see how it fits within the larger context of the services delivered by the city-operated shelters and the expectations the City has of all shelters. That is why the divisional and unit mission statements are here for review.

shelter, housing and support division – mission statement

The Shelter, Housing and Support Division contributes to healthy communities by ensuring that vulnerable people have a range of shelter and affordable housing options. We provide temporary shelter and support for homeless individuals and families while creating and maintaining permanent housing solutions.

hostel services unit – mission statement

Hostel Services is committed to providing high quality service, which supports the dignity, diversity and self-determination of individuals in a safe and supportive environment.

Our mission statement captures the goal of helping our clients return to the community.

The case management model shows how this is done. The model defines 'high quality service' in City-operated shelters and provides a road map to organize the variety of work shelter case management staff have to do. Each shelter is unique in terms of the resources it has, the needs of its population and the partnerships it has developed. We share a common goal: we want to work with our clients and enable them to move from the shelter system to fulfilling lives in the community. We want our clients to keep their new housing and experience success.

Caseworkers spend every day having lengthy discussions, phone calls, meeting, solving crises and documenting everything. How do we organize the work from the moment a person walks through the shelter door? How do we address the many problems one individual may have? Is the housing appropriate? What is 'high quality service'? How can you promote independence in your client? Have you done enough work or too little and how do you know?

The goal of the model is to guide your day-to-day activities through each phase of your work with and for your client.



2 what is case management?

Case management is a model of service delivery widely used in the human services and the health sector. It lets workers manage the resources required to meet their clients' complex needs. It is adaptable to a wide range of settings and is used in fields such as shelter services, Community Care Access Centres, addiction treatment services, health care facilities, correctional services, and child and youth services. It is adaptable to the sub-groups who make up Toronto's homeless population. Shelter staff can adapt this model to meet the needs of each unique client. It ensures that both accountability and structure is in place such that each client's needs are identified and addressed.

Case management, as a model of service, is a learned skill. To be effective, staff must receive case management training and learn how it is applied to the unique demands of their shelter. This model will meet the common organizational needs of individual shelters and will accommodate the diverse needs of our clients.

why are the city-operated shelters standardizing case management now?

Shelters in the City of Toronto have responded to changing social, political and economic needs for the past 100 years. The Case Management Model for City-Operated Shelters was recently developed during a period where demands for accountability in government and the ways that services to homeless people are provided were under scrutiny. During the development of this handbook, Shelter Standards and the related Quality Assurance Review were implemented by Hostel Services. These initiatives influenced changes that are included in our model. The Shelter Management Information System (SMIS), the new integrated computerized system currently under development in partnership with the federal government, is a third and related initiative that will also support caseworkers in their application of the model.

People accessing the shelter system are entitled to the same standards of service no matter where they are sheltered. The case management model provides a standardized format to guide workers when they are identifying and addressing individual and families' needs. Client support is tailored to meet each person's unique circumstance while they stay in the shelter and when assisting with their return to housing.

how does case management support system effectiveness?

The effectiveness of the entire system will improve when we apply a standardized model of service delivery. The model provides us with a tool that allows individual caseworkers to set goals and measure outcomes with the client, and it also allows the shelter system to set its goals and measure outcomes. The effectiveness of each case plan and the system as a whole can be measured by providing a common format to set and measure goals and outcomes.

By agreeing on standardized components of services, i.e., housing, finances and employment, we can document and track the volume of work we do, identify service gaps and improve service co-ordination. Using the components of service as a common framework

allows us to improve service co-ordination with external agencies by assigning specific tasks or components to the various supports, build on each other's work with our shared client and avoid duplication of service.

how does case management support an improved service delivery?

The City is accountable for how our services are managed.

Shelter Standards and Quality Assurance are council-approved guidelines for how shelter operations and services should be delivered in Toronto.

Because of the complex needs of our client population, they may move between different shelters and within specialized programs in an individual shelter.

The shared case management model, coupled with common standards of care, allows clients to be transferred more efficiently between programs and shelters within the City-operated system. The model ensures that information is gathered and shared in areas relevant to the clients' service needs and within the programs' criteria.

The demands on shelters to provide a wide range of services have increased meaning that the specialized roles of shelter staff must become integrated.

The case management model, tailored to City shelters, promotes the team approach and encourages the sharing of tasks in a consistent manner.

Due to the increasingly complex needs of clients, many organizations may be involved in providing care.

The City promotes partnerships with community agencies. The case management model provides guidelines for sharing the work between agencies and planning for follow-up care in the community.

how does the model address the increased needs of shelter users?

Clients' needs have become more complex because of factors like:

- Insufficient appropriate and affordable housing
- Insufficient community supports
- Insufficient case management resources in the community
- Clients' complex needs require the involvement of multiple agencies
- Reduction in primary health care supports
- Aging population
- Poverty
- Restrictive legislation and policies (i.e., Tenant Protection Act and low Ontario Works rates)

The demands on shelter programs that support individuals with issues in the areas of mental health, substance abuse and low financial resources have increased as the programs and supports in the community have diminished. The model serves as a framework for you and the client to review the various areas of their life, identify barriers and work through them.

shelter standards

Over the last ten years, the shelter system has become both more specialized and flexible to meet the complex needs of homeless people. Today, the shelter system includes more transitional shelters, specialized programs like harm reduction and pregnancy supports, plus a wide range of programming and services. The City is committed to ensuring that shelter services are delivered so that homeless people gain access to housing and support, and are given choices while diversity is respected. To meet this commitment, the

City of Toronto Shelter Standards were developed. The standards provide shelter operators and clients with a set of expectations and guidelines detailing shelter services in Toronto. The expectations specific to counseling supports are:

shelter standards 6.2

All shelters must provide assistance and support to clients in the following areas:

- Assistance and referral to appropriate housing
- Assistance in obtaining financial benefits if eligible
- Referrals to appropriate services or resources
- Assistance to obtain clothing and transportation

In addition to the counseling supports, Shelter Standards guides the delivery of services in many other areas related to case management, such as:

Program Standards

- Services to children
- Duty to report suspected cases of child abuse and neglect
- Confidentiality
- Sharing of client information
- Client information and client files

Access to Shelter

- Overnight and/or late passes
- Substance use
- Service restrictions
- Meeting the needs of transgender/transsexual/two-spirited clients

guiding principles

The Shelter Standards' philosophy of service provision is grounded in the following values and principles,¹ and we have highlighted those points that are relevant to case management in the shelters.

- "All homeless persons have the right to shelter service regardless of political or religious beliefs, ethno-cultural background, (dis)ability, gender identity and/or sexual orientation. Staff must respect and be sensitive to the diversity of clients. Discriminatory and racist incidents or behaviours are not tolerated."
 - *All shelter clients in city-operated shelters are entitled to case management services.*
- "The shelter will provide an atmosphere of dignity and respect for all shelter clients, and provide services in a non-judgmental manner:"
 - *Caseworkers accept clients for who they are and the choices they have made.*
 - *Caseworkers maintain a dignified interview setting by minimizing distractions.*
 - *Caseworkers show respect for clients by safeguarding their privacy and maintaining confidentiality.*
- "Clients are capable of moving toward increasing levels of self-reliance and self-determination. Shelter staff will work with clients to assist them in achieving their goals."

¹Guiding Principles, Toronto Shelter Standards, page 7

- *Caseworkers work with clients, not “for” them.*
 - *Caseworkers present clients with a range of options in order to allow them to make informed choices.*
 - *Caseworkers help clients clarify their goals by recognizing clients’ strengths.*
- *“Shelters will be sensitive to the ethno-specific and linguistic needs of clients. Staff will work to ensure clients have access to culturally appropriate interpreter services and that written materials are available in other languages.”*
 - *Caseworkers will provide clients with qualified interpreters whenever possible.*
 - *Caseworkers will try to ensure that information is presented in a language the client understands.*
- *“Gender identity is self-defined. Sometimes this may not correspond with a person’s physical appearance. Service providers need to accept gender identity as defined by the individual rather than by the perception of staff and/or other clients.”*
 - *Caseworkers will support the client to access services in the gender they identify with.*
- *“Shelter staff often have access to detailed and highly sensitive personal information about clients. Protecting the privacy and confidentiality of shelter clients and their personal information is of the utmost importance.”*
 - *Caseworkers are responsible to meet the legislative requirements set by Ontario’s Municipal Freedom of Information and Protection of Privacy Act (MFIPPA), the Personal Information Protection and Electronic Documents Act (PIPEDA) and the Personal Health Information Protection Act (PHIPA).*
- *“In order to provide effective shelter programs and services, shelter clients must be involved in service provision, program planning, development and evaluation, and policy development.”*
 - *Caseworkers involve clients in all aspects of their case plan where possible.*
- *“Shelters are part of a larger network of homeless services and agencies. Collaboration with this network is important to ensure effective and co-ordinated services.”*
 - *Caseworkers collaborate with other agencies by sharing best practices, developing service partnerships and by ensuring community resources available to the client are used efficiently.*



3 the case management model for city-operated shelters

The goal of case management in City-operated shelters is to facilitate the shelter client's optimal reintegration into the community.

This Case Management Model is an organizational framework designed to assist caseworkers when identifying and addressing the complex issues facing homeless people in a variety of shelter settings. This model has the structure to meet the common needs of each shelter while keeping the flexibility that allows each shelter to focus on the needs of their target population. The model is a matrix that allows individual shelters to employ the same stages of service (structure) while placing greater emphasis on some components or aspects to meet the special needs of its population (flexibility). The case management model encourages caseworkers to assess their clients' strengths and preferences as well as needs.

In order to recognize the challenges faced by caseworkers in the shelter system, the Case Management Model for City-Operated Shelters has some unique features.

The Case Management Model for City-Operated Shelters:

- uses a holistic approach to assess important aspects of the individual's current situation. A comprehensive assessment, applicable to people living in shelters, examines the many areas of the individual's functioning and can be found in the Components of Service section.
- encourages and develops client independence by involving them in finding solutions and making decisions whenever possible. Caseworkers recognize the right of the individual to make free choices. They are responsible for informing the client of their options and the consequences while assisting them in making the best possible decision. This is the definition of a 'client-centred' approach to case work.
- recognizes that some people who leave the shelter system will need to plan for continued support in the community. This is called the 'continuum of care' and requires the planning and co-ordination of services.
- recognizes the importance of using a range of services and resources from formal and informal systems to address complicated problems. Formal systems may include community health centres, employment-training programs, external case management programs, child protection agencies or court diversion programs. Informal systems usually include friends, family members and religious or cultural organizations. Case conferences ensure that services are co-ordinated, not duplicated, and the client is involved in deciding which services will be part of the case plan. This is an 'individualized' case plan.
- recognizes and utilizes the different roles and duties of shelter staff to assist clients' successful return to housing. This team approach to service delivery brings different perspectives and skills together when working with people who face many barriers. The team may include dietary and childcare staff, an addictions caseworker, client service workers, housing workers, a health care co-ordinator, activity organizers and support services workers. Team members complement and supplement each other's work.

The caseworker is responsible for co-ordinating the client's access to both in-house and external services, and collecting information necessary for assessment and case planning.

- recognizes that the client's goal and the shelter's goal (of moving a client into a community setting) are not always the same. Clients who are not ready to move on voluntarily are a reality of case work in the shelter system and present a challenge to caseworkers and shelters.

case management models

Case management shares the following stages and components of service regardless of the setting. The stages of the generic model have been adapted to the stages of service in City-operated shelters.

In the chart below, each model moves the client through different stages of case management over a period of time. The composition of each model includes an assessment, a case plan based on the assessment, and a re-examination of the assessment and the implementation of the case plan. In the shelter system, assessment and re-assessment take place during each stage of service and is not limited to intake or the initial interview. The case plan remains flexible because its progress is continually monitored by the caseworker who can always modify it to reflect the new information or the changing needs of the client.

stages of service	generic case management	case management model for city-operated shelters	shelter standards core functions
	Engagement*	Intake	Assessment
	Assessment	Admission	Planning
	Plan	Initial Assessment	Referrals
	Intervention	Case Plan	Monitoring
	Evaluation of Plan	Case Plan Evaluation	Advocacy
	Follow-up	Discharge Follow-up	Collaboration Follow-up

* Engagement means establishing of a working relationship between caseworker and client.

the matrix

The service matrix (see next page) captures all the work required to develop and complete a case plan for a shelter client. It illustrates the many decisions, discussions and referrals that go into developing each unique case plan. The Case Management Model for City-Operated Shelters uses 'Stages of Service' to capture progress through the case plan and 'Components of Service' to capture a holistic assessment of needs and strengths. Note that each component of service is maintained through each stage of service.

The stages of service are noted along the top of the matrix with the components of service in the left-hand column. For each stage of service, check that you have addressed all components of service. It is mandatory to follow these steps and adhere to the structured system of documentation in the case management process.

For example, on admission a client will be asked questions about safety, health, identification, finances, legal issues, housing, education and employment. As shown on the matrix, this information is re-examined during each stage of service in order to ensure that all aspects of the client's situation have been addressed and integrated into the case plan.

stages of service

case management model

	Intake	Admission	Initial Assessment	Case Plan	Case Plan Evaluation	Discharge	Follow-up
Safety	Determine immediate safety issues	Record details regarding immediate safety issues Address immediate safety issues Review safety and security expectations at shelter	Review safety concerns Provide info on safety resources	Establish short/long-term goals re safety Provide resources/referrals to support safety goals	Reassess plan re safety goals and supports Monitor progress and evaluate outcome	Provide referrals, resources and support in community Establish activity plan	Monitor and revise activity plan Ensure community supports are in place
Health	Determine health concerns	Record current medications Record health concerns Record special diet/allergies where applicable	Review health concerns Review existing health care supports Provide info on health care resources	Establish short/long-term goals re health care needs Provide resources/referrals to support health care needs	Reassess plan re health care goals and supports Monitor progress and evaluate outcome	Provide referrals, resources and support in community Establish activity plan	Monitor and revise activity plan Ensure community supports are in place
Personal ID	Record client's personal data and status in Canada	Record, photocopy and certify personal IDs and status	Review ID and ensure copies on file Provide info on resources to obtain ID	Establish short/long-term goals to get IDs Provide resources/referrals to support ID goals	Reassess plan re obtaining ID goals and supports Monitor progress and evaluate outcome	Provide referrals, resources and support in community Establish activity plan	Monitor and revise activity plan Ensure community supports are in place
Financial	Determine source, type and amount of income Determine savings on hand	Record assets/incomes Record savings on hand	Review prior and current income/assets Provide info on financial resources	Establish short/long-term goals re financial goals Provide resources/referrals to support financial goals	Reassess plan re financial goals and supports Monitor progress and evaluate outcome	Provide referrals, resources and support in community Establish activity plan	Monitor and revise activity plan Ensure community supports are in place
Legal	Determine immigration status Determine current legal issues	Record presented legal issues	Review legal issues Provide info on legal resources	Establish short/long-term goals re legal goals Provide resources/referrals to support legal goals	Reassess plan re legal goals and supports Monitor progress and evaluate outcome	Provide referrals, resources and support in community Establish activity plan	Monitor and revise activity plan Ensure community supports are in place
Housing	Determine current housing situation Determine shelter history	Record housing issues Record address history for past 12 months	Review history to determine housing needs Provide info on housing resources	Establish short/long-term goals re housing goals Provide resources/referrals to support housing goals	Reassess plan re housing goals and supports Monitor progress and evaluate outcome	Provide referrals, resources and support in community Establish activity plan	Monitor and revise activity plan Ensure community supports are in place
Education	Determine location and hours of school/training for placement purposes	Record literacy observations	Review level of education obtained Review interest in further education/training	Establish short/long-term goals re education/training goals Provide resources/referrals to support education/training goals	Reassess plan re education/training goals and supports Monitor progress and evaluate outcome	Provide referrals, resources and support in community Establish activity plan	Monitor and revise activity plan Ensure community supports are in place
Employment	Determine if employed	Record current info re location, earnings and hours of work	Record current employment issues	Establish short/long-term goals re employment goals Provide resources/referrals to support employment goals	Reassess plan re employment goals and supports Monitor progress and evaluate outcome	Provide referrals, resources and support in community Establish activity plan	Monitor and revise activity plan Ensure community supports are in place

components of service

The components of service are safety, health, identification, finances, legal issues, housing, education and employment, and are the important factors in a person's situation. They are the building blocks of each assessment and client case plan. The pieces interlock and influence other areas of functioning, which result in a holistic assessment of the client's current situation. A well-structured assessment tool can guide the caseworker in looking beyond the seemingly obvious presenting issue and explore further. Each component of service must be addressed at each stage of service – it is not negotiable.

The stages of service are standardized for each shelter but the emphasis given to each of the components can vary depending on the target population and the individual client's situation. The target population (single men, youth, single women or families) determines which community agencies the shelter will partner with, and the relative weight given to each component.

For example, Birkdale Residence and Robertson House serve single women with small children and focus on educational and developmental needs, and child protection responsibilities. Neighbourhood schools are major partners of family shelters. Family Residence has expertise in immigration issues gained from years serving refugee families and also has a strong eviction prevention program. Seaton House offers a number of specialized programs designed for clients who are dealing with physical health issues, harm reduction as it relates to alcoholism, employment, transitional housing, addiction rehabilitation, addictions and behavioral issues, mental health and interim care for chronically homeless seniors. Similarly, Women's Residence focuses on mental and physical health support, addictions, chronic homelessness and seniors.

Shelter Standards identify the core areas to be addressed for each client – identification, financial assistance and housing. The Case Management Model for City-Operated Shelters allows the client and caseworker the flexibility to address underlying concerns and broader issues such as literacy, mental illness and legal problems. Our model also acknowledges the client's strengths and identifies areas of self-sufficiency and success. The caseworker and client identify and prioritize needs, eligibility for services, preferences and strengths when assessing each component of service.

definitions of the components of service

Safety

The caseworker, with the client, reviews the broad issue of safety at various stages of service, recognizing that there may be immediate and acute safety concerns that need assessment. Homeless people may be leaving environmentally unsafe conditions such as extreme weather, decrepit housing or life on the streets. They may be fleeing an abusive partner or addressing child protection issues. Shelters safeguard their client's confidentiality in order to protect their privacy and location. People with mental or physical illness may be prematurely discharged from hospital and have no one in the community to help them. People may arrive in the shelter system because they are unable to manage the demands of every day life. People with mental illness who are at risk of self harm or harming another person need to be assessed in the context of safety.

Health

The health component covers a wide range of activities like applying for a health card, accessing primary health care and allied services, assisting clients in travelling to appointments and helping them to fill prescriptions. Health care workers are often required to fill in forms to apply for income assistance, supportive housing and special diets and mobile devices. Clients needing help in filling prescriptions are matched with a pharmacist who does not charge a co-payment fee and will help them fill repeat prescriptions. The caseworker can supply an Ontario Drug Benefit card if eligible.

This component encompasses physical and mental health, addictions and positive health promotion like flu shots, nutritional education and health workshops. Toronto Public Health assists high-risk pregnant women, new mothers with infants, runs harm reduction programs and is responsible for infectious disease control. Community Care Access Centres provide at-home nursing and home care support, complete applications for mobility devices and are responsible for nursing home referrals. Community Health Centres provide

services for marginalized people and will provide primary health care to people who do not have health cards. Case management organizations such as Community Resources Consultants of Toronto (CRCT) and Community Occupational Therapy Associates (COTA) provide long-term case management to people with severe and persistent mental illness. Metro Area Addictions Referral Service (MAARS) assesses and refers people seeking treatment for addictions to appropriate programs. Some shelters have their own existing health supports or have established health care partnerships. Dental care for children and seniors can be accessed through Toronto Public Health.

Identification

Personal identification is needed to access income, housing, health care, legal aid, employment, education services and to open bank accounts or cash cheques. Accepted identification includes birth certificates, health cards, social insurance cards, proof of status in Canada (refugee claimant, landed citizenship, convention refugee, Permanent Residency card). Programs such as Partners Access and Identification (PAID) fill out applications for clients, charging minimal fees. Clients can also store identification with ID Safe to prevent loss and theft. Shelter Standards state that certified copies of the identification must be on file for every client.

Financial

The financial component addresses the client's eligibility for and access to income support programs, and/or exploring opportunities for employment income. The worker assesses budgeting skills and may refer the client to a trustee if he/she is not capable of managing their funds. Where clients have income, staff will assist them in developing a financial plan to support them in their future housing goals. Shelter residents are not eligible to receive Ontario Works (OW). A Personal Needs Allowance (PNA) provides a weekly sum to clients without an income while staying in the shelter. Family shelters that do not provide meals issue a food allowance for the purchase of food which clients prepare themselves. Clients are encouraged to develop savings plans wherever possible.

Disability related income includes Workers' Safety Insurance Board (WSIB), Canada Pension Plan – Disability (CPP-D), Ontario Disability Support Program (ODSP) and Employment Insurance Sick Benefits and Maternity Benefits. People can access OW for short-term illness or while waiting for ODSP. People with an employment history may be eligible for Long-Term Disability (LTD) or a private pension.

Age related benefits, associated with years employed, include Canada Pension Plan (CPP), Old Age Security (OAS), Guaranteed Annual Income Supplement (GAINS) and Guaranteed Income Supplement (GIS). Retired clients may also be eligible for private and foreign pensions. People over 65 are not required to pay for prescriptions.

Child-related income includes the National Canadian Child Tax Benefit (NCCTB), the Child Tax Benefit (CTB) and child support payments.

Ontario Works also provides assistance for eligible clients who have no other means of support. While in the shelter, clients may access OW for special needs items and the Learning Earning and Parenting (LEAP) program. When moving out, clients can access OW for the Shelter Fund, Shelter Integration Fund and Community Start Up Funds.

Legal

The legal component helps caseworkers assist clients in accessing Legal Aid, securing a lawyer and providing support around court appearances. Clients can be referred to local Legal Aid clinics for Landlord/Tenant disputes, OW, ODSP and WSIB appeals. The Victim/Witness Assistance Program is available in courthouses to assist victims/witnesses, including children, testify in court and acts as liaison with police and Crown Attorneys. Family Court has a roster of lawyers to assist with child support issues and separation payments. Drug Court is located at Old City Hall. Each provincial courthouse has mental health diversion workers to assist with assessments and lawyer referrals. Duty Counsels are available in each courthouse to assist defendants who are not represented by lawyers. Names of immigration lawyers or other specialized lawyers can be obtained from the Law Society of Upper Canada.

Housing

The housing component addresses clients' preferences, eligibility, income and possible need for support and accessibility when applying for housing in the community. Types of housing available include subsidized, supportive, transitional, seniors, private market and institutional. Where daily functioning is impaired, the appropriate level of support is determined with the client. The caseworker and client will discuss the client's ability to complete Activities of Daily Living (ADLs), such as planning, shopping for and preparing meals, managing money, self care and housekeeping. Portable supports, like Meals on Wheels or home care, can be added where some assistance is needed to maintain independence. Age may be an eligibility factor when applying for seniors' housing.

Education

The educational component examines the client's preferences, strengths, ability, eligibility and motivation for pursuing educational/training opportunities. Many educational programs are linked to eligibility for OW, ODSF, EI and WSIB. Single parents may have access to programs geared to their specific needs such as Opportunities for Advancement or LEAP. Clients with mental health and/or developmental delay have limited options and may require ongoing support to help access programs such as Trinity Square Café, Redirection through Education (George Brown College) or the Centre for Opportunities, Respect and Empowerment (CORE). In family shelters, the Child Advocates address the educational needs of the children. They help register the children at local schools, provide homework help through after school programs, and assist families getting daycare and special education supports.

Employment

The employment component helps the client access resources to obtain and maintain employment. This may include receiving OW funds for transportation and work attire, and accessing childcare. Practical assistance includes help in getting to work on time, arranging for saved meals or bagged lunches, and referrals to job readiness groups that are often run in shelters or by local community agencies.

definitions of stages of service

The following stages are common to all City-operated shelters and have been included in the case management model. All stages work to gather information from the client in progressively more depth ensuring that the case plan is individualized and meets the client's goals and aspirations. The movement from one stage to another by the caseworker and client is flexible and fluid and depends on the client's progress. The caseworker thus is constantly monitoring the accomplishments and barriers the client has encountered in accomplishing the goals of the caseplan, modifying the plan itself as needed.

Intake

Intake is a phone or walk-in assessment to determine a person's eligibility for shelter service. It could include investigating the current issues, like the need for housing and safety, and exploring other possible services or ways to help the client to remain in their community.

Admission

The client is welcomed and put at ease. Depending on the time and circumstances, the client is given an orientation of the shelter, the admission package is completed, rights and responsibilities are explained and shelter services are reviewed. The admission process is an opportunity to engage the client and address their immediate needs and obtain more in-depth information than what is presented at intake.

Initial Assessment

The initial interview and assessment marks the first step of the ongoing relationship between a client and their caseworker. It is an important part of the assessment process and is an opportunity to share information along with developing a rapport and trust for the working relationship of the caseworker and client. This is not limited to one meeting and is aimed at addressing immediate needs. Information about the facility and services that are available is shared with the client. The roles and responsibilities of both the client and shelter are explained at the same time that information from intake and admission are reviewed and discussed. Consent to Release Information forms are signed and the information gathered is documented in the case file. The initial interview may take from a few minutes to one hour or more, depending on the client's state of mind and the complexity of issues.

Case Plan

A case plan is developed over a series of meetings with the client to identify their strengths and needs. The caseworker assesses the components of service by looking at the client's health care needs, their informal support system, involvement with other agencies, economic and employment status, and other relevant cultural and religious influences. Where possible, the caseworker collaborates with the client and develops a case plan that meets the individual needs of that client. The caseworker is responsible for monitoring and documenting relevant information.

The case plan includes the client's expectations and choice of service providers. It includes both short- and long-term goals as defined by client and their caseworker. The plan is implemented by arranging for services or resources the client needs and linking the client to them. Services may be located in one agency or spread across numerous agencies and organizations. When referring clients to other agencies, the caseworker selects agencies that meet the particular needs of that client. The caseworker will explain her/his role in arranging for services, describe the services that will be provided, tell the client when services begin, establish timelines and complete signed consent forms. Caseworkers continue to promote those activities that foster client self-sufficiency through their case planning.

Case Plan Evaluation

The caseworker monitors the case plan to ensure the services outlined in the plan are appropriate, that the services are meeting the client's needs and goals, and are being delivered in a timely manner. The case plan is driven by the continuing process of assessment and is reviewed at regular intervals - a minimum of every two months. Each component of service is reviewed and documented to show that the case plan was evaluated and any progress is reported. If a case plan is not producing planned changes and the client is not meeting their goals, the match between the client and the services needs to be re-assessed.

Discharge

Planned Discharge

When the case plan is in place and the client has housing, they are ready for discharge to the community. The caseworker ensures that community connections outlined in the case plan are established and the client knows that the services are available both now and in the future. All details about the client's new address, and the current and future services to be accessed must be documented along with a summary of the successes and challenges experienced during their shelter stay. This is a valuable synopsis of the client if there are any future admissions to the shelter.

Unplanned Discharged

Unplanned discharges occur for different reasons like hospital admission, violence or breach of shelter rules, or the client does not return to the shelter. The various reasons for an unplanned discharge result in different case work requirements and documentation. For example, shelter transfers in the family sector require Shelter Transfer Forms and a protocol that must be followed. When a client is discharged to hospital, the documentation provided by the shelter helps the hospital provide better health care. In all cases, documenting a summary of the shelter stay is necessary.

Follow-up

The outreach worker provides follow-up case management for the client in the community and monitors the follow-up case plan. They ensure that there is continuity of care and that services are being delivered effectively or changed if the client's needs have altered. Depending on the client's needs, follow-up may be intensive or contracted for a specific period of time. The follow-up services are meant to bridge the transition from the shelter to the community or from the casework services offered by the shelter to those of community agencies.



4 the role of the caseworker

A caseworker must fulfill many roles as broker, caseworker and advocate, direct service provider and coach. The needs of your client will dictate which role(s) you will take on. This requires flexibility and the ability to research and develop different techniques and perspectives. Knowledge of community resources is key to your effectiveness, as is the need to be current about legislative changes and practices.

SKILLS

a) communication

Active listening involves

- ability to reflect back to the person what they said for confirmation
- focusing exclusively on what the person is saying, not thinking about your next question
- allowing the person to talk uninterrupted (this often allows the person to sort out his/her issues in the course of the conversation)

Client interaction includes

- open and closed questioning, info seeking and giving
- relationship development
- assessment skills
- contracting
- professional conduct
- the ability to engage the client in the interview process by putting him/her at ease

Understanding body language means

- the ability to read the non-verbal cues a person gives such as facial expressions, eye contact and body position
- being mindful of the messages conveyed by one's own body language

Empathy is

- the ability to understand and feel what the other person is feeling without losing your professional objectivity
- conveying understanding in a non-judgmental way

Effective documentation requires

- the ability to communicate effectively in writing
- writing clear case notes, log notes, letters and reports
- the ability to clearly distinguish the difference between subjective opinions and factual observations

Effective verbal communication requires

- diplomacy and tact

- the ability to express view points in a professional manner at various types of meetings (i.e., case conferences, client interviews, court appearances)
- the use of language appropriate to the client
- mediation and negotiation skills

b) organization

Time management involves

- effective multi-tasking and systematically organizing appointments and tasks
- the ability to prioritize while continuing to be flexible
- doing one important thing at a time, but several trivial things simultaneously
- making use of waiting time and doing something productive
- dividing up each project into manageable components
- reserving time during the day when others don't have access to you
- starting, not procrastinating
- doing busy work at one set time during the day
- keeping on schedule
- setting time limits for specific activities
- setting deadlines
- starting meetings on time, using and adhering to agendas and keeping track of time
- establishing daily routines with time for documenting, follow-up calls and other standard activities

Information management

- have a place for everything and everything in its place
- be decisive with every piece of paperwork handled and handle each piece of paperwork once
- prepare minutes of meetings and follow-up
- scan information, highlight pertinent parts and distribute to peers

Office management

- keep your workplace clean and organized
- standardize systems to track resources, forms, files and other relevant documents

Goal setting

- encourage clients to suggest solutions to their challenges
- share the work with the client and identify how much initiative the client should take on with the tasks they are assigned
- give them credit for their success
- list long- and short-term goals and accomplishments
- reach closure on at least one thing every day

c) guidelines for conducting interviews

Guidelines will help you establish the working relationship with your client and help you organize the steps involved in an interview. Your skill will be in varying your approach with the client, for example, going to their rooms, having informal discussions in other locations or groups and workshops while always respecting the client's need for privacy

STEPS

1. Preparing for an Interview

- review previous activities and information about the client
- organize activities
- plan for content of the discussion and the direction the meeting should go

2. Open the Interview

- explain the purpose of the interview
- create climate of trust and understanding
- establish and explain your roles and responsibilities as caseworker
- establish and explain the roles and responsibilities of your client

3. Explore Needs and Abilities

- start the holistic assessment
- identify needs
- identify strengths

4. Agree on Identified Needs

- summarize information obtained
- identify additional needs
- prioritize needs
- obtain your client's agreement of identified needs

5. Establish Goals

- help the client identify short-term goals
- help the client identify long-term goals
- obtain agreement of identified goals
- develop time frames to address and accomplish the goals

6. Examine the Options

- what can be done with the client rather than for them
- describe various options/services
- assist in decision making
- inform client of other eligibility requirements

7. Action Plan

- summarize agreed action steps
- negotiate mutual responsibilities for both the client and caseworker
- establish time frames
- seek client's agreement

8. Summarize

- review discussions
- provide an opportunity to answer questions and clarify any other items

d) documentation

Files are the record of completed work and provide information to other staff who may be required to provide follow-up with the client. A good system of documentation is important because it helps us recognize problems, organize and condense information discussed with the client into a comprehensive case plan. Up-to-date and clearly written files provide an effective tool for case planning and a source of needed information for all staff. Caseworkers are held accountable for the quality of their files. Files can be subpoenaed and audited.

General Guidelines for Documentation

The following general guidelines are non-negotiable. Everyone working as a caseworker must adhere to these guidelines throughout the various stages of service.

- All information gathered during the various stages of service must be organized by the components of service outlined in this document.
- Each component of service outlined in this document (safety, health, identification, financial, legal, housing, education and employment) must be discussed at every stage of service (Intake, Admission, Initial Assessment, Case Plan, Case Plan Evaluation, Discharge, Follow-up).
- Case plan reviews (re-assessment of the case plan) must be completed at least every two months.
- All contacts including in-person, telephone and e-mail contact with client and other parties (individual or agency) should be recorded in the case file.
- Each entry must be dated and, if the interaction is not recorded immediately, you must identify the date the interaction/contact took place.
- List all parties present at the meetings or contacted – including name, agency, association to client and respective phone numbers.
- State the purpose for the contact/interview.
- Collect as much information as possible from the client directly and use direct quotes, she said, he said.
- Whenever possible, verify information with a third party - identifying the source of information (name of agency, contact person and telephone number).
- Summarize presenting issues or key elements. Information should be specific, relevant and concise.
- Record tasks/actions requiring follow-up including who will perform the task and when it will be completed.
- If documentation is completed in writing, use only blue or black ink, never a pencil.
- All entries recorded must be signed and dated by the author.
- If documentation is completed on a computer, notes must be printed after each entry and placed in the case file.

Formats for writing case notes

There are a few methods that are widely used for organizing case notes. Each lists the presenting situation or problem, a list of needs that are to be addressed, intervention plans and notes the progress in implementing the plans.

1. The Problem-oriented Format

This style uses a problem-oriented approach that can be adapted to incorporate strengths.

Presenting Problem

This entry includes basic information such as the client's name and age and other demographic information collected during intake. State the presenting problem – why is the client in a shelter?

Prioritized Needs

This section lists the problems you and the client have agreed to work on. Go through each component of service and determine areas that require attention. Prioritize this list with the client in order of urgency.

Intervention Plans

This section lists the planned intervention for each problem.

Progress Summary

State the progress of the intervention plan to date.

This style can be adapted to include strengths in each area.

2. Subjective Objective Assessment Plans (SOAP) Format

The SOAP format is another widely used method of organizing case notes. Client strengths can also be incorporated into this format.

Subjective Information

State the problem in the client's words or state the client's perception of the problem.

Objective Information

State factual information you feel is relevant and your observations of the client.

Assessments

State how much progress you feel has been made. State the client's current situation and whether it has improved or not.

Plans

This section should be written clearly so that any subsequent reader of the file will know what the next steps are. If the assessment of the situation has changed, this must be addressed in the plan's section of client's notes.

3. Stages of Service Format

This format incorporates the stages of service as the guide to organizing notes while the caseworker works with clients from Initial Assessment to Outreach. The individual sections can be divided by stage of service categories by using easily found headings arranged chronologically in the client file.

Initial Assessment

The historical background and current status of the client or family is documented in the Initial Assessment using the components of service headings. This assessment is usually completed over one to three meetings between the caseworker, child advocate and the client. Once completed, this tells a thorough story of what occurred prior to shelter admission, and begins to outline the action needed to move towards a planned discharge.

Case Plan Summary/Review

This is an ongoing document that includes objective information about the action or service plan decided on by the client and caseworker together. It is organized by date using the components of service as headings. This is a list of items to be done by various members of the service team including the client, caseworker and any other service providers involved. The case plan is reviewed with the client every month or two, and updated to reflect outcomes, outstanding items and any new items identified.

Ongoing Notes

This is where the caseworker and other staff members document all interactions with client, such as phone calls, meetings, referrals, case conference, workshop attendance or letters written. These brief notes outline action taken, discussions that occurred or requests for service, such as savings withdrawals or issuing TTC tickets.

Discharge Summary

This outline explains the details of the planned discharge. It is a review of the successes and challenges faced during the client's stay at the shelter. This is also where the outstanding case plan work is documented. The summary is particularly important for the continuum of service work that the outreach workers provide. The Discharge Summary is also a helpful tool should clients find themselves homeless again. It gives the new caseworker an overview of the client's past stay.

Outreach Initial Interview

The outreach workers document in a similar system to the in-house caseworkers using the stages and components of service. At the Initial Interview and Assessment, the worker gathers information about the move out and any settlement issues that arise.

Outreach Case Plan Summary/Outreach Ongoing Notes/Outreach Discharge Summary

Documentation by outreach workers follows the same details as above.

4. Progress Summaries

Progress summaries are widely used where clients may have periodic shelter stays over a number of years. Case summaries are useful for organizing quantities of information gathered over time or for compressing files. A summary report does not replace case notes and may be updated every six months or yearly, depending on the client's situation. Each component of service is addressed and progress and outstanding objectives are noted. This format is useful when a client transfers to another program and the staff is not familiar with the new client.

5. Service Plans

The service plan is a list of the tasks and steps involved in putting the case plan into action. The service plan details who is responsible for accomplishing each task and is helpful when multiple workers/agencies are involved. Along with the case plan, the service plan is modified to reflect any changes in the client's progress.

e) cultural competency

Caseworkers practise cultural competency by

- being sensitive to the ethno-specific and linguistic needs of the clients
- having some knowledge of different cultures and norms
- being knowledgeable of where to go to learn about new cultures
- being knowledgeable about ethno-specific resources
- developing relationships with members of ethno-specific communities who can act as facilitators/interpreters for clients



5 case management tools

1. role of supervision

We are discussing supervision in this guide as it is used in the context of social work. The primary purpose of supervision is to ensure that the best interests of the client are met. It is a process in which the supervisor enables, guides and facilitates the caseworker in meeting both the shelter and client's objectives. Supervision has many functions, educational, supportive, administrative and task focused.

Educational

- To develop an understanding of the skills necessary for effective case work
- To receive feedback about one's work
- To identify ongoing training and self-developmental needs

Supportive

- To provide support to the caseworker so they can maintain a professional relationship and perspective
- To provide a forum to identify barriers faced by the caseworker in achieving client and organizational goals

Administrative

- To ensure compliance with policies and procedures, Shelter Standards and divisional goals and directives
- To enhance accountability

Task

- Tasks are assigned in order to improve personal and organizational effectiveness

Supervision is performed in a variety of ways, such as one-to-one, peer and group supervision. The caseworker is an active participant in all aspects of supervision and is responsible for bringing relevant issues to the supervisor's attention.

Sample issues or concerns that should be brought to the supervisor's attention:

- Comprehension and application of legislation
- Application of the Shelter Standards or shelter policies and procedures
- Barriers to establishing a working relationship with client or community partner
- Training needs
- Identification of service gaps
- Conflict of interest

2. group activities

Group Supervision

Group supervision supplements individual supervision and has the added benefit of other staff members making important contributions to one another's professional development. The focus remains on the development of the worker's assessment, planning and intervention skills while maintaining the focus on client-centred casework.

Case Planning Meetings/Team Meetings

Meetings are designed to concentrate the group discussion on a particular case or group of cases. The caseworker presents their case to the in-house co-workers who will help in thinking through the case, assessing the situation and developing strategies for intervention. Child advocates, client service workers, daycare staff and health care workers attend these meetings and contribute to the caseworker's assessment and case plan. The focus remains on the case and service delivery to the client. Clients do not attend these meetings. Generally, this is an internal team meeting to get peer support.

Case Conferences

The difference between this and case planning is staff involvement from external agencies. This is an excellent way to improve skills, evaluate one's abilities with other, more experienced workers and to receive other professionals' perspective on a particular case or situation. It also allows for the efficient delegation of tasks and improved case co-ordination. Clients usually attend these meetings.

Kardex (other sites may call this by another name.)

This is a task focused and planning activity, which allows staff to share information and involve other workers (housing, nursing, and support), in implementing the case plan. Tasks include activities such as accompanying the client to a housing appointment or arranging a client referral to an in-house doctor.

3. informal supports

Informal supports can help in case management, such as peer support or consultation with external supports.

4. ongoing training

Every employee is responsible to remain informed of changes to policy and procedures, relevant legislation and to remain abreast of current best practices in the field of case work.



6 conclusion

Services provided to homeless clients in City-operated shelters have been changing over the past few years. Along with this, there are increased expectations of accountability, performance evaluation and standardization. Clients' issues are complex and force the caseworkers to work collaboratively with both in-house and community supports and services to help the clients receive the best possible integration into their community.

The Case Management Model for City-Operated Shelters is an organizational framework for the delivery of case management services, and it sets out the stages and components of service that are applied to every case whether the client is an individual, a child or a family.

This handbook outlines the caseworker's role, skills and documentation that will help each worker deliver consistent, efficient and high quality service.

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appendix 1

WEBSITES

The following list of websites provides additional resources to assist you in your day-to-day case management.

Canada Customs and Revenue Agency

www.cra-arc.gc.ca

Information about Income Tax, GST, and National Child Tax Benefit (NCTB)

Canadian Mental Health Association

www.ontario.cmha.ca

Information regarding types of mental illness and provides links to local CMHA branches.

Centre for Addiction and Mental Health

www.camh.net

Information regarding addictions, mental health, community health, training and research.

Children's Aid Society of Toronto

www.casmt.on.ca

Information about the Child and Family Services Act, duties to report, roles and responsibilities of CAS

Citizenship and Immigration Canada

www.cic.gc.ca

Information about immigration policies and procedures, as well as links to services and online application forms.

City of Toronto

www.toronto.ca

Information about City of Toronto policies and protocols, including Conflict of Interest Policy and Shelter Standards. Also provides information regarding services and programs, including Ontario Works (OW).

Community Care Access Centres

www.health.gov.on.ca/english/public/contact/ccac/ccacfaq.html

Information from the Ministry of Health and Long-Term Care about services offered by CCAC, information regarding specific health issues, and links to other related sites.

Government of Canada

www.gc.ca

Information about the Government of Canada.

Government of Ontario

www.gov.on.ca

Information about government of Ontario programs and services, including Mental Health Act, Health Care Consent Act, Substitute Decision Makers Act, Ontario Disabilities Support Program.

Human Resources and Skills Development Canada

www.hrsdc.gc.ca

Information about federal services and programs such as Employment Insurance, Aboriginal Human Resources Development, Youth Employment Strategy and the Canada Student Loans Program.

Information and Privacy Commissioner/ONTARIO

www.ipc.on.ca

Information about the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA).

Legal Aid Ontario

www.legalaid.on.ca

Information about applying for Legal Aid, financial eligibility requirements, and legal services for low-income people, including families and newcomers to Canada.

Ontario Council of Agencies Serving Immigrants (OCASI)

www.ocasi.org

Information about supports and services for refugees and immigrant serving agencies in Canada.

Ontario Non-Profit Housing Association

www.onpha.on.ca

Listings of non-profit housing associations across Ontario and information about affordable housing in the province of Ontario.

Ontario Rental Housing Tribunal

www.orht.gov.on.ca

Information about the rights and obligations of tenants and landlords, the Tenant Protection Act and resolving landlord/tenant disputes.

Social Development Canada

www.sdc.gc.ca

Information about federal programs and services such as Canada Pension Plan, Old Age Security, Guaranteed Income Supplement, National Child Benefit and CPP Disability Benefits.

Toronto Community Care Access Centres

www.torontoccac.com

Information about CCAC located in Toronto, services that are offered, resources available and links to other related sites.

Toronto Public Health

www.toronto.ca/health

Information about health programs like Healthy Babies Healthy Children Toronto, and a wide range of health education and disease prevention initiatives to promote health across the city.

Steps	Purpose	Action
Preparing for the interview	Review previous activities and data in the case file	Review previous data already gathered
	Organize activities	Gather required information/forms/pamphlets
	Plan for content and direction of meeting	Prepare checklist to guide discussion
Open the interview	Explain the purpose of the interview	Be on time
	Create a climate of trust and understanding	Minimize distractions
	Establish caseworker's roles and responsibilities	Give your client your full attention
	Establish client's roles and responsibilities	Give information
	Give business card containing name and direct telephone number	
Explore needs and abilities	Start the holistic assessment	Clarify, elaborate and specify
	Identify needs	Respond to client by asking for specific examples
	Identify strengths	Explore past successes/coping skills
		Obtain related consent forms and explain purpose
Agree on identified needs	Summarize information obtained	Review and check for accuracy
	Identify additional needs	Check for understanding and readiness
	Prioritize needs	Facilitate transition from one step to the next
	Obtain agreement of identified needs	Clarify timelines
Establish goals	Identify short-term goals	Review identified goals with client
	Identify long-term goals	Ensure timelines are realistic
	Obtain agreement of identified goals	Prioritize goals
	Develop time frames	Clarify timelines
	Check for understanding	
Examine options	Do with rather than do for	Name program or service
	Describe various options and services	A brief description and its purpose
	Assist in decision making	How a referral takes place
	Inform client of other eligibility requirements	Obtain relevant consent forms
		Check for understanding
Action plan	Summarize agreed action steps	Ensure action plan is clear and specific
	Negotiate mutual responsibilities of client and caseworker	Check for understanding
	Establish time frames	Give client a copy
	Seek client's agreement	Place a copy in case file
		Set time for interview
Summarize	Review discussions	Check for understanding of agreed tasks
	Provide opportunity to clarify/answer questions	Where possible, give a written list of responsibilities/tasks before the next meeting
		Set the next appointment