Case Planning Guide

for Homelessness Services Providers

BRITISH COLUMBIA

BC Housing

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Overview

Introduction to the Guide **1**

The Case Planning Guide 1

Case Planning for Homelessness Service Providers in BC 1

Sections of the Guide 2

1 Understanding Case Planning **3**

What is Case Planning? 3

Why is Case Planning Important? 4

Principles of Case Planning 4

The Case Planning Process 4

The Goal Areas 5

Common Terms 7

EXERCISES *8*

2 The Case Planning Tool **9**

About the Case Planning Tool 9

Case Planning Stages and Steps 9

Client Information 11

Engagement/Referral and Screening 12

Intake and Assessment 12

Case Plan 13

Follow-up and Review 14

File Closure 14

Key Ingredients of Case Planning 15

How to Use the Case Planning Form 16

Reporting 18

EXERCISES *18*

3 Tools & Resources 19

A. Engagement/Referral Form (sample) 21

B. Consent to Release Information Form (sample) 22

C. Intake Information Form (sample) 23

D. Personal Goal Setting Form – Basic (sample) 24

E. Goal Identification Form (sample) 25

F. Personal Goal Setting Form – Enhanced (sample) 26

G. Outcome Tracking Form (sample) 27

4 Information Sheets 29

About Homelessness Services 31

Special Populations 35

Cultural Sensitivity 39

Building Effective Relationships 41

Defining Professional Boundaries 43

Effective Communications 47

Motivational Interviewing 49

Problem Solving and Decision Making 53

Documentation 55

Introduction to the Guide

THE CASE PLANNING GUIDE

This Case Planning Guide introduces the approach of case planning and outlines how it can be implemented in the context of BC's homelessness services. The Guide is based on the case planning development work outlined in the Bridging the Gap report, a document prepared by consultants from the homelessness services sector in 2009.[1] It was designed to assist emergency shelter workers and outreach workers with providing case planning services to their clients.

The content in this Guide was reviewed by staff and management from non-profit service agencies who provide emergency shelter and homeless outreach services. In November 2009, representatives of the Emergency Shelter Program, the Homeless Outreach Program and the Aboriginal Homeless Outreach Program in BC attended five regional sessions to review the draft Case Planning Guide and case planning tool. A total of 158 participants attended the regional meetings and discussed the applicability of the materials to BC's Homelessness Services and provided feedback, which was incorporated into the Guide.

CASE PLANNING FOR HOMELESSNESS SERVICE PROVIDERS IN BC

Emergency shelter and outreach service providers are most often the first point of contact for individuals in need of health, housing and support services. Emergency shelters and outreach service providers respond to the immediate needs of the homeless, addressing food, shelter and security. At the same time, emergency shelters and outreach service providers are part of the housing and services continuum. Their function is to act as a gateway to stable housing and support services along the housing continuum. To fulfill this gateway role, homelessness service providers help to facilitate access to services such as health care, addictions treatment, or employment programs. Case planning is one way that BC homelessness service providers can identify and help prioritize clients' needs and the support services and linkages that would be most beneficial for them.

Case planning work often involves many of the aspects underlying the gateway function of homelessness service providers, such as:

- Assessment and goal setting;
- Referrals to appropriate services or resources such as medical services, mental health services, alcohol and drug treatment services, employment programs and life skills training;

[1] *Elizabeth Fry Society, Lookout Emergency Aid Society and OPTIONS for Communities Society.*

- Assistance and referral for obtaining appropriate housing;
- Assistance in accessing income assistance, pension benefits, disability benefits, obtaining a BC identification card and/or a bank account;
- Advocacy and legal services support; and
- Linkages and referrals to support services.

As part of this gateway function, homelessness service providers in BC are now required to offer case planning services continually to all interested clients. It is recognized that at certain periods of time, such as in cold weather spells or when service providers are over capacity, it may not be possible to provide this service on a regular basis. It is also recognized that clients may not choose to engage in case planning.

It is also recognized that the nature of the service provided by emergency shelter providers and homeless outreach workers is different and, therefore, the way that they approach case planning will also differ. The Guide provides a framework for implementing case planning in a variety of settings and is intended to be flexible so that it may be used by both emergency shelter workers or outreach workers.

SECTIONS OF THE GUIDE

The Case Planning Guide consists of four sections. Two sections introduce case planning and present a framework for how to use case planning in the BC homelessness services context. Each of these sections is followed by some suggested exercises that may be used to discuss the challenges and to practice the skills required for effective case planning. A third Tools & Resources section provides a set of forms and resources to be used as a reference and to be adapted by service providers as needed. The fourth section is supplementary to the Guide and presents a series of skills and areas of competency that are essential to undertaking case planning.

Section 1: Understanding Case Planning provides an overview of a case planning model, the purpose and principles underlying the approach, and highlights elements of the process and key terms.

Section 2: The Case Planning Tool introduces the case planning tool for BC, and describes the stages and steps of case planning implementation and reporting.

Section 3: Tools & Resources includes samples of forms, training information and other resources.

Section 4: Information Sheets presents a series of short briefing papers on key skills and social service areas of practice that are essential to undertaking case planning work.

1 Understanding Case Planning

What is Case Planning?

Case planning is an approach to providing service that identifies needs, sets goals and determines the priority actions that are to be taken by a client and/or the social service worker. This model of service delivery is used widely throughout the social services sector. This Guide presents a model of case planning that is intended to be undertaken by homelessness service providers. It can be adapted by staff to fit into any organizational setting and to meet the individual needs of the client.

Case planning is a method of providing service that involves assessing a client's complex needs and designing an individualized package of services and actions to meet them. Case planning can therefore be described as the process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's needs through communication and available resources.

Case planning is a collaborative process between the individual and the service provider that includes:

- Assessing an individual's current situation, needs and goals.
- Exploring available options and developing a strategy to support an individual to meet these needs and to achieve desired goals.
- Identifying the benefits, alternatives, and consequences of planned services.
- Documenting the strategy in the form of an individualized personal service plan or case plan.

Case planning is known by other names including "personal development planning", "personal service planning", among others. A service plan is the package of services and support identified to meet the goals of a case plan.

Case management and case planning are terms often used interchangeably. Case management is slightly different than case planning in that it typically involves multiple social service staff, often from different professions and agencies, working collaboratively to assess a client's complex needs and then coordinating, monitoring and evaluating the delivery of services to meet those needs.

Case planning is future-oriented. It is a practice that focuses on planning, assessment and action in response to clients' goals and aspirations. Case planning goes beyond the provision of basic services such as food and shelter and stands apart from the immediate crisis intervention work that dominates homelessness services.

Why is Case Planning Important?

As a first point of contact for many clients, emergency shelter and outreach workers have an early opportunity to assist clients to make a plan for positive steps forward. Case planning helps homelessness services providers to work with the client to determine the preferred course of action for the individual and to connect them to the appropriate health and social services. The case plan or personal service plan is a tool to facilitate the client's progress toward greater independence and reintegration into the community. In many ways, its an empowering activity that enables clients to see and pursue opportunities that help them to achieve their goals. As part of the gateway function of homelessness service providers, it has also become a requirement for service providers to offer case planning to all interested clients.

Principles of Case Planning

In order to be effective and appropriate, case planning should be guided by the following set of principles:

- Client-centred — based on the individual client's situation, needs and goals;
- Strengths-based — focused on the individual client's strengths and skills;
- Uses a team-based approach to coordinate and integrate health and social services;
- Seeks to engage the client's social support network, if appropriate;
- Seeks to enhance prevention, health-promoting behaviours and the client's capacity for self-care;
- Involves respectful and collaborative relationships;
- Provides accountability to the client and to the funder;
- Is guided by ethical principles; and
- Involves advocacy and innovation.

The Case Planning Process

The process of case planning involves multiple steps or stages including:

- Building a trusting relationship with the client;
- Working collaboratively with the client to identify and prioritize their needs;
- Developing an individualized plan to address the client's goals and aspirations;

- Taking action to meet those goals;
- Monitoring the client's progress and achievements; and
- Providing encouragement and positive reinforcement.

The specific steps and stages associated with case planning are described in more detail in Section 2.

The case planning process is designed to:

- Respect the strength and dignity of clients;
- Reinforce a welcoming, safe, and secure environment;
- Use a holistic approach that proceeds from an assessment of the client's current situation;
- Encourage clients' active engagement, involving them in choosing and reviewing goals; finding solutions; making decisions; and charting successful accomplishments;
- Be individualized, responding to each person's unique circumstances and requirements;
- Ensure clients understand their right to make free choices; and
- Encourage client feedback to provide accountability and evaluation of the service provided.

In order for case planning to be effective, it relies on the following key elements:

- Building effective relationships based on respect and trust
- Being client-centered
- Working with clients' strengths
- Working collaboratively with the client
- Using available community resources and services.

The Goal Areas

To assist with the organization of factors and action areas, a set of goal areas have been identified. These are intended to provide a holistic overview of the major factors or areas that affect a homeless individual or family. They include:

- Safety and harm reduction;
- Housing;
- Health and hygiene;
- Mental health management;
- Addiction issues;
- Social, spiritual and cultural connections;
- Financial, legal and identification;
- Life skills; and
- Training and employment.

These inter-connected elements form a comprehensive view of an individual's life that can be considered during the assessment and case planning stages of service delivery. The following table provides an overview description of each.

	Goal Area	Description
1	Safety & Harm Reduction	Addressing ongoing safety issues where the client is potentially at-risk or there is the risk of possible harm to others.
2	Housing	Finding appropriate housing, addressing barriers and putting in place necessary supports to allow people to maintain their housing.
3	Health & Hygiene	How well clients look after themselves — taking care of physical health, dealing with acute and chronic health issues, dental care, medication management, keeping clean, dealing with stress, and knowing how to keep feeling well.
4	Mental Health Management	Managing symptoms, addressing medication issues and building a satisfying and meaningful life, which is not limited by the client's mental health issues.
5	Addiction Issues	This is about managing and addressing addictive behaviours, such as drug or alcohol misuse, or other addictions, such as gambling.
6	Social, Spiritual & Cultural Connections	This is about developing or reconnecting to positive relationships in the client's life.
7	Financial, Legal & Identification	Working to resolve issues related to a client's source of income, obtaining identification and addressing other legal matters.
8	Life Skills	This is about the practical side of being able to live more independently, or look after dependents — access to food resources or clothing, shopping and cooking, parenting skills, housekeeping, and managing money.
9	Training & Employment	Considering opportunities for personal capacity building through education, training, employment or volunteer work.

Common Terms

CLIENT-CENTRED APPROACH

A client-centred approach is based on what is meaningful to the individual client. Any housing and support options are determined according to the individual goals of the client. A client-centred approach to case planning requires that the shelter or outreach worker put aside what they think is best for the client and trust that the client can and will, with support and assistance, identify the behaviours they wish to change and the goals they want to pursue.

STRENGTH-BASED APPROACH

Rather than trying to resolve an individual's issues or problems, the strengths-based approach focuses on an individual's strengths including their resiliency, knowledge from past experiences, personal interests, hopes and skills, and on supporting a client to use those skills in new ways to set goals and resolve issues.

A strengths-based approach to case planning means that the shelter/outreach worker assists clients in identifying their strengths rather than to focus on their weaknesses or problems. Through the identification of strengths, clients understand what resources they can bring to resolve an issue or to change a behaviour.

TEAM-BASED APPROACH

A team-based approach implies that a group of service workers or service providers will collaborate in the support, care and treatment of clients. Shelter and outreach workers, even those who work alone, are part of a larger team. Although a client may have a primary worker, there is always a team of people who help to facilitate a clients' movement towards access to housing and support services. Having a team approach in place also allows for the quieter people to get deliberate attention. The keys to good teamwork are communication, a commitment to collaboration, and clear and consistent documentation. Information sheets on communication and documentation are contained in Section 4.

COMMUNITY OF PRACTICE

A community of practice can be described as a group of people who have something in common that they need to know how to do — a shared "practice" — and who interact regularly to learn how to do it better. A community of practice is a group of people who share a common interest or goal, and who find ways for cross-organizational collaboration. In this case, the community of practice is all the individuals and organizations who are committed to addressing the needs of those who are homeless. Emergency shelter workers and homeless outreach workers are part of a community of practice.

Exercises

The following exercises may be useful in a team setting to supplement other skill development training. The Guide contains some other suggested resources for skill development, and many agencies include mentoring programs to assist new workers with learning effective case planning skills.

1. Discuss the benefits and challenges of using a client-centred approach, particularly where a client's goals may be different than the case worker's goals.
2. Discuss the skills and techniques that are needed to build a trusting relationship and to initiate case planning with a client. Role play with a colleague so that one plays the client and the other a shelter or outreach worker. The worker who is interviewing the client discusses the idea of initiating a case plan with the client. Then switch roles.
3. Discuss the challenges a worker might face in doing case planning work, and brainstorm ways to address those challenges.

2 The Case Planning Tool

ABOUT THE CASE PLANNING TOOL

The case planning tool structures the process of case planning and suggests a framework by which staff can work with their clients. The case planning tool provides a standardized process to engage clients in developing personal goals and making an ongoing commitment to work towards achieving those goals. The case planning tool is designed to:

- Be used in a non-clinical environment by front-line emergency shelter staff and homeless outreach workers;
- Serve as a standardized guide for emergency shelter staff and homeless outreach workers;
- Be used by a single staff person or by multiple staff working with the same client; and
- Be flexible to respond to clients' specific needs and varying staff capacities.

CASE PLANNING STAGES AND STEPS

Most homelessness service providers have implemented a multi-staged process of information gathering and working with a client. The following steps are presented here to demonstrate how case planning fits into the service delivery framework from engagement and intake to file closure. However, each provider will likely implement the process and steps that are best suited to their shelter or outreach environment, staff capacity and what has worked well for them in the past. The specific approaches may vary across service providers. The steps include:

	Stages of Case Planning	Description
1	Engagement & Referral	Connecting with a homeless individual at an emergency shelter, drop-in centre or on the street. Engagement is the point at which a professional working relationship is formed between the client and the staff person. Referral can be by a government agency, hospital or institution, or by the client directly.
2	Intake & Assessment (Identification of Need)	The identification of the client's health, housing and other support service needs, and review of existing community service links.
3	Goal Setting	The identification of the client's goals and support service needs.

	Stages of Case Planning	Description
4	Actions & Interventions	Agreement between the client and the staff person on the actions to be taken by the client and the specific tasks to be pursued by the worker. These actions are to respond directly to the client's goals and aspirations.
5	Monitoring & Follow-up	Regular review of the case plan with the client to identify progress on goal areas. Follow-up continues with new or revised goals and actions identified over time.
6	File Closure	Where possible, the case plan actions and achievements are reviewed with the client.

In reality, the six stages of case planning cannot be presented in a linear fashion as clients' goals or needs may change over time. Staff need to accommodate these shifts and continually monitor and re-assess the case plan to ensure it is relevant and client-driven. The approach needs to be flexible and fluid because client motivation and commitment to the process can be anticipated to wax and wane periodically and over time. To address barriers that threaten the success of the plan, service workers will need to advocate or re-engage the client and modify the plan as needed.

It is also important to be aware of the context as every client situation is unique and every client has a different reason for engaging with an outreach worker or staying at a shelter. In all cases, responding to a client's immediate needs come first. This includes addressing issues of safety and basic needs. It is not appropriate to initiate case planning until a client has had some food and preferably some sleep and comfort. A client also needs to feel safe in their surroundings and trusting of the relationship with the worker before they are able to engage in a discussion around case planning.

CLIENT INFORMATION

From the point of intake, each stage of the process seeks to gather more in-depth information, allowing the client and shelter or outreach workers to develop an individualized plan to address the client's goals and aspirations. When this information is to be collected will depend largely on the organization's own reporting structure, the workers' style of engagement, staff capacity and other demands. The information needs are presented below:

Steps	Information Collected
Engagement & Referral	Basic information — name, DOB, where client slept last night.
Intake & Assessment	Personal information — medical issues, history of homelessness, sources of income.
Case Planning: Goal Setting, Actions & Interventions	Recording of client's priority goals within different goal areas.
	Recording of past/current service links and service worker contacts.
	Recording of client's desires for community linkages and service connections.
	Listing of actions to be taken by staff and by client.
Case Plan Review & Follow-up	Notes recorded regarding the steps taken by staff and by client.
	Notes recorded regarding the achievement of desired outcomes in the case plan.
File Closure	Notes recorded regarding the achievement of desired outcomes in the case plan.
	Notes recorded describing the reason for the file closure.

In general, the referral and intake information is to be collected within the first day of working with the client, a more in-depth assessment could occur over the first week or as a trusting relationship is built between staff and the client. A case plan can be initiated at any point in time as long as the client is willing and ready. For some clients, this may be within days of intake and for others, it may be weeks or months.

ENGAGEMENT OR REFERRAL AND SCREENING

At the point of engagement or referral, shelter or outreach workers collect basic information about the client to determine eligibility for service and to find out "where they are at" and what their immediate needs are.

INTAKE AND ASSESSMENT

The intake/admission process is an opportunity to engage clients, address their immediate needs, and obtain more in-depth information than what was presented in the screening or engagement stage. During this initial intake process, an opportunity is created to begin a dialogue with the client to identify what is going on in the client's life that has contributed to his or her becoming homeless. It is an opportunity to share information, to develop rapport and build trust, and to begin establishing a working relationship between staff and the client.

During this initial intake and assessment dialogue, staff can seek information regarding life issues such as housing, medical needs or income sources. Shelter and outreach staff request that Consent to Release Information forms are signed.

The assessment process is closely tied to the development of rapport with the client, occurring in association with the process of intake, rather than being completed solely for the purpose of information gathering. The shelter worker usually aims to minimize the potentially intrusive nature of assessment and to maximize responsiveness to the needs of the client by:

- Finding out whether there are any crisis issues that are occupying the client's emotional or physical attention — e.g., hunger, hygiene, first aid.
- Finding out if the client had any specific physical needs — e.g., assistance in climbing stairs, special dietary needs? These may need to be dealt with immediately.
- Finding out what brought the individual to the shelter or outreach team — e.g., self-referred or referred by whom/which agency.
- Finding out how they feel about how they came to be there — acknowledging their feelings, as appropriate, and discussing them.

The initial assessment may take from a few minutes to one hour or more, depending on the client's state of mind and the complexity of issues. The assessment may also take several conversations or meetings to be completed. Service providers have suggested that the intake and assessment process be completed within the first few days following intake or admission.

Most homelessness service providers have an established process for intake and assessment that they will continue to implement according to their own program guidelines and standards. For reference purposes, a sample form for intake and assessment is attached in Section 3: Tools & Resources.

CASE PLAN

Developing the case plan is the next step in working with the client. This can be initiated with a client immediately after the intake and assessment step or several days or even weeks later. When to broach the subject of developing a case plan will be up to the homelessness service provider to determine. This will depend largely on "where clients are at", in terms of their frame of mind, sense of being respected, having a trusting relationship with a staff person and their general ability to engage and open up to others.

When the time is right, staff will encourage clients to develop a case plan. In other words, staff will suggest a more complete review of the clients' life issues and priority areas of need (some of which may have been raised in the earlier steps of referral, intake or assessment) and assist the client to select actions to address them.

The case planning process may occur in a single meeting or require a number of meetings depending on the client- staff relationship and the ability of the client to engage for a period of time.

The delivery of services (i.e. access to emergency shelter) is not contingent upon clients' participation in the case planning process. Participation is up to the individual and clients should be made aware of this at an early stage of the process.

Part of the case planning process is developing a service plan. This involves identifying current resources, service contacts and other hook-ups that the client has. Staff can then work with the client to select or identify service areas that they would like to address that relate to their priority goals. Staff can review various service options, help clients make choices, and refer and support them to access appropriate community resources. This includes:

- Identifying new service links (or hook-ups) where needed, particularly where the client is unfamiliar with available resources.
- Making re-connections with service links that made a difference in the past — where the service was effective, or where the client worked well with certain individuals.
- Matching services to the client's specific situation and needs.

In writing up the case plan, the client identifies a set of prioritized issues or needs. Usually three to five issues are raised by the client at any given time. Together, the client and staff person set the goals to be achieved for each selected issue and identifies priority actions.

To assist with the organization and recording of client needs, nine categories of goals or goal areas have been identified:

- Safety and harm reduction;
- Housing;
- Health and hygiene;
- Mental health management;
- Addiction issues;
- Social, spiritual and cultural connections;
- Financial, legal and identification;
- Life skills; and
- Training and employment.

A table describing these goal areas was outlined in Section 1: Understanding Case Planning.

FOLLOW-UP AND REVIEW

To the extent that staff capacity allows, homelessness service providers will monitor clients' progress and achievements and provide encouragement and reinforcement on an ongoing basis. Staff will advocate or engage the client in modifying case plans as needed to address barriers or to respond to shifts in a client's priorities.

Through ongoing monitoring, staff, together with the client, are able to evaluate the plan's effectiveness, modify it when needed, and provide any necessary assistance. Homelessness workers usually use this stage in the process to:

- Record client progress toward completing actions and achieving goals;
- Ensure services outlined in the plan are appropriate and continue to meet the client's needs and goals;
- Assist clients to maintain their commitment; and
- Ensure that the plan is adjusted as necessary.

FILE CLOSURE

There are different times when a case plan file is closed such as when a client exits the community or passes away. It may also be appropriate to close a client's file if they move into a housing or care environment where other service workers will be able to carry on working with the client to manage their goals and support service linkages. At such a time, a record of the clients' achievements and outcomes is made in the case plan and the client's case plan file is subsequently closed.

KEY INGREDIENTS OF CASE PLANNING

A number of key skills and core competencies are critical for the successful development and implementation of a case plan. Building trust, identifying a client's strengths and using motivational interviewing are but some of the techniques that will facilitate this process. Many of these skills and other core competencies have been presented in Information Sheets available in Section 4 of this Guide. Other ingredients that facilitate case planning work are:

- The process of identifying goals and desirable outcomes for change will usually follow a thorough intake assessment or other discussion that explores a client's homelessness and life issues.
- Identifying the key issues and barriers that prevent the client from achieving his or her goals may assist both staff and the client in finding creative solutions to addressing these barriers. Barriers may include such things as addictions, lack of identification, family problems, lack of employment skills, or behaviours associated with mental illness.
- For other actions, clients are asked to identify what improvements would look like for each of the goal areas they have identified. It could be useful to ask them to identify how they would know when they have achieved their goal.
- It is important that clients have a realistic, achievable plan. They may need to be assisted to develop shorter-term, sequential goals to highlight the steps necessary to reach longer-term goals.
- Some clients may have developmental disabilities, brain injuries or afflictions that prevent them from making decisions that protect their safety and wellbeing. In these situations, it is up to the worker to use their best judgment to maintain a client-centred approach to case planning, while ensuring that their client's safety and wellbeing is protected.

How to Use the Case Planning Form

The following section provides an overview of the case planning form and how it can be used. The form is titled "Personal Goal Setting". A complete version of this case planning form is provided in Section 3: Tools & Resources. The form can be used in hard copy format or electronically.

The form may be used in a variety of ways. It may be completed partially or in its entirety, depending on the level of client engagement and trust. The form includes nine goal area boxes for the staff person to note what areas the case plan is focusing on. The example form below includes notations to explain how the tool can be used.

PERSONAL GOAL SETTING *[For illustration]*

Client Name *Enter client's name*	**Staff Person** *Enter worker's name*

PLEASE CHECK GOAL AREAS THAT CLIENT & STAFF AGREE TO WORK ON

☐ SAFETY & HARM REDUCTION	☐ HOUSING	☐ HEALTH & HYGIENE
☐ MENTAL HEALTH	☐ ADDICTIONS ISSUES	☐ SOCIAL, SPIRITUAL & CULTURAL
☐ FINANCIAL, LEGAL & ID	☐ LIFE SKILLS	☐ TRAINING & EMPLOYMENT
GOALS: WHAT DO YOU WANT TO DO DIFFERENTLY IN YOUR LIFE?		
Describe client's goals and list in this box. Goals will correspond with goal areas checked above.		

GOAL SETTING MAP

SERVICES: WHAT SERVICES DO YOU USE RIGHT NOW?	**SERVICES: WHAT SERVICES WILL HELP YOU MEET YOUR GOALS?**
Note client's current or past links with service agencies. Ask client if he/she would still use this service and try to identify services that are the best match to client's needs today.	*Client's desires for new or improved links with service agencies can be listed here.*
ACTIONS: WHAT ACTIONS WILL YOU TAKE?	**ACTIONS: WHAT ACTIONS WILL BE TAKEN BY STAFF?**
Describe actions that the client intends to take here.	*Describe actions that client has asked staff to take on his/her behalf.*

SIGN OFF

Client Initials *Ask for client sign off/initial here*	**Staff Initials** *Staff to sign off/initial here*
Date	**Date**

In addition to identifying the client's goals, case planning involves continued monitoring and review. The following Outcome Tracking form can be printed on the back side of the Personal Goal Setting form to facilitate ease of use. It creates a framework by which the client and the staff person can have regular conversations about the client's progress and challenges with each of the goals. The following illustrative version includes notations on how to use it. A complete version is included in Section 3: Tools & Resources.

OUTCOME TRACKING *[For illustration]*

This form can be printed on the back side of the Personal Goal Setting Form for ease of use.

GOALS	OUTCOME PROGRESS				
	1 Preliminary action	2 Some progress	3 Solid progress	4 Outcome achieved	5 Goal/action changed
1 *In each of these goal boxes, briefly re-write what the clients goals are.*	*Put a check mark in the outcome boxes that best describe the client's progress with each goal. Add notes along the way to describe the type of progress.* *Ask client to initial the progress box to confirm that the process is client-centred, the client is engaged at each step and there is agreement as to the level of progress achieved.* *Staff should indicate date of review in outcome box.*				
2	*Preliminary action, or initial steps are taken.*	*Some additional progress is made, but lots of work still to be done.*	*There is serious headway being made on this goal. Only a little bit more work is needed.*	*The client has reached his/her goal.*	*The goal has changed due to client circumstances and new actions are planned.*
3 [example] Reconnect with family members			✓ 01/09/10 SM		

Level at Follow-up: ✔
Date: Staff to indicate date of review of progress.
Sign-off: Client to initial in outcome boxes to confirm there is agreement on level of progress.

Reporting

The case planning tool is designed to allow for tracking of the information needed to complete the case plan. It records significant steps taken by clients and others involved in assisting them, records progress towards the plan, and reports on the information collected.

The reporting requirements of BC Housing will be limited to tracking the actions taken within the framework of case planning. That is, the primary interventions undertaken by staff and actions taken by a client are to be reported in the BC Housing database. Drop-down boxes will allow staff to note the goal area (e.g. housing, physical health) and the type of action (e.g. appointment, follow-up).

Reporting on case planning will be limited to the following performance indicators:

- Number and percentage of clients who have initiated a case plan.
- Number of actions taken by the client as part of case planning work.
- Number of interventions taken by a staff person on behalf of a client as part of case planning work.
- Number of completed actions or desired outcomes achieved.
- Number of case plans closed and reasons why.

Client-specific information attributed to case planning work is to be used internally by service providers for the purposes of case planning and case management. It is not to be shared externally with other service providers or with BC Housing without the consent of the client. For reference, a sample Consent to Release of Information form is included in Section 3: Tools & Resources.

Exercises

1. **Think about how the case planning tool might facilitate client engagement, and discuss examples or client scenarios where the case planning tool would have helped you with your work.**
2. **Discuss how you would engage the client and use the case planning tool to initiate an appropriate action plan.**
3. **Please discuss what some of the barriers might be to using this tool, and how you would overcome these challenges.**

3 Tools & Resources

It is recognized that case planning is an activity that is undertaken throughout the homelessness services sector and that there are a variety of ways to implement this work. The following section presents a set of forms that have been designed to further facilitate the work that the sector has been doing in the area of case planning, allow for documentation and reporting and ensure that a minimum level of service (case planning work) is being undertaken by all emergency shelter and outreach providers throughout BC.

This section presents a series of sample forms that are relevant to case planning and homelessness services work in general. They include:

A. Engagement/Referral Form

B. Consent to Release of Information

C. Intake Information

D. Personal Goal Setting (Basic)

E. Goal Identification

F. Personal Goal Setting (Enhanced)

G. Outcome Tracking

These forms have been adapted from earlier versions that were prepared for the regional consultation sessions held with emergency shelter and outreach sector representatives. These versions have incorporated the sector's feedback that the case planning tool and associated forms needed to be comprehensive, yet flexible and simple to use. They were designed to be used in multiple environments, by both outreach and shelter workers.

The seven forms cover the different stages of homelessness services work from engagement to outcome tracking. It is recognized, however, that many service providers will have existing forms, policies and procedures for engagement (Form A), consent (Form B) and intake (Form C). As such, Sample Forms A, B and C are presented here for reference purposes. If a service provider does not have such forms that they use regularly, Forms A to C can be used "as is" or adapted to better suit the particular shelter or outreach context as needed. Otherwise, there is no expectation that service providers will replace the forms and structure that they currently have in place for these stages.

Case planning work essentially begins at the goal setting stage. For this stage, two sets of forms have been made available. The first set, Forms D and E, is intended to be used on the street or in less formal settings. This set is intended to facilitate an open discussion with a client about his/her goals and actions. Form D is a basic version of the Personal Goal Setting form and it can be accompanied by Form E, which is used for goal identification. It is expected that the staff person

may need to later transcribe the content from these basic forms into BC Housing's database with details regarding the client's goal areas where possible.

The second set, Forms F and G, addresses the client's goal setting and outcome tracking stages. This set presents a framework that facilitates discussion with the client and is the main component of the case planning tool. Form F presents a more detailed version of the basic personal goal setting form, Form D, and should be accompanied by Form G for ongoing outcome tracking. It is envisioned that these forms can be used in a variety of settings by both outreach and shelter staff. In all cases, the BC Housing database will be updated to allow for electronic reporting of the case planning stages in a simple and convenient manner.

Sample Form A

BC Homelessness Services

ENGAGEMENT/REFERRAL

Date	**Staff Person**
Referred by	**Reason for Referral**

PERSONAL INFORMATION

Last Name	**First Name**	**Street Name** (Alias)
Agency Client ID	**Date of Birth** (dd-mm-yyyy) __/___/_____	**Age Estimate** (if DOB unknown)
Gender __M __F __T	**SIN**	**Has Identification** __Y __N
Family Status __Single __Couple __Family (i.e has children)	**Family Size** (e.g. 3) __	**Accompanying Children** __Y __N
Identifies as Aboriginal __Y __N	**Refugee/Recent Immigrant** __Y __N	**Preferred Language:**
Source of Income __None __Employment __Employment Insurance __Income Assistance(IA) __Income Assistance - PPMB __Income Assistance - PWD __Canada Pension Plan (CPP) __Old Age Security (OAS) __INAC Band Other: _____		

INITIAL QUESTIONS

Do you have a place now? If yes, why can't you stay there? __Y __N
Do you have any physical health problems we should be aware of? __Y __N
Do you take any medications, including methadone? __Y __N
Do you have any medication on you? __Y __N __; Meds turned in? __Y __N
Are you currently working with any other community agencies on your mental health, physical health, substance use or housing? __Y __N
Would you like us to contact them to get any information about your situation? __Y __N

CONSENT TO RELEASE

Signed consent to release __Y __N

BC Housing

Sample Form B

CONSENT FORM
▪ We would like to record some personal information about you. The information gathered will remain confidential and is collected and protected under the privacy laws.
▪ If you are accompanied by your children who are under the age of 19, we will also need to collect personal information about them. This is to ensure that information about families using services is recorded accurately.
▪ BC Housing funds our program. Statistical reporting from the information collected will be shared with BC Housing under s.26 of the Freedom of Information and Protection of Privacy Act. BC Housing needs the statistical reports to improve services and funding to help as many people as it can. Any reports generated from the statistical data will not include information that identifies you personally.
▪ If you choose not to sign this document, services will still be provided to you.
▪ We will protect your personal information and will only use the information to help you as allowed by law.
▪ If you want to withdraw your consent at a later date you can, but we cannot destroy the information we have collected so far. From the date your consent is withdrawn, no more of your personal information will be shared with BC Housing.
▪ If you want to talk to somebody about the use or withdrawal of your personal information, you can call the Director, Business Support Services at BC Housing at 604 433-1711 or write to #1701 – 4555 Kingsway, Burnaby BC V5H 4V8.
Client Name (print) | **Date**
Client Signature
Name of Service Provider / Program

Sample Form C

BC Homelessness Services

INTAKE INFORMATION

EMERGENCY CONTACT INFORMATION

Name	Phone #	Relationship

HEALTH & SAFETY

Are you facing any immediate safety risks?
Are there any emergency health needs or factors that put you at risk, e.g. epilepsy, diabetes, other?
Current medical/physical health issues?
Are there any dietary/nutrition needs?
Are there any daily activities that you need help with?
Are there any immediate things that you need to take care of (belongings, appointments)?

HOMELESSNESS

What led you to needing services today?
How long have you been homeless?
How long have you lived in this community? __<1 Year __1-3 Years __ 3+ Years

ACCOMPANYING CHILDREN *Additional Information Attached __*

__Y __N If yes, number of children _____		
Child's Name	**Gender** __M __F	**Date of Birth/Age**
Child's Name	**Gender** __M __F	**Date of Birth/Age**
Child's Name	**Gender** __M __F	**Date of Birth/Age**
Social Worker(s) __Y __N Name(s):		
Is there anything that you think we need to know about in relation to your children (e.g. custody issues, allergies)?		

Sample Form D

BC Homelessness Services

PERSONAL GOAL SETTING — BASIC

Client Name	Staff Person

GOALS: WHAT DO YOU WANT TO DO DIFFERENTLY IN YOUR LIFE?

ACTIONS: WHAT ACTIONS DO WE NEED TO TAKE TO GET THERE?
1
2
3

SIGN OFF

Client Initials	Staff Initials
Date	Date

Sample Form E

BC Homelessness Services

GOAL IDENTIFICATION

Client Name	Staff Person

HEALTH AND WELL BEING *(physical health, mental health, addiction issues, safety)*	HOUSING
FINANCIAL AND LEGAL *(financial, legal, ID, life skills, training)*	**SOCIAL, SPIRITUAL & CULTURAL CONNECTIONS**

SIGN OFF

Client Initials	Staff Initials
Date	Date

Sample Form F

BC Homelessness Services

PERSONAL GOAL SETTING — ENHANCED

Client Name	Staff Person

PLEASE CHECK GOAL AREAS THAT CLIENT & STAFF AGREE TO WORK ON

☐ SAFETY & HARM REDUCTION	☐ HOUSING	☐ HEALTH & HYGIENE
☐ MENTAL HEALTH	☐ ADDICTION	☐ SOCIAL & CULTURAL CONNECTIONS
☐ FINANCIAL, LEGAL & ID	☐ LIFE SKILLS	☐ TRAINING & EMPLOYMENT

GOALS: WHAT DO YOU WANT TO DO DIFFERENTLY IN YOUR LIFE?

GOAL SETTING MAP

SERVICES: WHAT SERVICES DO YOU USE RIGHT NOW?	SERVICES: WHAT SERVICES WILL HELP YOU MEET YOUR GOALS?
ACTIONS: **WHAT ACTIONS WILL YOU TAKE?**	**ACTIONS:** **WHAT ACTIONS WILL BE TAKEN BY STAFF?**
1	**1**
2	**2**
3	**3**

SIGN OFF

Client Initials	Staff Initials
Date	Date

Sample Form G

BC Homelessness Services

OUTCOME TRACKING

GOALS		OUTCOME PROGRESS				
		1 Preliminary action	2 Some progress	3 Solid progress	4 Outcome achieved	5 Goal/action changed
1						
2						
3						
4						
5						

Level at Follow-up: ✔
Date: Staff to indicate date of review of progress.
Sign-off: Client to initialize in outcome boxes to confirm there is agreement on level of progress.

4 Information Sheets

About Homelessness Services

Homelessness services are intended to assist individuals and families who find themselves homeless for a variety of reasons, and may include the absolute homeless, those who are homeless due to crisis, those who are at risk of homelessness and the hidden homeless.

Homelessness services in British Columbia are provided through three major programs administered by BC Housing: The Emergency Shelter Program, Homeless Outreach Program and Aboriginal Homeless Outreach Program.

EMERGENCY SHELTER PROGRAM

The Emergency Shelter Program (ESP) comprises emergency shelter accommodation, seasonal shelter services, drop-in services, as well as a range of specialized programs. There are approximately 60 government funded homeless shelters and drop-in centres throughout British Columbia, which are managed by community-based agencies. Many of these facilities serve individuals who have health, addiction and other barriers that may have contributed to their homeless state and make it difficult to secure stable housing. Some facilities provide temporary accommodations for families.

In 2008, a new program framework was developed to better integrate the Emergency Shelter Program into the housing continuum, making it easier for people facing homelessness to move from emergency shelters into housing with supports. The framework articulates the key objectives of the Emergency Shelter Program, which are to:

- Provide safe, accessible, emergency shelter accommodation services for homeless clients where demand exists throughout the province.
- Facilitate the movement of homeless individuals and families through the continuum of housing and support services.
- Ensure high quality client services are provided and that services are accountable, effective, and responsive to client needs.
- Support communication, partnerships and innovative initiatives.

The Framework also outlines the outcomes and standards that funded shelters are required to achieve.

HOMELESS OUTREACH PROGRAM

The Homeless Outreach Program, established in 2006, connects homeless people to housing, income assistance, and community-based social and health services in over 49 communities across British Columbia. By its nature, the program is client-centred. Homeless outreach workers work in consultation with community-based agencies and engage individuals who are homeless or at risk of homelessness, linking them to the appropriate services and housing. Outreach workers undertake a wide range of support activities, including:

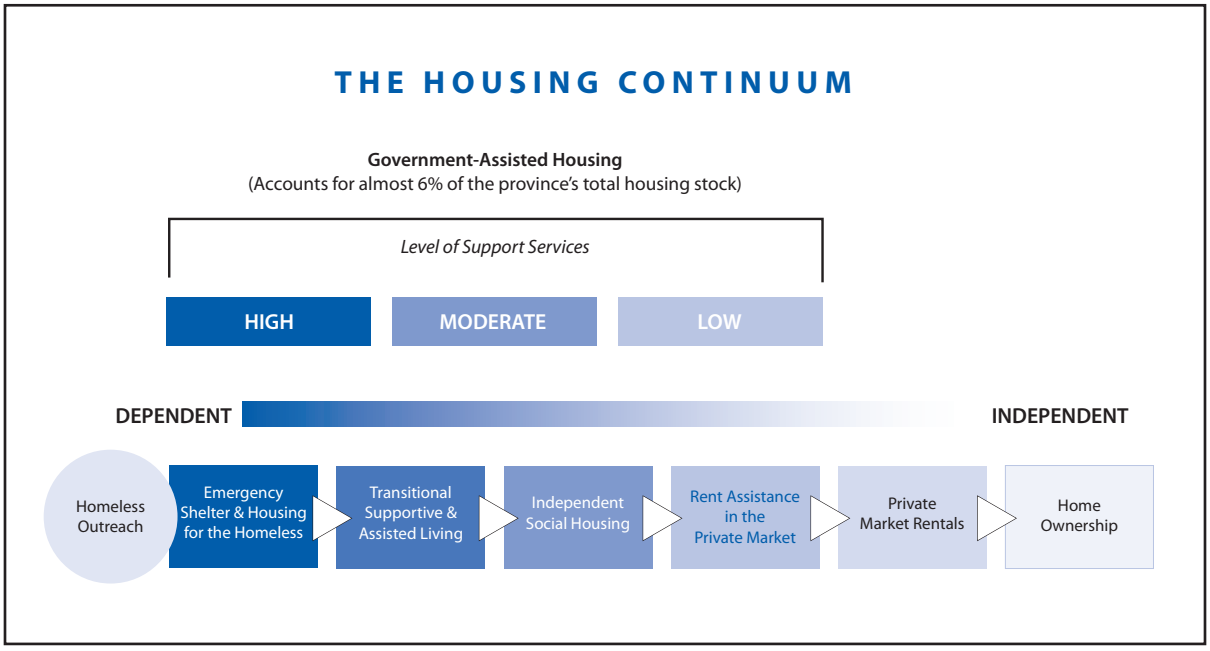
- Addressing immediate physical and safety needs, such as food, warm clothing and a place to stay;
- Connecting people with housing and income support, including making and accompanying them to appointments;
- Provideoing links to other support services, such as life skills training, personal health, household and financial management; and
- Acting as a landlord liaison.

ABORIGINAL HOMELESS OUTREACH PROGRAM

Across the province, a disproportionate number of homeless individuals are Aboriginal. However, Aboriginal homeless individuals have unique cultural and social needs and abilities — an understanding that is the foundation for the Aboriginal Homeless Outreach Program. The program aims to reduce the number of Aboriginals who are homeless by providing direct access to housing with linkages to support services to address the individual's housing, health, and cultural needs. The program provides outreach services for chronically homeless, urban and rural Aboriginals who are living off-reserve. In particular, the program focuses on individuals who have been homeless for longer periods of time, or the street entrenched.

THE ROLE OF HOMELESSNESS SERVICES IN THE HOUSING CONTINUUM

As shown in the diagram below, homeless outreach and emergency shelters act as an important step in helping individuals to move towards greater independence along the housing continuum. The diagram also illustrates the relationship among housing services and support services along the continuum.



Emergency shelter and outreach providers can function as a bridge between the "street" and the opportunity to find long-term or more stable housing options and connections to appropriate support services. It is not assumed, however, that all homeless people will use every step in the continuum. In some cases, individuals may move backwards and forth along the continuum in a non-linear way. A person's progression through the continuum should be tailored to his or her unique situation.

Special Populations

The experience of homelessness results in a loss of community, routines, possessions, privacy, and security. Individuals respond differently to these factors. However, special populations have specific needs and circumstances that homelessness service providers should be familiar with in advance of initiating case planning work. These groups include Aboriginal people, women, children and gay/lesbian/transsexual/transgendered people.

ABORIGINAL PEOPLES

Aboriginals make up almost one third of the homeless population and this proportion continues to grow.[2] However, many Aboriginal homeless individuals do not find shelters suitable, either because they are not culturally appropriate or they are unacceptable for some other reason. Research has shown that certain shelter practices may be considered harmful, and serve to deter Aboriginal homeless individuals from seeking shelter. These include:

- *Religiosity*: Overt proselytizing or requiring religious observant behaviours as a condition of assistance;
- *Institutional structures*: The similarity of shelter routines and expectations to residential schools, including architectural design and disciplinary practices to regulate behaviour;
- *Assimilation practices*: Treating all people the same; failing to recognize or allow for differences, including cultural practices and observances; Eurocentric emphasis of available books, pictures on the walls, or other decoration; and
- *Paternalism*: Rules and staff expectations that infantilize clients, such as regulating television shows watched; management of money; curfews; and types of food eaten.[3]

To provide effective case planning, homelessness providers need to be sensitive to the unique cultural and social needs of Aboriginals and to create linkages to appropriate support services.

WOMEN

The 2008 Metro Vancouver Homeless Study found that roughly one quarter of the homeless population is made up of women. The study found that:

- Almost half of the women enumerated identified themselves as being Aboriginal;
- Almost three quarters were between 25 and 54 years of age;
- Roughly one fifth were youth, 24 years and younger;

[2] *Social Planning and Research Council of BC et al., Still on our Streets: Results of the 2008 Metro Vancouver Homeless Count, December 2008. Available at http://www.metrovancouver.org/planning/homelessness/ResourcesPage/HomelessCountReport2008Feb12.pdf.*

[3] *Andrew Webster, Sheltering Urban Aboriginal Homeless People: Assessment of Situation and Needs (Winnipeg: National Association of Friendship Centres, 2007).*

- More than half of the women reported having addictions or medical conditions;
- About one third reported a mental illness or physical disability; and
- Women were five times more likely than men to be involved in illegal activities, primarily prostitution, as a source of income.

Women tend to be part of the hidden homeless population, often doubling up with families, friends, or staying in inappropriate relationships rather than being on the street or accessing services for the homeless. For some women, homelessness is an escape from oppressive home or family environments, including violence and substance abuse.[4]

Women remain homeless on the street due to addictions, mental health issues, loyalty to other homeless individuals, and for other reasons. Homeless women are also challenged by their socioeconomic status, typically having less education, fewer marketable skills and lower employability than men, which may relate to increased reliance upon income assistance and higher reported rates of involvement in criminalized activities.

To be effective, case planning needs to be sensitive to women's particular needs, such as the need for freedom from oppressive conditions and complex health issues. Women's lower body weight places them at increased risk associated with drug use (with higher drug concentration in their bodies); increased rates of transmittable disease due to their involvement in prostitution and drug use; and increased rates of victimization.

CHILDREN

Homeless children have significant challenges in a shelter setting. Along with the challenges the family faces living in shelters or in unstable housing with others (hidden homelessness), children are confronted with interpersonal difficulties, mental and physical problems, including illness, and other personal difficulties.

Homelessness makes families more vulnerable to other forms of trauma such as physical and sexual assault, witnessing violence, or abrupt separation. The stress related to these risks, besides the stress resulting from homelessness, deeply affects children. Besides stress from hunger at a rate of twice that of other children, homeless children:

- Are sick at twice the rate of other children. They suffer twice as many ear infections, have four times the rate of asthma, and have five times more diarrhea and stomach problems.
- By the time they are preschoolers, they have significant rates (20%) of emotional problems that are serious enough to require professional care.
- Have twice the rate of learning disabilities and three times the rate of emotional and behavioural problems than other children.
- Are twice as likely to report failing a grade in school.

[4] *Shyanne Reid, Helen Berman, and Cheryl Forchuk, "Living on the Streets in Canada: A Feminist Narrative Study of Girls and Young Women", Issues in Comprehensive Pediatric Nursing 28:4 (2005), 237-256.*

[5] *Susan Talamantes Eggman, "Homeless Women and Children," in Social Work Practice with Children and Families: A Family Health Approach, ed. Francis Yuen (New York: Routledge, 2005), 207.*

- Who are of school age, experience anxiety, depression, or withdrawal at a rate of 50% compared to 18% for other children.
- By the time they are eight years old, one in three has a major mental disorder.[5]

Homeless children and parents struggle with significant issues, and these problems compound and affect children's ability to manage trauma or other risk factors. Homelessness providers are likely to be faced with one identified client — the mother — and the imminent and emerging needs of children. Case planning for families may need, therefore, to address parental support and capacity building.

Where children are present, homelessness service providers must provide for their best interests through:

- Respecting and actively supporting the emotional attachments children have with their parent(s) and families, consistent with the children's best interests; and
- Ensuring that steps are taken to provide as much continuity as possible in the children's care and relationships.

Continuity in a child's life encompasses a number of areas including relationships, community living, spirituality, daily care, supervision, guidance, education, and health care. It is intrinsically linked to the child's individual, racial, and cultural identity, as well as his or her emotional and behavioural development and overall well-being. Matters of accommodation within a shelter such as placement of the parent and child in the same room, placement in a room that is removed from the 24/7 aspects of the shelter, or familiar food can support the child's adjustment to the shelter. The goal is to provide each child with a safe and secure "homelike" environment and support the parent-child attachment.

GAY/LESBIAN/TRANSGENDER/TRANSSEXUAL

Gay, lesbian, transgender and transsexual people often face challenges in accessing homelessness services where they feel comfortable and safe. Expressed concerns include feeling unwelcome or experiencing verbal, physical or sexual harassment. Transgender women required to stay in men's facilities report that they are sexually propositioned, verbally harassed, and sometimes assaulted. It has been reported that some service providers ask intrusive questions during intake.[6]

Effective case planning for individuals within this population must include:

- Provision of a safe, welcoming environment, including appropriate facilities, that is open and accessible to gay/lesbian/transgender/transsexual individuals.
- Avoiding intrusive questioning about the client's sexual orientation, hormone replacement therapy or sexual reassignment.

[6] *Christina Strange and Deanna Forrester, Creating a space where we are all welcome: improving access to the Toronto hostel system for transsexual and transgender people, 2004, http://www.the519.org/programs/trans/resources/HSH- Creating_ Space_Where_we_Are_All_Welcome_.pdf.*

- Messaging/dialogue with individuals to make them feel welcome, safe, their rights will be protected, and that staff are approachable and open to conversation, including on gender issues. The decision to disclose sexual orientation or trans status rests with the client.
- Ensuring confidentiality of client information or disclosure of information according to a client's wishes.
- Recognize clients by their preferred pronoun of he or she.

Homelessness service providers should recognize and address the challenges and concerns of this population. Shelters that allow people to be housed in a facility based on the gender with which they self-identify need to have clear policies, guidelines and training protocols in place to create a comfortable and safe environment. Protocols should address safety, confidentiality, harassment and discrimination, sleeping accommodations, and ensuring privacy in dressing areas and bathrooms. Staff, particularly front-line workers, should be provided with all appropriate training.

Within this framework, case planning should be approached as it would for any other individual client. Clients should be encouraged to identify their needs to develop an appropriate action plan. All clients will do their best in a safe and supportive environment.

Cultural Sensitivity

Culture has historically been associated with race or ethnicity but, in actuality, can be defined more broadly as the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group.[7] It also refers to how people with disabilities, people from various religious backgrounds, or people who are gay, lesbian, transgender or transsexual experience the world.

CULTURAL COMPETENCE

Canada's population is ethnically and culturally diverse and ever-changing. Individuals accessing homeless services have diverse ethnic and cultural backgrounds. Being sensitive to this diversity is essential to delivering culturally competent services.

For homelessness service providers, cultural competence is the way in which service providers and the program structure respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors. Cultural competence recognizes and values individuals, families, and communities and protects their dignity. Cultural competence is also a lifelong process for providers who will continually come across diverse clients and new situations in their practice.

In shelters, cultural competence involves integrating and transforming cultural knowledge of individuals and groups into specific standards, policies and practices to increase the quality of services to clients including approaches to case planning. Essential elements for cultural competence in the shelter setting include:

- Valuing diversity;
- Having the capacity for cultural self-assessment;
- Being conscious of the dynamics of cultural and cross-cultural interaction;
- Institutionalizing cultural knowledge into practice; and
- Developing programs and services respecting diversity between and within cultures.

These elements must be manifested in every level of service to homeless clients and should be reflected in attitudes, structures, policies, and services.

APPROACHES TO CULTURAL COMPETENCE

For homelessness service providers, the following approaches are suggested:

- Consider each client as an individual first, as a member of a minority next, and then as a member of a specific ethnic group. Never assume that a person's ethnic identity defines their cultural values or patterns of behaviour.

[7] *National Association of Social Workers, "Cultural Competence in the Social Work Profession," in Social Work Speaks: NASW Policy Statements (Washington, DC: NASW Press, 2000), 59–62.*

- Treat all "facts" about cultural values and traits, whether heard or read, as hypotheses to be tested with each client. Turn facts into questions.
- Remember that all minority group people within the Canadian context are bicultural and may have had to resolve cross-cultural conflicts.
- Understand that a client's background, values, and lifestyle are relevant to working with the client. Do not prejudge what areas are relevant.
- Identify strengths in a client's cultural orientation that can be built upon. Assist the client in identifying areas that create social or psychological conflict related to cross-culturalism and seek to reduce the conflict that the client is experiencing.
- Engage a client in identifying what cultural content should be considered in programs and services.
- Remember the importance of good interview skills, empathy, caring and a sense of humour.

CULTURAL SAFETY

The term "cultural safety" originated in the 1980s in New Zealand in reference to Maori people who reported that nursing services provided to them were not culturally appropriate and failed to recognize their cultural identity. In the homelessness services environment, cultural safety relates to an environment that is safe for individuals and where there is no assault, challenge, or denial of the identity that clients define for themselves. The foundational principle of cultural safety is that clients have the right to self-determination, identity, and practices that empower them.

Providers should consider how this may affect their shelters. For example, asking clients to self-identify with one cultural identity may be alienating for bicultural or multicultural clients because such a choice requires they deny part of their identity. Other culturally insensitive practices and restrictions may include not allowing lighted materials (candles and smudging) or the possession or touching of Medicine Bundles, religious and spiritual articles, or other sacred objects.

CONSIDERATIONS FOR CULTURAL SAFETY

Considerations for cultural safety require shelters to be flexible in their procedures and structure. Consistency and equal treatment are two principles that shelter providers often value for the efficient operation of programs. Providing flexibility that affords clients the cultural safety of their identity challenges this efficient operation because it involves departing from standard procedures to accommodate certain clients and managing the implications of these changes. Liaison with Aboriginal providers and cultural support networks are valuable resources for homelessness service providers to develop cultural competence and cultural safety for clients.

Building Effective Relationships

At the core of human service work, is the ability to develop effective, respectful relationships with clients. These are formed where the behaviours of a worker provide clients with information about the motivation and integrity of workers. Clients must be able to trust in the consistency and integrity of the relationship.

Forming respectful relationships also require homelessness service providers to be aware and sensitive to the particular needs of special populations, including Aboriginals, women, children, and gay/lesbian/transgender/transsexual individuals.[8]

MODELING RESPECTFUL RELATIONSHIPS

Positive and respectful interpersonal relationships are vital for optimal human growth and the psycho-social development that occurs for individuals in their lifetime. Interpersonal and group effectiveness skills are needed to maintain positive friendships, stable families, successful careers, and strong communities. Furthermore, supportive interpersonal relationships satisfy personal needs, build trust and confidence, and encourage cooperation with others. Being able to model such relationships through interactions with clients is essential to case planning.

STRATEGIES TO MODEL RESPECTFUL RELATIONSHIPS

Respectful relationships with clients can be modeled or demonstrated by:

- Assuming a caring, non-threatening stance;
- Having patience for gradual change and not becoming discouraged by slow progress;
- Using effective communication;
- Recognizing clients' cultural, racial, and gender identity;
- Providing clients with consistent expectations;
- Informing clients of what they can expect from the homelessness provider including professional motivation, the client-service provider relationship, confidentiality and disclosure of information;
- Recognizing that all clients have had unique life experiences which shape their perspectives;
- Providing service with the least amount of intrusion possible; and
- Positively acknowledging client compliance with expectations, achievement of goals, and use of new behaviours that support positive interpersonal relationships and communal living.

[8] *For more information, please refer to the case planning information sheets entitled, "Special Populations" and "Cultural Sensitivity".*

AN EMPATHETIC STYLE

Empathy is important precursor to developing an effective relationship with a client. Empathy involves listening in a supportive, reflective manner and demonstrating that the listener understands the speaker's concerns and feelings. This skill allows a service provider to understand and demonstrate understanding of the meaning of a client's words by reflecting back what the listener has heard. It requires sharp attention to each new client statement and the continual generation of hypotheses as to the underlying meaning. The key to expressing empathy is reflective listening. An empathetic style communicates respect for, and acceptance of, clients and their feelings. It encourages a non-judgmental, collaborative relationship.

Defining Professional Boundaries

Defining the professional staff-client relationship and the boundaries of this relationship are critical to effective case planning. Service providers must establish rapport with clients and provide support to help clients to achieve their goals. The professional context for working with clients is governed by basic values and principles:

- Boundaries define the limits of behaviour, which allow a service provider and a client to engage safely in a supportive, caring relationship. These boundaries are based upon trust, respect, and the appropriate use of power.
- The relationship between a service provider and a client is a therapeutic, caring relationship that must focus solely upon meeting the client's needs. It is not established to build personal or social contacts for service providers.
- Moving the focus of care away from meeting the client's needs towards meeting the service provider's own needs is an unacceptable abuse of power.
- Occasionally, a service provider may develop an attachment towards a particular client. While this may be natural, the service provider must ensure that it does not lead to a breach of professional boundaries. Service providers should be encouraged to discuss these kinds of difficulties with their supervisor as part of practice supervision.

PROFESSIONAL BOUNDARY ISSUES

Professional boundaries are complex and multi-faceted. The following include some of the key issues related to professional boundaries:

Befriending

Service providers must understand the difference between befriending and becoming a client's friend:

- Befriending a client – a professional relationship, designed to address client needs.
- Becoming a client's friend – a relationship that focuses on the needs of both people. A professional relationship focuses solely on the needs of the client.

Befriending is an appropriate relationship for service providers and is part of building the necessary trust to work with clients. Becoming a friend is inappropriate. Service providers are employed to work with clients as part of an employment contract.

Counselling

Service providers must be aware of the difference between being a counsellor and using counselling skills (such as active listening with a non-judgmental approach) that are appropriate for case planning. Counselling is not an appropriate role for service providers unless they are professionally trained and have been employed as a professional counsellor. Where a client may

appropriately be in need of counselling, service providers who are not professional counsellors should follow program guidelines and provide the client with advice and support in accessing appropriate programs and services.

Providing Advice

Generally, advice should only be offered to clients when they request it, unless there are good reasons to be more assertive (e.g. where there is a potential for physical harm or danger). If it is necessary to be more assertive, this should be done in a non-judgmental manner.

When service providers do offer advice to clients, they should ensure that they provide sufficient information for clients to make an informed choice. Service providers should only provide advice if qualified to do so and, also, to know when it is inappropriate to offer advice. In such situations, service providers should inform clients and make every effort to assist them in accessing qualified advice.

Influence

Service providers must be careful not to influence clients with their own beliefs and personal values and should also be aware of their potential to influence vulnerable and/or impressionable clients. Although morality, religion, and politics are common areas of conversation and clients may wish to discuss their views with service providers, service providers should never state or impose their own values.

Approachability

Service providers should be approachable, open to fair challenge and criticism, and available to engage in discussion. They should not be seen as intimidating or inaccessible. Clients must not be discouraged from accessing support within agreed boundaries or from making complaints.

Privacy

Service providers must respect clients' rights to privacy, and be sensitive and responsive to any different personal and cultural needs for privacy that may arise. Service providers must be aware of the limitations of privacy within the extents of harm to self or others.

Inappropriate Personal Disclosure

Service providers must not divulge any personal information about themselves or other service providers.

Concealing Information about Clients from Colleagues

Service providers must not conceal important client information from colleagues, including:

- Personal information;
- A client's intention to self-harm or harm others;
- Information about a violent or critical incident or issue; and
- Child protection issues.

Touch – Physical Contact

Staff should approach touching with great care and caution. Physical contact should only take place if necessary within the context of a professional relationship and with the client's agreement. Some clients may misinterpret physical contact as affection outside the professional relationship. Clients may also see physical contact as an expression of favouritism (e.g. where a service provider hugs one client and not another). Staff should be aware that physical contact risks being misunderstood and may result in allegations of inappropriate professional behaviour. Where touching is an integral part of service delivery, staff should discuss the subject regularly at staff meetings to ensure there is a consistent approach.

Prior Knowledge of Clients

Staff with prior knowledge of a client must inform their supervisors. The supervisor will explore, with staff, issues around confidentiality and risk assessment. Staff with prior knowledge of a client should not be assigned the role of case worker.

Contact with Clients Outside Work

- Staff must not provide clients with their personal contact details.
- Staff must not arrange after hours contact with clients.
- Staff who encounter clients outside work should be pleasant and civil if approached by the client, but should avoid prolonged social contact.
- Staff should not approach clients in any social setting, especially where the client's behaviour indicates that she or he does not want to be recognized or identified as a homelessness service user.

Discussing Others

- Gossip or hearsay is unacceptable among both service providers and clients.
- Staff must never share personal details about other staff with clients.
- Staff must never talk about other staff with clients except on issues relating to the client's care and case planning.
- Staff must never talk to clients about other clients or third parties.

Financial Relationships

- Staff must not enter into any financial transactions with clients including buying, selling, exchanging, or bartering goods or services.
- Staff must not borrow money or possessions from clients.
- Staff must not lend their personal money or possessions to clients.
- Staff should not give or accept gifts from clients.
- Staff should only handle money on behalf of clients within clearly defined program instructions.
- Staff should not agree to become trustees, beneficiaries, or executors of the wills of clients.

MANAGING BOUNDARY VIOLATIONS

Boundaries may be crossed intentionally or unintentionally, potentially putting the client, staff and the client's stability or therapy at risk. Staff may unwittingly be put in a position where their relationship with clients is compromised or they may be drawn into conversations or situations where their boundaries are being stretched or crossed. In some situations the line between good and bad practice may not be immediately obvious.

The program supervisor and other people in the program team, particularly those who are likely to work with the client, must be informed when a boundary has been blurred or crossed to:

- Maintain consistent practice with that client (and a consistent explanation with other clients); and
- Ensure that the action taken does not look like a "guilty secret".

A written record of a boundary violation must be kept to ensure openness and consistency. Boundary issues should be discussed with the supervisor and within the team on a regular basis, and specific team training or facilitated discussion may be appropriate on occasion.

Some arrangements with clients, intended to serve clients' best interests, may present potential boundary issues so there needs to be some flexibility. On occasion, crossing a boundary may serve a therapeutic purpose so there needs to be some flexibility concerning professional boundaries. For example, there may be a clear benefit to a client by escorting a client to a family funeral in the community or providing transitional support for a client in a supportive housing program. Such instances where there are clear potential benefits to clients should be discussed with a supervisor. The situation may then be "risk assessed" with the supervisor and necessary safeguards can be agreed upon, and a record kept to ensure a positive, transparent approach has been taken to manage risk.

Service providers should seek the guidance of their supervisor if they are unsure about the nature of a relationship developing with a client or if they need advice on how to deal with a situation. In circumstances where it has not been possible to access support in this way, any action taken by service providers must be discussed with the supervisor as soon as possible.

Effective Communication

Communication is the process of transmitting information — a message — between individuals, including sender and receiver. Verbal and non-verbal communication occurs in many ways, through speaking, reading, gesturing, writing, listening and watching.

It is important to be aware that communication may be heavily influenced by a person's tone of voice and body language — a form of non-verbal communication. Examples of body language include eye contact, facial expressions, head or hand gestures or body posture. Non-verbal communication varies in different cultural contexts. For example, in India, people fold their hands in greeting; in Japan, people bow from the waist; and in Pakistan, people touch their foreheads with the right hand. Simple gestures such as these are an effective means of communication. An effective and culturally sensitive communicator is able to read feelings and reactions through body language or non-verbal cues.

BARRIERS TO COMMUNICATION

There are many barriers to communication, which may impede the communication process by blocking, distorting or altering information such as:

- A judgmental attitude (i.e. advising, moralizing, ordering, patronizing, threatening, or lecturing);
- An unconcerned attitude (i.e. avoiding issues, ignoring a client, pretending to listen or only selectively listening, not making eye-contact, or being flippant);
- Non-assertive behaviour;
- Being preoccupied with a task;
- Anger or frustration;
- Personal bias;
- A lack of confidence;
- Organizational structure;
- Distractions/Interruptions; and
- Inappropriate priorities.

EFFECTIVE COMMUNICATION

To effectively communicate with clients, case workers must be able to send clear and appropriate messages, effectively receive information and provide feedback.

SENDING A CLEAR AND APPROPRIATE MESSAGE

To ensure that a client receives the appropriate message, a case worker should:

- Ensure a client is able to pay attention;
- State one idea at a time using plain language or clear non-verbal cues;
- Explain and repeat ideas when appropriate;
- Convey a consistent message with verbal and non-verbal communication (i.e. using body language and gestures consistent with what is being communicated verbally);
- Use the appropriate vocal tone and volume; and
- Encourage feedback from the client.

Most importantly, the message being sent must be relevant to and understood by the client as this will affect his or her willingness to listen and respond.

EFFECTIVELY RECEIVING INFORMATION

The key to effectively receiving information from a client is to pay attention to how they respond to the message being sent. This occurs through active observation and listening. To actively listen, a case worker needs to:

- Focus attention on the message, giving it momentary priority.
- Keep an open mind and avoid being judgmental.
- Listen to what the client is saying while looking for non-verbal cues. Word choice, tone of voice, body position, gestures, and eye movements reflect the feelings behind the spoken word.
- Verify what is heard. Your perception of the message and the sender's intent for the message may be different.

PROVIDING FEEDBACK

Providing feedback is important to confirm a client's message. Forms of feedback include acknowledgment, parroting, and paraphrasing.

- **Acknowledgment** or "rogering" a message is a common courtesy. It demonstrates that the receiver has heard the message. However, with complex information, acknowledgment may be insufficient to ensure that the client's message has been understood.
- **Parroting** is repeating what the client has said. It confirms to the client that their message has been received. However, as with acknowledgement, it does not ensure that the client's message has been understood.
- **Paraphrasing** is rephrasing what the client has said. Paraphrasing ensures that the case worker received and understood the client's message. If the case worker listened inaccurately, they have an opportunity to correct the miscommunication.

Motivational Interviewing

Motivational interviewing (MI) is an approach to communicating with clients to resolve ambivalence about and to build motivation for change. It is based on the belief that most individuals can modify their lifestyle. This approach uses strategies to enhance the client's own motivation for and commitment to change.

Choice is at the heart of MI. The client is in charge of making their own decisions for change. Clients are able to convince themselves that they ought to change.

MI is not a specific technique or techniques to be learned by rote, but rather a way of working with clients that involves a fundamental belief in the client's abilities and strengths. It is a client-centred, strengths-based approach

It establishes a safe and open environment for the client to examine issues and to identify personal reasons and methods for change. It allows service providers to be supportive of the client and reinforces a client's strength and capacity for change. By listening rather than telling, the service provider reinforces the client's capacity to change.

MOTIVATIONAL INTERVIEWING SKILLS:

The following skills can be useful in Motivational Interviewing, but are not prescriptive. They are part of a tool kit the interviewer can use.

Open-Ended Questions invite fuller responses than those that are closed-ended questions (one word answers).

e.g. "Where did you live before coming to the shelter?" — Closed-ended

"Tell me about your living situation before you came to the shelter." — Open-ended

Reflective Listening means reflecting back to the client what you have heard.

Simple Reflection paraphrases what was heard.

e.g. Client: " I moved here six months ago. I thought I would have no trouble getting work. I found a job, but it didn't pay enough to get a place and then I got laid off."

Simple reflective response: "So, you are from elsewhere in Canada, and your job search here hasn't worked out for you. "

Double-sided Reflection says back both sides of what a client is saying (shows their ambivalence).

e.g. Client: "My parents are back in Ontario. My friends have pretty much moved away. My dad lost his job a few years ago and has had nothing since. The

manufacturing sector is going nowhere there. I need to get something going for myself so I can build a life. I miss them and I miss my home town. But everything is closing down there."

Double-sided reflective response: "So, you have decided to build a life with job security, but it's been a struggle to do that. You love your family and hometown, but there is no work there. And so far you haven't been able to get a job here that pays enough to find a place to live."

Amplified Reflection heightens the resistance that is heard.

e.g. Client: "I'm stuck. The money doesn't go far in BC. I've got nothing to go back to in Ontario. "

Amplified reflective response: "It sounds like you are caught in a vise."

Self-Motivational Statements get clients to give voice to how they are changing by pointing out some changes you have observed and asking how they did this.

e.g. "Moving to BC was a big decision. It looks like you have some good skills if you can go from working in a factory to working in a parts shop."

Affirmation expresses support, encouragement, and recognizes the client's difficulties.

e.g. "It sounds like you are still struggling with missing home, and trying to meet people here while you find work. You obviously get along with people. What are your thoughts on shared accommodation?"

Summary Statements pull together the comments made and transition to the next topic.

e.g. "You've got a plan for yourself. You've got some skills that will help you get a job above minimum wage. We can help you see what benefits you might be entitled to, and help you develop a plan to find accommodation you can afford. What do you think might help you figure out where to look for work?"

Reframing is a technique to assist in resolving ambivalence by placing a different meaning on what a person says so that the person doesn't seem so resistant.

e.g. Client: " I don't even know where to look for a job I can do. I don't want to work in a restaurant. They pay crap."

Reframed: " It sounds like if you knew where the factories, manufacturers, or warehouses were in the area, you would target your job search there — where the jobs pay closer to what you are looking for."

There are many resources available in developing MI skills. The following weblinks contain additional resource materials, training videos and other training opportunities:

- www.motivationalinterview.org
- www.paulburketraining.com
- www.hcip-bc.org/documents/MIresourcelist_2009_000.pdf

Problem Solving & Decision Making

Problem solving and decision making are closely linked but serve different purposes.

- **Decision making** enables a case worker to determine a course of action through thoughtful consideration of the implications and to take a course of action.
- **Problem solving** is an approach that considers the immediate situation of here and now and the development of a solution.

PROBLEM SOLVING

Problem solving focuses on changing the current situation by thinking of and generating alternatives and then choosing one of them. If the solution selected turns out to create more problems or a different problem, then the thinking process begins again to find another solution as an alternative. The following steps may be taken to solve problems:

- **Accept** that there is a situation that needs resolving and commit yourself to dedicating sufficient energy to address it.
- **Define the problem** in concrete and specific terms. This includes identifying the people (or groups) involved and the needs of each person (or group). This is a very important step. If the problem is not defined properly, the rest of the problem solving process may not be effective.
- **Gather information**. This includes facts as well as feelings.
- **Brainstorm potential solutions**. Think laterally and be creative to come up with as many solutions as possible.
- **Evaluate the potential solutions**. Examine each idea to see how well it meets the needs of everyone involved.
- **Select the best solution** where the needs of all involved parties are met.
- **Implement the solution**. Be specific as to who will do what, when, and how.
- **Evaluate**. Take another look at the situation to see if a problem still exists. If there is still a problem, repeat the process. If no satisfactory solution is identified consider involving a mediator.

DECISION MAKING

Each day shelter and outreach workers are required to work out interpersonal problems with clients and make decisions for which there are no clear policies. Making decisions can be difficult, particularly for new staff, to be confident that all potential implications have been considered. A model of decision making, developed by Dr. Frederick Bird at the University of Waterloo, can assist staff by providing a framework to enable confident decision making by first asking a series of questions.[9]

DETERMINE THE SCOPE AND NATURE OF THE PROBLEM OR DILEMMA

- What is the problem?
- How is it affecting myself or others?
- Who are those involved in the dilemma?
- When would be an appropriate time to address the matter?
- Why is it that I am the correct person to address this issue? If you are not, then provide an overview to your supervisor and seek direction.
- What are you hoping to achieve? Your goal will shape your stylistic approach.

SEEK MORE INFORMATION

- To whom do you need to speak to ensure that you have all the information?
- Are there external standards or internal policy and procedures that apply to the resolution of the problem or the way it will be handled?

SEEK GROUND

- Has the information I received changed my goal?
- Are there systemic issues involved? Where should those go to be addressed?
- Does the other person have expectations or issues to be addressed?

TAKE ACTION

- Does something need to be done? Who will do it? When will it be done?
- Is an offer of assistance appropriate?
- Is this a learning scenario that can be discussed with the team for group improvement or knowledge?

[9] Dr. Frederick Bird is a Research Professor in the Department of Political Science at the University of Waterloo and former Research Chair in Comparative Ethics at Concordia University. Dr. Bird has written extensively on decision making that is ethical and that enables a business to carry out the common good.

Documentation

Documentation is used to communicate client information through:

- Reflecting the client's perspective;
- Ensuring continuity of approach or care; and
- Describing the services and the client approach used and its effect.

Documentation also supports effective and consistent team work and demonstrates accountability. Documentation can also play an integral role in quality improvement, research and potentially the allocation of funds. In short, good documentation:

- Facilitates accountability to the client and the funding agency;
- Ensures there is a record for legal and administrative purposes;
- Enables information sharing between staff and providers (when there is client consent); and
- Is a requirement for accreditation purposes.

DOCUMENTATION TOOLS FOR EMERGENCY SHELTERS

A **Daily Communication Log** is a running record of activities within a shelter or other service provider. Along with date and time, the log will include a record of:

- All phone calls, and the caller's specific information (name, title, telephone number);
- The entry or exit of any person to or from the program;
- Notes of scheduled visitors to the program or appointments to remind residents;
- Specific safety concerns for a resident;
- Any security concerns; and
- Necessary exchange of information for shift change.

Some shelters also use a running record for residents to record their arrivals and departures with expected return times to enable effective supervision of the residence and number of individuals for which the staff are responsible if there is an emergency such as a fire.

A **Shift Change Record** is an anecdotal record of the exchange of information between shifts. It is the structured exchange of information between departing and arriving staff. The information is generally recorded in the Daily Communication Log including:

- Who is in the shelter, including staff;
- Any phone calls to be made or forthcoming;
- When residents will return;

- Any unusual circumstances or events;
- A general overview of each resident including problems or concerns, medication and instructions, outstanding chores or any consequences;
- Any expected and pertinent details from the residents' personal logs; and
- Day-to-day running of the house (i.e.: meal preparation, garbage to take out, visitors, or any immediate specific responsibilities).

DOCUMENTATION STANDARDS

Documentation must be relevant, client focused, comprehensive, accurate, and timely. It must provide a clear, concise record of any pertinent incidents, interactions, or events including accidents, incidents, and complaints or requests for assistance or intervention. It should be factual and record nothing that the writer would not want to have read aloud to the client or supervisor.

All documentation must be recorded in a manner that is permanent and retrievable. Entries should summarize issues, key elements, and/or details and should be made at regular intervals during a client's stay. Documentation should be kept confidential.

CONTEMPORANEOUS NOTES VERSUS EXTEMPORANEOUS NOTES

Information recorded during or immediately after an event is considered more reliable than information recorded later. Notes taken at the time of meetings with individuals, telephone calls, visits to premises and so on are referred to as "contemporaneous" notes. These kinds of notes are particularly important if a worker thinks that there might be an investigation or the event involves any potential civil or criminal allegations.

If a writer is making contemporaneous notes judged to be of particular importance, they should record the date and time when the event occurred, record the date and time of the notation entry, and sign their full name.

CLIENT-FOCUSED DOCUMENTATION

- Includes incidents and reports relevant to the client.
- Contains information relevant to the client, including third party information.
- When documenting an incident, document who else was present.
- Subjective versus objective:
  - Subjective data includes statements and or feedback from the client. Quotation marks should be used to identify words used by the client.
  - Objective data includes observed or measured data. It includes interventions, actions, or procedures and the client's response.

- Errors, changes, and additions:
  - When making a correction, the purpose of the correction and the content that was changed should be clearly identified and signed.
  - All errors must remain visible.
  - Do not delete, alter, or modify documentation that is not that of the writer or from another provider.
  - Avoid duplication of information (i.e. recording of medication).

GUIDELINES FOR ACCURATE AND OBJECTIVE RECORDING

- Record only facts.
- Record every detail without omitting anything.
- Use action words (verbs) whenever possible.
- Observe without interpreting.
- Record only what you see or hear. Be careful to avoid recording something that did not occur.
- Use words that describe but do not judge.
- Record the facts in the order they occur. Order makes a difference.

KINDS OF OBSERVATIONS

There are many kinds of observations:

- **Running records** are brief, continuous descriptions. Staff use a narrative style to record information. Examples of running records are communication logs. A communication log is a running log of activities detailing date, time, name and content of phone calls, and other business operations such as people entering and leaving a shelter.
- **Anecdotal observations** are recorded information about one specific event or behaviour. The observer determines the event, timeliness of the record, and the richness of detail. To be most helpful, anecdotal records should be objective, factual, and followed up with supportive information. Critical incident reports are an example of anecdotal observations.
- **Diary observations** are also known as journal entries. These observations are written narrative accounts of what happened during a brief period of time. Entries can vary from a minimal, daily commentary to detailed reports. Resident logs are an example of diary observations and can include such detail as where the client went that day, his or her activities, information related to the client service or case plan, or information important for other staff members to know.
- **Checklists** are observations of a specific list of items, skills, or behaviours to be performed. Checklists generally require a response of yes, no, or sometimes and can be completed during the observation period or later. Many safety and health-related observations are conducted using checklists. Fire drill records, safety inspections, shift duty records, and other routine or critical information activities are often recorded in this manner. Client medication records are an example.

OVERCOMING PRECONCEIVED NOTIONS

Preconceived notions are stereotypical opinions that people hold about one another. Having preconceived notions is part of human nature. More often than not, there is not willful intent behind preconceptions. Rather, they occur because people have an instinctive desire to simplify things into predictable patterns. The problem with preconceived notions is that they tend to blur one's vision. If one believes that people will behave in a certain way, there is a predisposition to observe those behaviours even if the facts are contradictory. This can interfere with the collection of objective data.

The following guidelines can help in overcoming preconceived notions during observation to maintain accuracy and objectivity:

- Acknowledge that most people have some preconceived notions; denying their existence does not make the problem go away.
- Avoid attaching labels to clients. Positive labels can be equally as damaging to objectivity as negative ones.
- Before making an observation, write down any preconceived notions you might have about the client and his or her family.
- Anticipate examples of the client's behaviour in which these notions might come into play. For example, if you view a child as needy, you might anticipate that she would cling to adults while on the playground. This might predispose you be on the lookout for behaviour that confirms your expectations.
- Be watchful for examples of this type so that you are observing what you see, not what you think you see.
- Do not overcompensate. Your goal in this situation is to be objective, not to learn to see things in a different light.
- Be sure to check yourself for preconceived notions.
- Consider asking someone else to observe with you to ensure objectivity and reliability.

OVERCOMING LOGISTICAL CHALLENGES

Effective observation has logistical challenges, primarily related to making time for daily observation and recording. In principle, observation can be used to strengthen case planning. In practice, taking the time to observe and record information often competes unsuccessfully with time spent with clients and administrative responsibilities, leading many practitioners to despair of ever finding the time or opportunity to keep careful, consistent records.

As with preconceived notions, the best way for staff to overcome logistical challenges is to face them directly. Rather than getting caught up in what cannot be done, the best approach is to brainstorm solutions. The following strategies can be used to overcome logistical challenges:

- Supplement anecdotal records (residential program client logs) with running records and other forms of observation such as checklists for standardized routine record-keeping requirements. Include time for doing record-keeping and documentation in the schedule of shift duties.
- Wear clothing with pockets containing index cards or Post-Its to quickly record observations. Alternatively, organize the employee work area to facilitate effective documentation and record keeping.

CLIENT CONFIDENTIALITY

A critical aspect of documentation and building trust with the client is confidentiality and achieving client consent before sharing information with other providers or agencies.