Case Management in the Homelessness Sector

Supporting people from referral to move-on

Let's end homelessness together

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Introduction

What do we mean by case management?

Case management is a catch-all term that describes how you support the people who use your services.

It includes the processes that you use (referral forms, assessments, support plans etc), the way that you record information (your database) and your overall approach. Some organisations have a specific approach such as strengths-based working or broker case management. Some have devised their own approaches that may have been named and described in-house. Others don't have a specific approach or haven't yet put it down on paper.

However we describe it, case management is central to the work that we do. Every homelessness organisation aims to deliver high quality support with the aim of moving people forward in their lives. How we deliver this may differ but the intention is the same.

What did Homeless Link do?

This report presents the results of our work from April to September 2018 looking into case management across the homelessness sector. This was neither an evaluation of particular methods nor a formal research project, instead our aim was to gain a better understanding of the case management environment across the sector and to present the status quo.

We held conversations with more than 40 people from around 35 different organisations and services. We discussed a whole range of topics from how they approach support, to how they design their procedures, to how they store their data. A number of key themes emerged that we have written about in this report.

What is this report about?

The report discusses four key areas that stood out in conversations with partners. First, we asked about how services supported people. It was clear from talking to members that few homelessness services made use of formal case management styles, such as intensive case management. We have included case studies of those that do. However, the influence of some of the better known models such as strengths-based approaches is wide.

Secondly, we found that many organisations were in a process of change. We asked them to describe how they are approaching that change. This information forms the second section of this report.

Thirdly, we discussed how applying a new approach had influenced policies and processes such as assessments and support plans. In some cases, it was taking time for a new approach to be embedded. In the third section, we discuss how this process can be started and share detailed case studies of services that have made some of these changes.

Finally, we heard about a number of places that had implemented an area-wide system, and several more that were considering it. We collated what we learned into the final section on area-wide data management systems. This section also includes case studies from three systems.

Case management models and approaches

In the English homelessness sector we tend not to use the term 'case management' with any consistency. The conversations that we had during this project demonstrated that 'case management' means a range of different things to different services: for some it refers to data management and the system that is used to hold information; for others it refers to the quality assurance process by which the work of individual case managers is audited. Only a handful of services understood 'case management' to describe the approach and systems that they used to support people. In most cases the term caused confusion and had to be explained.

Defining case management

According to the Case Management Society of the UK:

> "Case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health, care, educational and employment needs, using communication and available resources to promote quality cost effective outcomes (CMSUK Standards of Practice 2005)."[1]

In the United States (which is one of the main sources of research and information on more formal forms of case management) a similar definition is used that includes more explicit reference to the role of advocacy.[2]

Most researchers and writers on case management go further to outline the processes that are referred to when the term is used. One study on case management described the following seven functions of case management:[3]

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

Willenbring et al (1991)

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

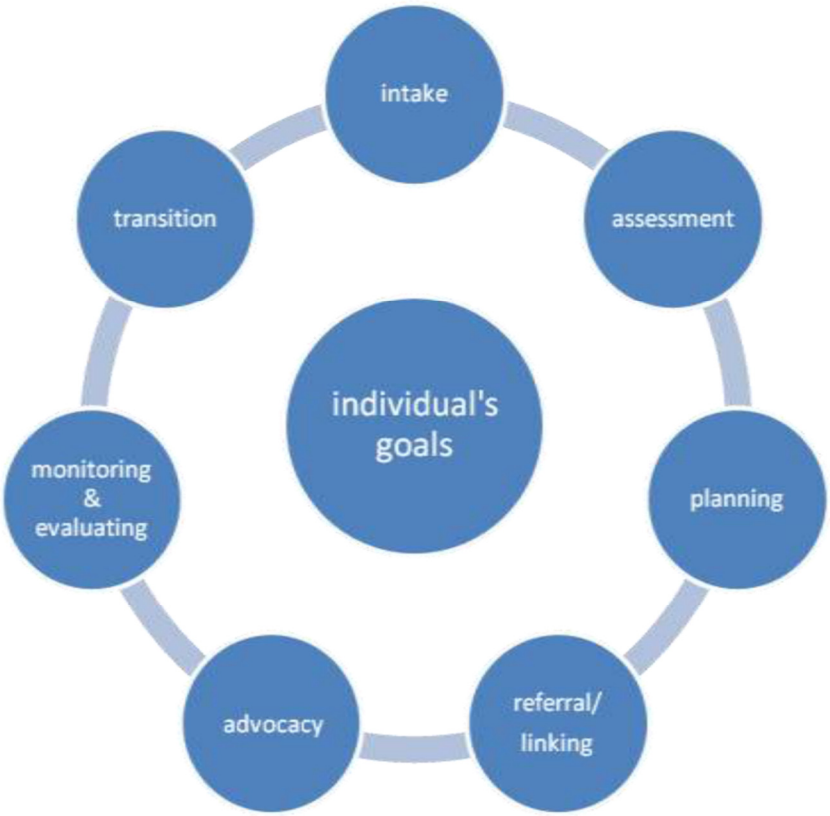
1. Direct service provision
2. Crisis intervention
3. System advocacy: to reduce barriers across services
4. Resource development: accessing additional sources and resources

[1] CSMUK Standards and Best Practice Guidelines 2nd Edition (2009). Accessed on 10/04/2018 at www.cmsuk.org/uploads/page/000standards-2nd-ed-hoZc.pdf

[2] Commission for Case Manager Certification. Accessed on 23/09/2018 at https://ccmcertification.org/about-ccmc/about-case-management/definition-and-philosophy-case-management

[3] Willenbring et al, (1991) cited in Morse, G. (1998). A review of case management for people who are homeless: Implications for practice, policy, and research. Practical Lessons: The 1998 National Symposium on Homelessness Research. and also in cited in Calgary Homeless Foundation (2011) Research Report Dimensions of Promising Practice For Case Managed Supports in Ending Homelessness.

A review of Case Management in the Homelessness Sector in Canada produced this diagram of the activities involved in case management:



Viewing the official definitions and activities of case management, it is clear that most services in England use case management to support the people using their services. All structured services use some form of assessment and will plan, refer and advocate. As such, case management is widely, if not universally, being used across homelessness services in England.

Formally recognised case management models

There are a number of specific case management models that have been formally described and, in some cases, researched. The best known of these are perhaps Broker Case Management, Assertive Community Treatment, Intensive Case Management, Strengths-based Case Management and Critical Time Intervention (see Table 1 for a brief description of the main case management models).

Few services in the UK are using internationally recognised case management models. The exceptions to this are the strengths or asset based approach used by Mayday Trust, and Critical Time Intervention used by Changing Lives in Newcastle. A number of services have Housing First projects – while these can be operated in different ways, projects adhering to the model defined by Housing First England could accurately be described as using an Intensive Case Management approach. In addition, many areas – in particular those part of either Fulfilling Lives[4] or Making Every Adult Matter (MEAM)[5] – deliver a systems broker model, although this differs somewhat from the formal model described in research studies.

[4] www.tnlcommunityfund.org.uk/funding/strategic-investments/multiple-needs
[5] http://meam.org.uk/

Table 1: Models of Case Management [6,7,8,9,10,11]

Name	Brief Description	Main applications
Broker case management	This is essentially about co-ordination with little or no service provision by the case worker. The worker supports the individual identify needs and helps to broker support services. Assumes an ability to access the support and aims for stabilisation and empowerment. Generally, workers have larger caseloads as less intense work is required. Although always important, there is less emphasis on development of the client-case manager relationship.	Broker case management in its clearest form can be seen in housing-related drop-ins where individuals can turn up and ask for general advice relating to their housing situation. The support workers would refer or link to the appropriate services. Some traditional forms of low-medium tenancy support would also come under this model. In a less 'pure' sense, England also has some systems broker type models where the worker's role is to develop ease of access to services. In these services, there tends to be less assumption that the client can access the services themselves and a higher level of support to attend appointments etc.
Clinical case management	As a clinician, the case manager provides direct therapeutic intervention. That might include mental health services, addiction recovery support, or treatment for serious or chronic health conditions. That increased level of understanding improves the case manager's ability to identify needed services and connect the person with community service providers as well as with informal resources such as family, friends, and peers. The worker generally has a very small caseload of around 10 people.	This form of case management has not as yet been identified within homelessness services in England although it is possible that some Psychologically Informed Services make use of clinical professionals to undertake broader case management as well as therapeutic support.

[6] www.socialsolutions.com/blog/unique-case-management-models/
[7] Strkalj Ivezic, S., Muzinic, L. and Filipac, V. (2010) Case Management – A pillar of community psychiatry. *Psychiatria Danubina, Vol 22 (1): 28-33*
[8] Vanderplasschen, W., Wolf, J., Rapp, R.C. and Broekaert, E. (2007) Effectiveness of different models of case management for substance-abusing populations. *Journal of Psychoactive Drugs, 39 (1`): 81-95*
[9] Homeless Link. Housing First England: Guidance for support providers. Accessed on 23/09/2018 at https://hfe.homeless.org.uk/sites/default/files/attachments/Housing%20First%20Guidance%20for%20Providers_0.pdf
[10] Homeless Hub California, accessed on 23/09/2018 http://homelesshub.ca/solutions/supports/intensive-case-management-icm-teams
[11] De Vet, R., van Luijtelaar, L.A., Brilleslijper-Kater, S.N., Vanderplasschen, W., Beijersbergen, M. and Wolf, J.R.L.M (2011) Effectiveness of case management for homeless persons: a systematic review. *American Journal of Public Health, 103 (10): 13-26*

Strengths based case management	In a strengths-based case management model, case managers focus on empowering and on creating opportunities for growth, education, and skill development. It encourages people to take the lead in identifying their own needs, take control over the search for resources and services to address those needs, and view the community as a resource and enabler of success. See below for more information on Strengths-based case management.	The best known examples of strengths-based work that adheres formally to the case management principles is the work of the Mayday Trust Personal Transitions Service (see case study below).
Assertive Community Treatment (ACT)	Assertive Community Treatment is a team-based approach, in which all of the staff work with all of the participants under the supervision and active participation of a mental health professional, who serves as the team's leader. It describes an interdisciplinary program of assessment, service planning, and intervention that typically involves professionals such as psychologists, nurses or social workers as part of the team. The team itself deliver most services and 'treatment' needed and as such it is a service provision model rather than a referral/coordination model. Other typical features include a holistic approach to all aspects of community functioning such as life skills and building links in the community. The support is available at all times and is not time limited. There is good research evidence that ACT has positive outcomes.	While there is a great deal of joint working taking place in England, we have not come across any specific examples of Assertive Community Treatment within the homelessness sector. Outreach or support teams that include a mental health worker or dual diagnosis worker and health professional may be the closest to the model. Even in these cases, however, it is rare for the full treatment to be delivered within the team rather than referring into mainstream or other NHS services. This is likely to be a by-product of the fact that, in contrast to the United States where most research takes place, all citizens are in theory entitled to free healthcare. As is well known, however, it can be challenging for people experiencing homelessness and in particular those with multiple and complex needs to access mainstream treatment. It might therefore be useful to start commissioning teams in this way. Whilst multi-disciplinary teams are useful, applying a specific and tested case management model could bring more specific and beneficial outcomes to this group of individuals.

Intensive Case Management (ICM)	Intensive case management is a form of one-to-one case management in which the worker delivers as much support as required including help to access other services or with any other relevant aspect of the individual's life. Support is usually unlimited and open-ended and there is a strong emphasis on harm reduction and following the goals of the individual. Building a relationship with the case manager is highly important. Caseloads should be small – different organisations have estimated them as between 7 and 15 people.	This model of support is best known as used by some Housing First projects in England. Although there may be other models of support, intensive case management is the most common and is the closest fit to the core principles. It is also not uncommon in the UK among assertive outreach teams, although they may not casework in the same way. See below for more information on Intensive Case Management
Critical Time Intervention (CTI)	A time-limited intervention that takes place at a point of transition such as release from prison or moving into new accommodation. The approach follows distinct time-limited phases of support and aims to connect to community resources. See below for more information.	This approach is new to England, and is being piloted by Fulfilling Lives Newcastle and Gateshead (see below for more information)

Strengths-based case management

Strengths-based practice originated from the mental health and social work fields in the United States in the 1980s. It grew out of a recognition of the power of working towards a goal set by the individual rather than seeking to address challenges. Its popularity has grown hugely over the years and spread across different sectors and continents.

The six essential ideas or principles of strengths-based work are:

1. People Can Learn, Grow and Change
2. The Focus is on Individual Strengths Rather than Deficits
3. The Community is Viewed as an Oasis of Resources
4. The Client is the Director of the Helping Process
5. The Worker-Client Relationship is Primary and Essential
6. The Primary Setting for Our Work is the Community[12]

Rapp and Sullivan (2012)

Some elements are shared by other approaches and widely adopted by homelessness support services. For example, the importance of the relationship between the 'worker' and the person receiving the service is well understood and the concept of being person-centred is also widely discussed by the sector.

The influence of strengths-based approaches specifically is widespread across homelessness and other social care sectors and this has, no doubt, had a constructive influence over many practices and services. A greater emphasis on positive characteristics and individual goals has been a significant improvement on previous working methods. However, truly working in a strengths-based way is a specific approach and cannot be seen as a simple 'add-on' to other work.

> "To embrace a resilience/strengths model is not just a matter of acquiring some new techniques or a different vocabulary." Saleeby (2001) [13]

> "It is common for people to treat the strengths perspective as merely a slogan where such superficial behaviors as "being nice to clients" or adding two lines on strengths to an otherwise deficit based assessment is seen as being a strengths approach." Rapp and Sullivan (2014)[14]

These statements from well-known strengths-based scholars may sound harsh and may ignore the positive steps many services have taken within significant constraints. Yet it is important to recognise the difference between the influence of strengths-based approaches and their full application. Research evidence is promising rather than conclusive (a common issue with research into support interventions which can be hard to study objectively), but there is some emerging evidence that the more faithful the organisation is to the model, the better the outcomes.

True strengths-based practice is a paradigm shift away from a culture that is "saturated with an approach to understanding the human condition obsessed with individual, family, and community pathology, deficit,

[12] Rapp, C.A and Sullivan, W.P (2012) The Strengths Model: Birth to Toddlerhood *Advances in Social Work* Vol. 15 No. 1 (Spring 2014), 129-142
[13] Saleebey, D. (2001) Human Behavior and Social Environments: A Biopsychosocial Approach. Columbia University Press.
[14] Rapp, C.A and Sullivan, W.P (2012) The Strengths Model: Birth to Toddlerhood *Advances in Social Work* Vol. 15 No. 1 (Spring 2014), 129-142

problem, abnormality, victimization, and disorder."[15] It is important to stress that this does not mean that strengths-based practitioners shy away from focusing on problems, challenges or issues – rather that they are addressed within the context of working towards goals identified by the individual.[16]

Strengths-based practice is intrinsically connected to the concept of resilience. Despite the genuine social challenges that experiencing trauma can pose, it emphasises that the vast majority of survivors continue to have positive, fulfilled lives. Nonetheless, as a society, we have spent more time examining the deficits that have arisen from these experiences than the resilient factors that have enabled people to survive and thrive.[17] Benard describes three key factors in developing resilience: caring relationships, high expectation messages founded in the individual's strength and hopes, and opportunities for participation and contribution.[18] These all relate closely to the strengths-based models that are emphasised by strengths-based case management, co-production and trauma informed approaches.

Strengths-based case management, co-production and trauma-informed care are far more than good practice or 'the right thing to do'. Strengths-based approaches have a key link, not simply to identifying and utilising an individual's strengths and assets, but also to playing an active role in building their resilience and working towards their recovery.

Strengths-based case management – Mayday Trust Personal Transition Service

Perhaps the best known example of a homelessness service using a strengths-based model is the Mayday Trust who run the Personal Transitions Service (PTS).

PTS pairs coaches with people experiencing homelessness. The individual identifies their strengths and ambitions with the coach, who works alongside the person to take steps towards them. There is a considerable focus on the development of a genuine, trusting relationship between the coach and the individual – an essential component of strengths-based practice. As Mayday Trust also operate some housing provision, the organisation separates support from housing, to ensure that the power sits with the individual and not with a housing professional who ultimately has the authority to make them homeless again.

PTS breaks away from traditional keywork and housing-related support and is a highly personalised, strengths-based and asset-based approach. There is a strong emphasis on evidencing that someone can achieve for themselves within the wider community rather than as part of homelessness services. For example, if there is an ambition to attend an art class, the PTS coach will aim to find a class within the local community rather than refer to the art group at a homelessness service. The aim is to develop community integration as well as real world positive relationships and opportunities outside of the homelessness 'bubble'.

PTS involves radically transformed structures and systems. There is no lengthy assessment and the coach is not looking to find out support needs. Instead, coaches have real world conversations to find out about people's abilities and interests. Deficit-based data capture methods have been replaced with a developmental asset tool, which is taken every three months, and highlights an individual's strengths and assets. The aim is to further build and focus on what is strong, linked to individual aspirations, which naturally over time improves

[15] Saleebey quoted in Rapp, C.A and Sullivan, W.P (2012) The Strengths Model: Birth to Toddlerhood *Advances in Social Work* Vol. 15 No. 1 (Spring 2014), 129-142
[16] Fukui, S., Goscha, R., Rapp, C.A., Mabry, A., Liddy, P. and Marty, D (2012) Strengths Model Case Management Fidelity Scores and Client Outcomes, *Psychiatric Services,* Vol 63, No 7
[17] Benard, B. (2006) '*Using strengths-based practice to resilience of families'* in Saleebey, D.(ed) Strength Perspective in Social Work Practice. 4th Edition. Boston.
[18] Ibid

other areas of their lives. It has also been designed to be personalised and built around the individual context in order to make it relevant and, ultimately, create sustainable change for the individual.

There is no office space and people meet wherever works best for them – this could be in a local café or park. Language is also very important – there is no labelling and the people the PTS works with are not called 'clients' or 'service users'. There is no cut-off date for working together and no conditions. Referral forms to the service are very basic and self-referrals are also welcomed. The service uses In-Form to record data and will put asset plans on the system for monitoring purposes.

PTS is based around the concept that people experience problems as a result of trauma and have developed coping strategies that are a normal response to their experiences. The service does not aim to fix problems or tell someone to stop a behaviour that may be an essential coping strategy. Instead it aims to uncover people's strengths and interests and, in doing so, to build resilience, community integration and support networks. Over time these may replace any other coping strategies.

If the person experiences a crisis, the coach can either support them or step back as the person wishes. The aim is to let the person lead so that they feel able to manage their own situation. People experiencing homelessness often feel dehumanised and can experience learned helplessness – the aim is to push back against this and support people to be more independent.

Coaches are employed based on their values, ethos and ability to naturally give their power away. They undertake two days of internal personal development training on the processes and approach, which also involves unlearning some mind-sets and behaviours. The team attend reflective practice sessions once a month in addition to regular supervision and there are also 'moving the model forward' days attended by all staff across the national PTS movement every three months. This enables coaches to reflect on their practice and the PTS framework to ensure the approach is genuinely person-led.

PTS draws on many of the key principles of strengths-based practice but also goes beyond this to call for genuine personalisation, organisational transformation, and cultural and systemic change so that people can sustainably transition out of homelessness. Staff undertake regular work to ensure this fidelity remains and improves.

For more information visit: https://maydaytrust.org.uk/

Critical Time Intervention

Critical Time Intervention (CTI) is an evidence-based case management model that has been extensively used in the United States. It is a time-limited approach that offers a structured model of support to people at a time of transition, such as discharge from prison or moving into independent accommodation. It is designed to acknowledge that people often have to negotiate complex and fragmented support systems once they enter the community, which can prove challenging and lead to the breakdown of housing.

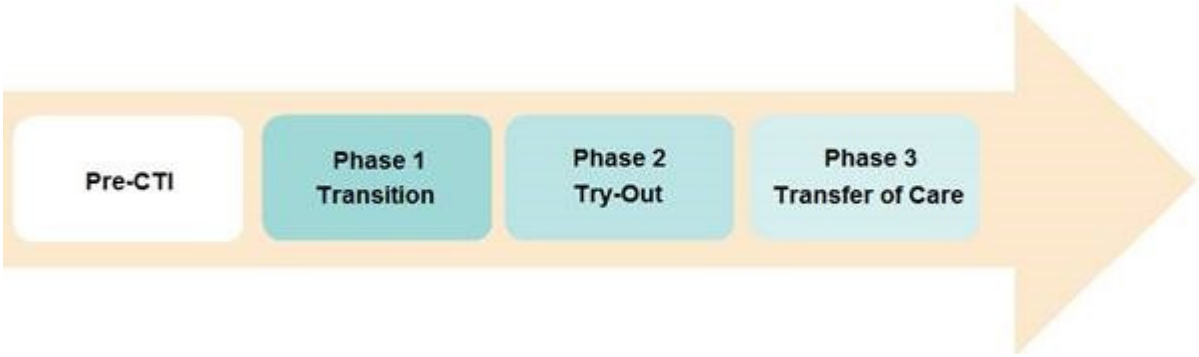
CTI workers seek to develop the individual's independent living and skills and build effective networks. The approach aims to link the individual into activities and support within their local community and to ensure that these links are strong enough to enable the CTI worker to step back at the end of nine months. The approach becomes less intensive over time, thus preparing someone for independence.
All information below is taken from the resource pages on: www.criticaltime.org

Homeless Link

The creators of CTI have highlighted 10 Core Components:

1. Addresses a period of transition
2. Time-limited
3. Phased approach, decreasing intensity over time
4. Focused
5. Community-based
6. No early discharge
7. Small caseloads
8. Harm reduction approach
9. Weekly team supervision
10. Regular full caseload review

Although different variations of CTI are in operation across the US, the original and evidenced model involves supporting the individual for a period of 9 months, divided into 3 phases with an additional Pre-CTI phase.



Pre-CTI

- Develop a trusting relationship with client.

Phase 1: Transition

- Provide support and begin to connect client to people and agencies that will assume the primary role of support.
- Make home visits
- Engage in collaborative assessments
- Meet with existing supports
- Introduce client to new supports
- Give support and advice to client and caregivers

Phase 2: Try-Out

- Monitor and strengthen support network and client's skills.
- Observe operation of support network
- Mediate conflicts between client and caregivers
- Help modify network as necessary
- Encourage client to take more responsibility

Phase 3: Transfer of Care

- Terminate CTI services with support network safely in place.
- Step back to ensure that supports can function independently
- Develop and begin to set in motion plan for long-term goals

- Hold meeting with client and supports to mark final transfer of care
- Meet with client for last time to review progress made

There is a strong body of evidence to support the use of CTI in the United States, and it has been adopted by different sectors in other countries, including the UK. At least one randomised study has compared CTI to alternative support similar to that used in the UK and found positive benefits. The evidence showed that CTI reduced the number of instances of homelessness amongst those receiving the intervention compared to standard case management, and also that those who received a more intense version of CTI prior to release had fewer instances of homelessness than those who received less intensive CTI.[19]

The use of CTI in the homelessness sector in the UK is in its infancy with Changing Lives in Newcastle, trialling the approach.

Fulfilling Lives, Newcastle and Gateshead

Fulfilling Lives in Newcastle and Gateshead (FLNG) have been working with people with multiple and complex needs for the past four years. Over this time, they have been offering an open-ended navigation service, which takes a 'refer and accompany' approach involving support planning and goal setting. This has worked well and has helped many people to mitigate crises. The service aimed to link people to other support services in the community. However, as few other services work in such an intensive and open-ended way, it proved hard to successfully move people on. In some cases, this has led to a dependence on the service. A need was identified to find an intervention that was more focused on moving people to successful independence.

There were initial challenges piloting Critical Time Intervention for both staff and those using the service. The concept of time-limited and decreasing support was a change for staff, but training and a phased approach to introducing CTI has aided the transition. The team worked hard to ensure that the messaging was right before talking to people using services so that they would fully understand what was happening.

The model only applies to those who are undergoing a transition – moving into a hostel or more permanent housing or leaving prison or residential treatment. The team are clear about the nature of the support from the outset and the limits of that support. In the past, navigators have supported people with all areas of their lives. CTI is more focused on key goals and this has been made clear to those enrolled in the programme.

CTI at FLNG is a strengths-based and person-centred model. The individual identifies three goals that they would like to work towards and the approach remains focused around these goals. The team have found that this has already led to richer conversations with people, some of whom were already known to them. This has also helped to shift the responsibility from the team to the individual. Examples so far have included someone who is working towards visiting family abroad, with an intermediate goal of getting a passport, and someone who would like to undertake a tattooing course. These person-centred goals have led to the development of broader networks with the individual.

There is a balance to be found between person-centred goals and meeting someone's basic needs. For example, during a phase the person could find themselves homeless, but housing may not be an area of focus. At the time of writing, CTI at Fulfilling Lives is very new, so these are challenges that will be met in the

[19] Herman, D., Conover, S., Gorroochurn, P., Hinterland, K., Hoepner, L. and Susser, E (2011) A Randomized Trial of Critical Time Intervention to Prevent Homelessness in Persons with Severe Mental Illness following Institutional Discharge. *Psychiatric Services 62 (7); 713-719*

future. However, the service aims to acknowledge pressing needs in addition to the three focused goals. They will provide support but look to build up the wider support network so that someone else can help in future. The aim is to prepare for these situations as early as possible using the WRAP method (see below).

The team will be using the classic CTI phases. There may be a considerable pre-CTI phase in which the relationship is built and, in some cases, goals will be identified at this stage. This phase is not time limited. The next three phases will each last three months and the 'clock starts' when the transition takes place. Phase 1 will involve intensive contact and support (e.g. one or more face-to-face meetings per week), reducing in Phase 2, and further still in Phase 3 as the individual prepares for the end of the service (see table below).

In the final phase the team will use Wellness Recovery Action Planning (WRAP). This is a detailed collaboration and involves identifying and triggers, what needs to happen if the person has a crisis, and how the individual will recover. It aims to build on strong relationships and networks that have been developed or re-kindled during the CTI phase.

CTI involves taking small steps and celebrating achievements. The network that is forming around the person aims to come together at the end of each phase. There is a further celebration as support comes to an end.

Example of activity in each CTI phase:

Focus	Pre CTI	Transition	Try-out	Transfer of Care
	Undefined: pre-transition	**0-3 months post-transition**	**4-6 months post-transition**	**7-9 months post-transition**
Focus 1 Housing stability		e.g. Weekly (or more) contact: Furniture; food; rent; lease; identify and connect community supports	e.g. Monthly visits: follow the routine; join community support; meeting with client & property manager, watch client cook	e.g. Monthly check in to see that connections continue to go smoothly – rent is paid and room is livable
Focus 2: Mental health access		e.g. help schedule, accompany & monitor meds	e.g. Attend home health appointment(s), check in with provider/ family member	e.g. Monthly check in to see that connections continue to go smoothly
Focus 3: Employment		Person indicates: "I'm not ready!" or "I need to get settled first!"	e.g. Strategize; Plan & help with resume; application process; community job center	e.g. Monthly check in to see that connections continue to go smoothly

Another key feature of CTI is small, balanced caseloads and regular supervision. Each worker will have a caseload of 16 people but these are weighted due to the amount of time spent on each. They will work with 4 people in each phase at any one time. Due to the structured nature of the project, workers spend the most time with those in pre-CTI and Phase 1 and considerably less with those in Phases 2 and 3.

As there is a different intensity of casework needed in each stage, it is important to ensure caseloads are balanced. In order to help to coordinator caseloads and maintain small caseload responsibilities for each worker, a Standard Caseload Equivalent formula can be applied. This means that caseloads are weighted to reflect how much time each person might require. For example, one person in Phase 1 of CTI 'counts' as two people when working out the size of the caseload. This is because it is expected that the caseworker will spend double the amount of time with them than they would spend with someone in Phase 2.

Actual numbers on caseload in each phase	Pre CTI	Phase One	Phase Two	Phase Three
	1	1	1	1
Standard Caseload Equivalent (e.g. number counted as being on caseload)	*x1.5*	*x2*	*x1*	*x0.5*
	1.5	2	1	0.5

The team have weekly CTI case management meetings, where practitioners are asked to prepare a case presentation to discuss a CTI case, exploring the successes and challenges and also asking key questions to the team and operational lead. The case management meeting is designed to be a collaborative space to explore CTI implementation on a weekly basis and ensure that the team are sticking to the 10 core principles. The team also have a casework support officer who keeps oversight of the phases and is an enormous support to staff. The project will also undertake a great deal of evaluation as the first of its kind in the UK.

CTI in Newcastle and Gateshead began in June 2018 and, at the time of writing, is phasing in gradually. FLNG will share their progress with the sector as time progresses.

> "I told him, we're not going to concentrate on the chaos going forward, we're going to focus on the goals you want. So seeing your grandma and grandad. After that his face lit up with a smile."
>
> System Change Practitioner introducing CTI to his client during a prison visit

> "Since the beginning of the Fulfilling Lives programme, transitions has been a key focus for Fulfilling Lives Newcastle Gateshead, with our clients experiencing some very difficult accommodation moves, prison releases and hospital discharges. CTI has offered an alternative way to approach transitions, with our hope being that we can really strengthen the relationships our clients have with their support networks and break those vicious cycles of bouncing around the system."
>
> Operational Manager

Intensive Case Management

Intensive Case Management is an outreach-based intervention, meaning that it takes place in the community rather than within a service. It is a comprehensive approach which involves a high level of contact between the worker and person being supported. The worker is able to offer a highly flexible support service and can also act as a broker, linking to other relevant services. Rather than simply referring someone onwards, however,

this could include a higher level of advocacy, accompanying to appointments etc. The worker can also deliver support with any aspect of the individual's life as requested. Support is driven by the goals of the person being supported.[20, 21, 22]

The relationship between the case worker and person being supported is a central and valued part of the model. In addition, the support is open-ended or at least long-term.

The most explicit use of this as a model of support in England is in some Housing First Projects. In the case of Housing First, the individual does not have to accept the support and this would not impact on their right to housing. Nonetheless, intensive case management in a Housing First setting involves active engagement methods to maintain contact with the individual. This means that the responsibility for remaining in touch lies with the worker, rather than the individual. The team will be persistent without being intrusive, and try a number of methods to keep in touch. Key to this is flexibility, developing relationships over time and developing and understanding of the best method of contact for that individual.[23]

There is good evidence of the success of Housing First itself both nationally and internationally, but only mixed research evidence for the effectiveness of Intensive Case Management specifically. An early review looked at five studies with substance users and found significant improvements in housing status, substance abuse, physical and mental health, quality of life and employment, although there was less evidence with those who were alcohol dependent. People experiencing homelessness with more severe substance abuse histories showed poorer outcomes. One study showed that the intervention was cost effective for chronic drinkers due to reductions in healthcare costs and those experiencing dual diagnosis also benefitted.[24]

A 2011 review found that, although there were occasional positive results reported on some measures (see below), overall there was little evidence that using Intensive Case Management was more effective than other types of case management.[25] However, a 2018 review of all research evidence was more positive. Compared to 'treatment as usual', intensive case management:

- Probably reduces the number of individuals who are homeless after 12-18 months (moderately good evidence).
- May increase the number of the number of people living in stable housing after 12-18 months (low quality evidence).
- May lead to little or no difference in the number of individuals who experience some homelessness during a two year period (low quality evidence).
- May reduce the number of days an individual spends homeless (low quality evidence).

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[20] De Vet, R., van Luijtelaar, L.A., Brilleslijper-Kater, S.N., Vanderplasschen, W., Beijersbergen, M. and Wolf, J.R.L.M (2011) Effectiveness of case management for homeless persons: a systematic review. *American Journal of Public Health, 103 (10): 13-26*
[21] Strkalj Ivezic, S., Muzinic, L. and Filipac, V.(2010) Case Management – A pillar of community psychiatry. *Psychiatria Danubina, Vol 22 (1): 28-33*
[22] Vanderplasschen, W., Wolf, J., Rapp, R.C. and Broekaert, E. (2007) Effectiveness of different models of case management for substance-abusing populations. *Journal of Psychoactive Drugs, 39 (1`): 81-95*
[23] Homeless Link. Housing First England: Guidance for support providers. Accessed on 23/09/2018 at https://hfe.homeless.org.uk/sites/default/files/attachments/Housing%20First%20Guidance%20for%20Providers_0.pdf
[24] Vanderplasschen, W., Wolf, J., Rapp, R.C. and Broekaert, E. (2007) Effectiveness of different models of case management for substance-abusing populations. *Journal of Psychoactive Drugs, 39 (1`): 81-95*
[25] De Vet, R., van Luijtelaar, L.A., Brilleslijper-Kater, S.N., Vanderplasschen, W., Beijersbergen, M. and Wolf, J.R.L.M (2011) Effectiveness of case management for homeless persons: a systematic review. *American Journal of Public Health, 103 (10): 13-26*

- It is uncertain whether high intensity case management leads to a difference in the number of days an individual spends in stable housing, the number of days an individual spends in their longest residence, and the number of individuals who do or do not move (very low quality evidence).[26]

Nonetheless, they found no impact in the studies that looked at work with offenders, substance users and those with mental health issues compared to lower intensity types of case management.

A lack of clear research evidence should not be taken to mean that there is no benefit from this intervention. In particular, there is no standardised model for ICM, which means there may be little consistency between the different services studied. It is also difficult to research case management interventions generally, as every project is in a different context (and nearly all research takes place in the United States). These reviews also only include quantitative or statistical studies and do not consider the more qualitative verbal reports of those experiencing the services.

Positive results from Housing First projects using intensive case management would suggest that, in the right project, this form of case management can have positive impact.

Service for Adults Facing Exclusion (SAFE), Harrogate

SAFE in Harrogate was commissioned for five years to work with entrenched rough sleepers who are experiencing mental health issues and/or alcohol or substance dependence, have contact with the criminal justice system, have frequent contact with emergency services and have a history of ineffective contact with and multiple exclusions from existing services. It is described as offering strengths-based, intensive, person-centred support.

SAFE was not commissioned or designed as an accommodation-based service but came to deliver Housing First in response to the needs of the people using the service. It was clear that those being supported would not be able to access traditional housing models or engage with a ‘staircase’ system.

The project offers support indefinitely with no end date and no limits. Support is driven by the individual so if they tell the support worker to leave, she will. However, she will continue to try to work with them and make continual offers and approaches. The project involves building trust with people who have often had their trust broken many times in the past, including (often unintentionally) by services. A key part of this involves building trust with police who offer a single point of contact to help build the relationship. The service also offers support 24/7 (making use of the wider team, including police).

SAFE currently employs one worker who has a caseload of seven, with one person currently in prison. While work is ongoing, this means that she is working with six people more actively. This is above the ideal maximum caseload.

The project uses no paperwork with people using the service but instead engages in informal conversations in different locations (notes are taken afterwards back at the office and added to a case management system). This could be out on the streets ‘walking and talking’ or in cafes or their flats once housed. The work is driven by what the individual wishes to achieve. Each person has a personal budget which can be spent flexibly to achieve the things of most interest to them. For example, purchasing a games console to alleviate boredom, furniture and household items to build a home, clothes to improve self-esteem. Several people have worked

[26] Munthe-Kaas, H.M., Berg, R.C. and Blaaxvaer, N (2018) Effectiveness of interventions to reduce homelessness: a systematic review and meta-analysis. Campbell Systematic Review. Campbell Collabotion.

towards reconnecting with their families and in one case, mediation has been facilitated to effectively rebuild the relationship.

SAFE is explicitly trauma informed. It uses a thorough understanding of the impact of trauma both to engage with individuals and to gain the support of other services. This lens has enabled the service to understand and accept particular forms of behaviour and to use this knowledge to deliver better results for the person. For example, one person had experienced significant abuse at the hands of a parent and responds negatively to being touched in a particular way. Informing the police of this has enabled them to work with him differently on arrest, leading to better outcomes from any arrests.

SAFE works as part of a multi-agency team. The service is embedded in the Community Safety Hub which involves partner agencies including the police, ambulance service, local authority, mental health, substance misuse and probation. It involves multiple and comprehensive inter-agency working. One agency alone cannot meet needs and all agencies need to take joint responsibility. There is a case management system shared within the hub which includes actions and accountability. Information is shared and the system creates red flags if a partner has missed an action which is then seen by others.

The project is overseen by a Strategic Board which includes Heads of social services, mental health, probation, Clinical Commissioning Group (GP leads for vulnerable adults and safeguarding) and substance misuse services, as well as police Inspectors and representatives of the local authority and County Council.

SAFE has involved an element of systems change. This has been achieved in part by the SAFE worker explaining the impact of trauma to the heads of services and other partners. The broader partnership is now receiving trauma informed care training. This has had a big impact. Services now work flexibly, meeting those engaged with the service at times and in locations suitable for them. Another impact of this has been the development of crisis management plans which outline how each service should respond in particular situations. This works well for both the services and the person involved.

Although it does not do so explicitly, SAFE uses a classic ICM approach, by working intensely one-to-one with individuals, being person-centred and by brokering exemplary multi-agency support as part of this work.

Broker Case Management

Broker case management is technically the most basic form of case management. A case worker would undertake a needs assessment and refer the individual to relevant services. This would generally take place in an office based setting and would not involve a long relationship. A 2018 systematic review found little evidence of impact on homelessness but there were not many research studies to include in their review.[27]

In some parts of England. we have seen more intensive versions of the broker model, with workers often known as ‘systems brokers’. These staff provide a service similar to intensive case management but with an explicit focus on supporting the individual to access other services that are required. This is often against a backdrop of a fragmented or complex system.

While this is a useful and interesting service (see case study below), it is not the same as the broker case management described internationally in research. This distinction is important when reading research evidence and briefings to back up use of the model. However, for practitioners the distinction is less relevant.

An example where classic broker case management is used is in standard street outreach services, low-medium level tenancy support, or tenancy support drop-ins. In these cases, workers complete an assessment and refer onto other relevant services.

[27] Ibid

Developing an organisational approach

A number of organisations have been developing or re-developing an organisational approach or model over the past few years. There have been different ways of doing this. Some have taken a top-down approach with minimal consultation. Others have embarked on large consultation exercises including staff and residents.

Out of the 30 organisations, services and local authorities we spoke to for this project, 12 were in the process of, or had completed the development of, a new model or approach to apply to their organisation.

Motivation – why develop or change your organisational approach?

The impetus for a new organisational approach can come from many sources.

Responding to contract specifications during the tendering process

In some cases, organisations are responding to commissioners who are increasingly requesting specific approaches in their contract specifications. This often includes requirements for services to be psychologically informed or involve elements of strengths-based practice or co-production. This can introduce services to new ideas and lead to organisations thoroughly re-examining their approach to support.

In our research, there were clear examples of services that had embraced change in a comprehensive way. On other occasions, this can lead to relatively superficial changes and box ticking. This may be well-intentioned: there are services who have taken genuine steps to change an approach without fully understanding the extent to which change might be needed, or where senior managers haven't managed to fully embed this with frontline teams. In other cases, frontline staff and operational managers are committed to the change but are limited by a lack of senior management input.

Response to specific incidents or poor outcomes
The recognition that a service that is delivering poor outcomes may lead it to reconsider its approach and whether things can be improved. For example, this happens in response to a serious incident, loss of a contract or other challenges. It could offer a positive opportunity for reflection and for all staff to come together to bring about a change. However, teams that have become over-stretched or de-moralised often struggle with change if it isn't introduced in a thoughtful and comprehensive way.

Desire for continuous improvements
Many of the larger organisations (and some of the smaller ones) within the sector constantly seek to evolve and improve their model with the aim of continually improving their outcomes. The ongoing reflection may be positive, although making changes too often can lead to staff fatigue and prevent meaningful change.

Change of leadership
New leadership usually involves re-examining an organisation's strategic direction and, often, wanting to make significant changes. Strong leadership can be a powerful force for change, although it can also be a challenge to ensure that other senior managers and existing staff are on board.

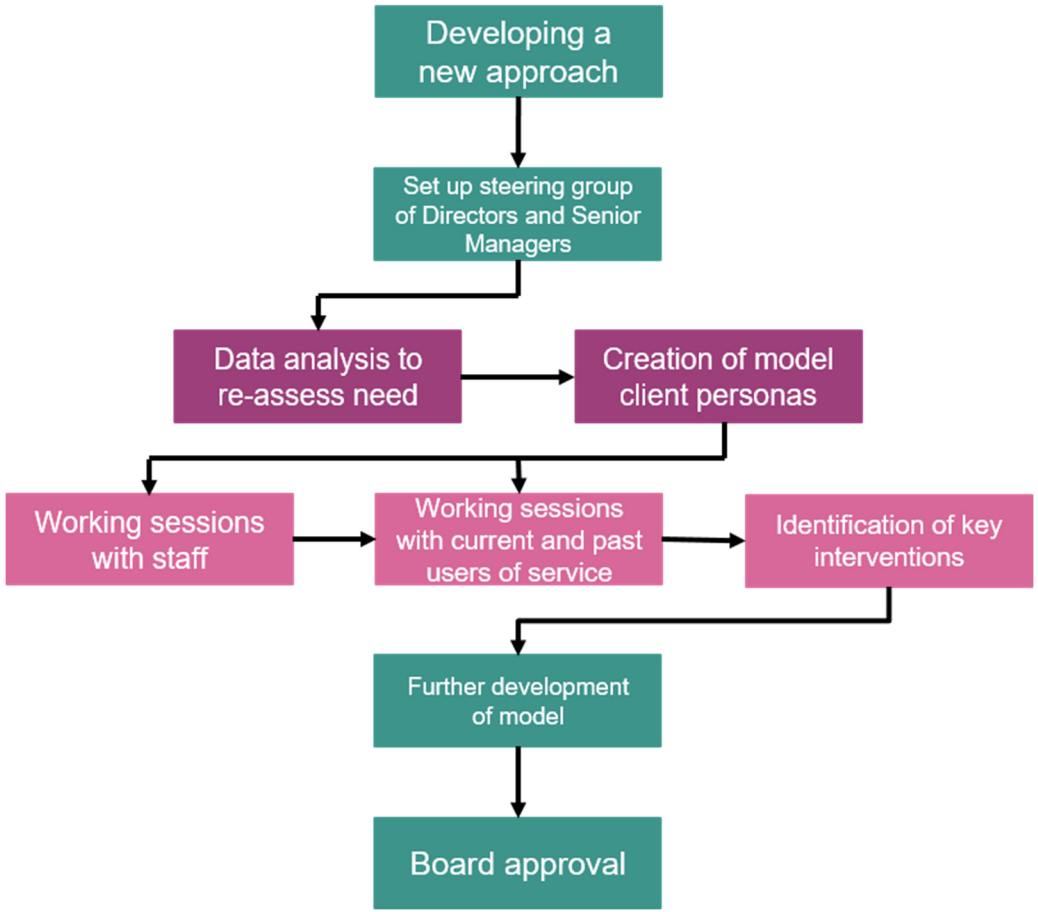
Responding to new ideas from inside and outside of the sector
Several of the services that we spoke to said they had initiated change as a result of learning from other agencies and thought leaders. Conferences and events promoting ideas such as trauma-informed care, psychologically informed environments and strengths-based approaches have been hugely influential in the sector. The inspiration of these events, coupled with an awareness that existing services can be improved, has sparked change.

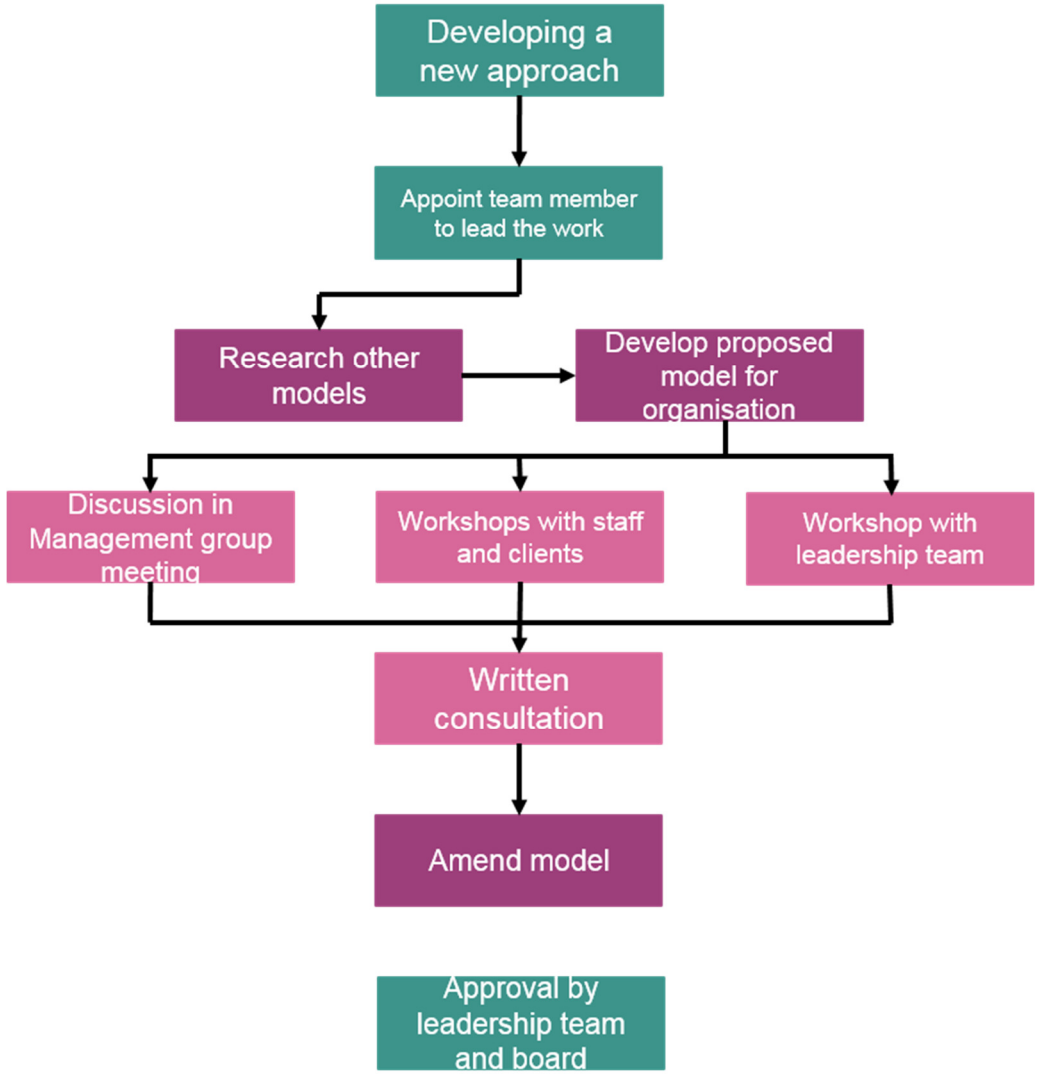
Responding to broader political and financial changes
Organisations have increasingly been required to do more for less over recent years. Many services have noted an increase in the number of people with complex needs using services at the same time as many have faced restrictions on their income. This has led them to review whether different approaches could have more impact on these client groups and support staff to cope in increasingly challenging circumstances.

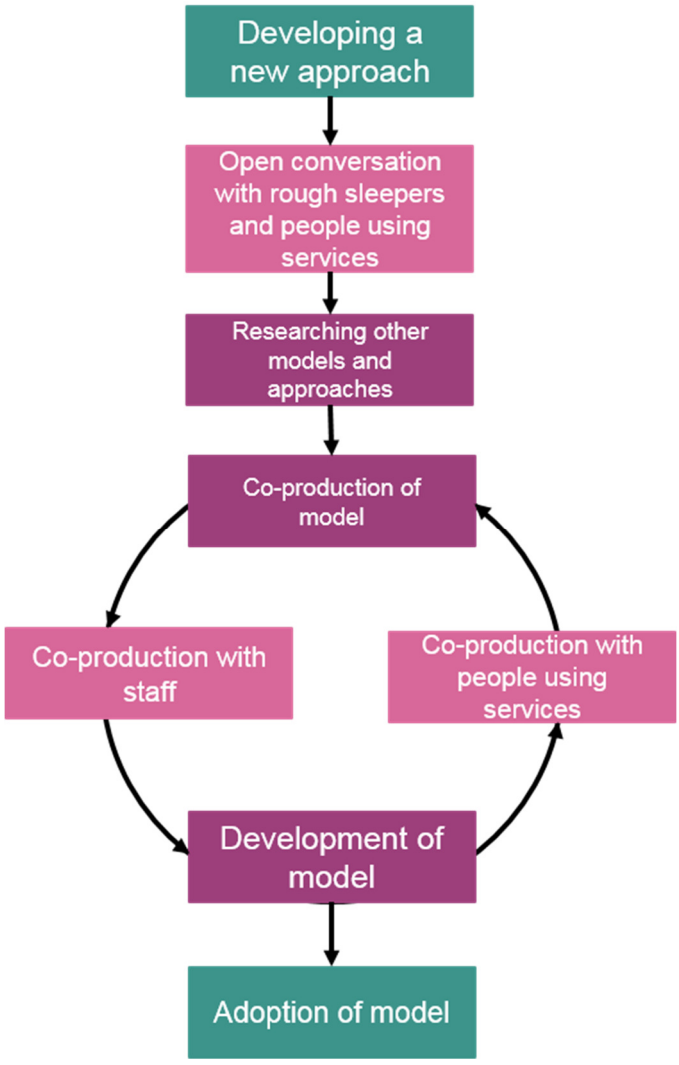
The development process

All 12 organisations developing a new approach have involved a number of members of staff, but the extent of consultation has varied greatly. Some have involved a small selection of senior managers. Others have consulted the whole organisation, including frontline staff and those with experience of using services. In some cases, the process has been managed by a member of the senior management team. In others, someone has been specifically recruited to oversee the change.

Below are some example processes undertaken by organisations spoken to during this project. These examples have been anonymised as, in most cases, the processes were ongoing.


Developing a new approach
Set up steering group of Directors and Senior Managers
Data analysis to re-assess need
Creation of model client personas
Working sessions with staff
Working sessions with current and past users of service
Identification of key interventions
Further development of model
Board approval


Developing a new approach
Appoint team member to lead the work
Research other models
Develop proposed model for organisation
Discussion in Management group meeting
Workshops with staff and clients
Workshop with leadership team
Written consultation
Amend model
Approval by leadership team and board


Developing a new approach
Open conversation with rough sleepers and people using services
Researching other models and approaches
Co-production of model
Co-production with staff
Co-production with people using services
Development of model
Adoption of model

Leadership
Developing and embedding a new organisational approach takes strong leadership. Although it is helpful when leadership of the change is shared across the organisation, it is essential that Senior Management are fully engaged and on board with the process. Strong leadership from a Director or CEO is a key component to ensuring that a new approach is taken seriously by the organisation.

Most organisations have found that introducing a new approach has worked best when involving a range of people at different levels of the organisation, in particular ensuring that service managers are on board, as well as regional and senior managers.

John Kotter is a leading researcher and author on change. He identified eight steps to leading organisational change in his seminal work Leading Change (1996), subsequently updated in Accelerate (2014).

Image copyright of Kotter Inc[28]

Of key interest in Kotter's work is his emphasis on involving a wide base of people in the change. Change leadership should include people at all levels on an organisation who contribute to the direction and strategy. He also recommends enlisting further volunteers to assist in the process. Organisations that have succeeded in doing this are ultimately more successful in particular because involving more people creates momentum. Kotter says that involving 15% of an organisation is enough to build momentum for change. Once you pass 50% you reach 'stickiness'.

[28] www.kotterinc.com/8-steps-process-for-leading-change/

A small number of homelessness agencies have taken this collaborative approach to leading the change within their organisations. In some cases, this has involved putting together action groups of interested members of staff, managers and leadership to work on different aspects of that change. This helps to ensure buy-in across the organisation and makes it easier to counterbalance any resistance. Senior leadership remains important to ensure that the changes take place and progress is made. However, the group work together to decide the nature of the change.

More commonly, however, organisations have led change from the top down. In most cases this has involved a group of managers or senior managers introducing the model to their staff teams, setting up workshops or training for staff and building in questions about the new model into supervision or reflective practice sessions. Typically, a group of senior managers (with or without the input of a staff and service user representative) have revised policies and procedures and then rolled them out across the organisation. Although there has been an element of consultation and involvement at most services, embedding a model has been led by managers.

Embedding a service model across an organisation

The larger the organisation, the more difficult it can be to ensure that your approach or ethos finds its way into the daily practice of the service. It can also be difficult to 'audit' ethos. A key way that organisations have tried to do this is through regular training sessions. For example, at one large service provider, in additional to training that new employees attend, there is an ongoing series of online training sessions for existing employees. It can be challenging, however, to ensure that training has an influence on practice. As a result, many organisations have ensured the model or approach is discussed regularly as an item in supervision sessions or team meetings.

A key way to ensure that the working model informs practice is to make sure that processes are influenced by them. If assessment and support planning processes reflect the model, it is more likely that the people using the service will receive the service as intended. For some organisations, the process of revising paperwork and procedures is ongoing. A few organisations that had very strong principles, ethos and approach, described assessment forms that showed little or no influence of the principles. The processes in which a person participates when accessing a service form a huge part of their experience of that service and, as such, should reflect the ethos of the organisation.

However, many organisations are limited, or feel limited, about how much they are able to change paperwork to fit in with new ideas and approaches. Some have recording requirements set by commissioners and funders. Others have to complete specific forms in order to access other services for their clients. Still more feel nervous about removing information from forms that could potentially warn services about risks. As a result, most organisations have made relatively few changes to bring their referral and assessment processes in line with their espoused approach and ethos.

Another way of embedding ethos is to have regular staff meetings. At one day centre, where their model and approach is key to all that they do, staff and volunteers meet every morning. They discuss and reflect on an element of their approach, sometimes inviting staff to share expertise. This ensures that the team are all connected and focused on their mission. There are other examples of services that lack a written or defined model but show consistent staff approaches and attitudes – a common thread is often regular staff meetings and/or reflective practice – which can help to instil a common approach, attitude and sense of purpose.
In the table below are the various methods organisations have used to try to embed a new model into practice. Most have employed a combination of several different methods at the same time:

Activity	Impact and Benefits	Limitations
Staff training (face to face)	• Staff learn about the model and have opportunities to ask questions • The model and its intended application is clearly communicated • Trainer can adapt to meet different learning styles.	• Training can be less interactive than a workshop and there may not be as much opportunity for staff to feed into the process or make change to the model • It can be challenging to ensure that training is applied in practice
Staff training (online)	• A cost effective method to reaching a large number of people • Ensures all staff receive identical training • Can be quick and easy to schedule into the working week • Useful as 'top up' or refresher training	• Not all staff engage well with e-learning • Cannot be adapted for individual recipients • It can be challenging to ensure the model is applied in practice
Staff workshops (one-off)	• Staff learn about the model • Staff feel consulted and are able to discuss the new model • Interactive sessions can make a bigger impression • Questions can be raised which can then be addressed by design team	• It can be challenging to ensure the model is applied in practice • May raise expectations of changes to the model that take time to develop
Staff workshops (regular)	• Staff are fully consulted and able to influence changes to the model • Staff have opportunity to learn more about the model over time • Staff can reflect on the process of applying the model • Model is reinforced	• This is time consuming and can be hard to schedule • Can be expensive to run (hiring venues, facilitators etc)
Management workshops and meetings	• Ensures that managers remain up to date with the model • Maintain the model as a priority • Enables managers to reflect back on the model • Supports managers in leading staff teams in using the model	• Can be challenging to find time for regular meetings/workshops • Larger organisations struggle to bring manager together on a regular basis
Support and supervision - discussion of the model is added to regular supervision discussions	• Ensures that staff reflect regularly on the model on an individual basis. • Supervisors have the opportunity to reinforce the importance of the model	• Depends on having a supervisor who is fully on board and fluent in the model

Activity	Impact and Benefits	Limitations
Team meetings – discussion of the model is added to the regular agenda	• Ensures staff reflect on the model as a group • Staff are able to develop collective response to the model • Staff can collectively troubleshoot and find solutions	• Added item can make meetings longer • If poorly managed could lead to staff group negativity towards the model
Reflective practice – reflecting on the model becomes a key part of reflective practice	• Safe environment for reflection • Staff can develop a collective response to the model • Staff can collectively troubleshoot and find solutions • Discussion is facilitated by a neutral observer allowing free expression	• May replace opportunity to reflect on client work which is often valued by staff
Service auditing	• Service is audited by senior manager or external auditor • Allows the service to be quality checked to ensure model is being used	• Easier to ensure that the 'letter' of the model is being applied than the 'spirit'. • Time consuming and resource intensive
Service monitoring	• Service managers complete regular returns which include discussion of the model and how it is embedded • Ensures that service managers reflect regularly on the model • Maintains the model as a key priority for managers	• May become a paper exercise and not reflect genuine experience of staff and people using the service.

Processes of case management

Most services, and in particular most housing projects, use broadly similar processes with the people they work with. These will include a referral form received prior to moving in (for housing projects), a detailed assessment form taking note of a wide range of potential support needs, a risk assessment and some form of support planning paperwork. Advice services and day centres are often more flexible but would usually have a similarly detailed assessment form for those receiving structured advice or support.

This section includes an introduction to adapting processes, followed by three in-depth case study examples to demonstrate how some services have achieved this, and what this looks like in practice.

Adapting your processes to fit your approach

As more organisations move towards approaches such as strengths-based practice or trauma informed care, new models of assessment and support are developing. However, at this time, only a handful of services have made significant changes to their paperwork. Some organisations are at the beginning of a process of review. Others are not intending to make changes. This is significant because, although the influence of these approaches is positive and a huge amount can change with culture and attitude alone, an organisation cannot fully adopt an approach without giving serious re-consideration to their methods.

There are genuine challenges to adapting paperwork. Certain information may be required in order to refer to hostels and other services. It can be that commissioners require specific information. Omitting information may also feel like an increased risk to residents and staff. Making significant changes requires culture change and this can feel uncomfortable. In many cases these can be overcome and, where they can't, it is possible to adapt and change within severe constraints as our Reading case study (below) demonstrates.

Perhaps the biggest challenge, however, is time. To fully adapt processes is time consuming and should involve a number of members of staff and users of the services. This shouldn't delay efforts to deliver things differently – it is better to change something than nothing. However, allowing sufficient time for the process is a key part of the commitment to changing the operational practices of a service.

Why adapt your processes?

Adopting a new case management style or approach is a holistic process. It should therefore impact on all aspects of the work of an organisation. For example, an organisation will be limited in their adoption of strengths-based practice if they continue to ask a series of deficit-based questions in their assessment. Similar principles apply to those organisations working towards delivering trauma-informed care (TIC) and psychologically informed environments (PIE).

Both TIC implementation guidance[29] and the PIE framework emphasise that applying these approaches is a comprehensive piece of work that needs to extend to all areas of an organisation.

[29] Fallot, R.D. and Harris, M. (2009) Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol, Washington, D.C: Community Connections

Figure 1: the 6 elements of PIE

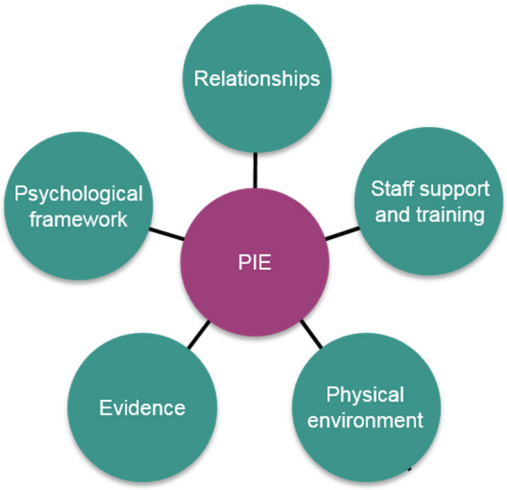


Figure 2: Domains to apply TIC

Figure 1 depicts the PIE framework but it could apply equally to adopting any new approach (with the possible substitution of a psychological framework for the relevant principles). Figure 2 identifies the different domains to consider when implementing TIC. This is similarly comprehensive and includes all aspects of policies, procedures and administration as well as trauma specific training and work.

One reason to adapt holistically is this can otherwise cause friction as people receive one type of service from one aspect of an organisation but a different one from another. One example of this was a trauma-informed service, where the finance staff were not trained in the approach. These staff sent abrupt and challenging letters and emails to residents relating to service charges and arrears. This was causing friction and was not resulting in better financial results until the trauma informed approach was adopted by the finance team.

Language, identity and stigma

Adapting your policies and procedures is about far more than changing language. However, the impact of changing language (and the attitudes and assumptions associated with it) should not be underestimated. Language is hugely powerful. Sociological theories have long discussed the impact of labelling theory on behaviour. They have most often been studied in the field of criminology but also related to mental health, sexuality and other groups. Being described or defined with negative words associated with criminality can affect an individual's self-image and can delay their desire or ability to change their lifestyle.[30] Our identity is crucially affected by how we are described and defined by others and many of us will adapt our behaviour accordingly.

Furthermore, our identity can also be affected by how we *perceive* others to view us – stigma that is perceived rather than actual can also have a negative impact.[31] This resonates with comments made by people with lived experience of homelessness, relating, for example, to how they have responded to entering services for the first time or being asked questions in an initial assessment.

[30] Becker, H. *(1973) Outsiders. New York: Free Press;* Sampson, R.J. and Laub, J.H. (2005) 'When prediction fails: from crime-prone boys to heterogeneity in adulthood' in R.J.Sampson and J.H.Laub (eds) *Developmental Criminology and its discontents: trajectories of crime from childhood to old age.* Sage, London.

[31] Link, Bruce G.; Cullen, Francis T.; Struening, Elmer; Shrout, Patrick E.; Dohrenwend, Bruce P. (1989). "A Modified Labeling Theory Approach to Mental Disorders: An Empirical Assessment". *American Sociological Review*. **54** (3): 400–423

> "There is still judgement and stigma in services. Whether it's very subconscious. We've all experienced it…even if you just perceive that you're being judged that can stop you."
>
> Female with lived experience, South of England, interviewed 20th June 2017.

See also Homeless Link's film 'The Assessment Process': www.youtube.com/watch?v=kwvFYGYWAg8

Similarly, several researchers have concluded that ultimately behavioural change (in this case desistence from crime) "rests on the person's cognitive shifts about who they are as the desistance process unfolds".[32] It has been argued that offenders who do not view themselves fundamentally as 'criminals' may be more likely to desist.[33] Having a 'delinquent identity' has been shown to be related to offending behaviour.[34]

It follows that a change in how a person views themselves (which can be linked to how 'society' views them) supports people to make lifestyle changes. These theories resonate with theories of strengths-based practice, trauma informed care or psychologically informed environments in which the necessity of both using language that supports a positive self-identify and responding to people in a way that reduces stigma is emphasised.

Language also has the power to include or exclude and to create and maintain a power balance. It can be enormously disempowering. Using terms that are not easily understood by the listener makes it difficult for them to fully participate in the conversation. It can also demonstrate that the worker is in control of the conversation and setting the tone, rather than it taking place in a more balanced way.

Use of formal language or describing things differently to those used by the person using the service, can inadvertently display value judgments. It can also make it difficult to communicate openly and easily. Asking someone, for example, whether they have ever sought 'treatment' for substance misuse, pre-supposes that their use is problematic. It may not be, or it may be that they do not view it this way. If you phrase a question in this way you can immediately close down opportunities for other conversations about this. Thus staff in services frequently make assumptions that someone should seek treatment for their drug use and put this into support plans when, in reality, this may not be of interest to the individual.

So, while adapting policies and procedures is about far more than changing language, the potential impact of this should not be under-estimated.

How to adapt your policies and procedures

There is not one way to adapt policies and procedures and in reality, this will be an ongoing process. The image below highlights some of the things to consider as you begin. All of these elements are significant when re-designing policies and procedures. Perhaps the two starting points are 'what and why' or 'content and purpose'. Often, if you have adopted a new approach, your purpose may have shifted. For example, evictions procedures may traditionally have been designed to ensure a clear and transparent method to end someone's license safely and fairly when they have seriously breached the terms of their agreement. However, with a new focus, your aim may now be to avoid evictions and maintain a licence wherever possible. As we shall see in the example below from Genesis Housing Association, this can lead to a vastly different procedure.

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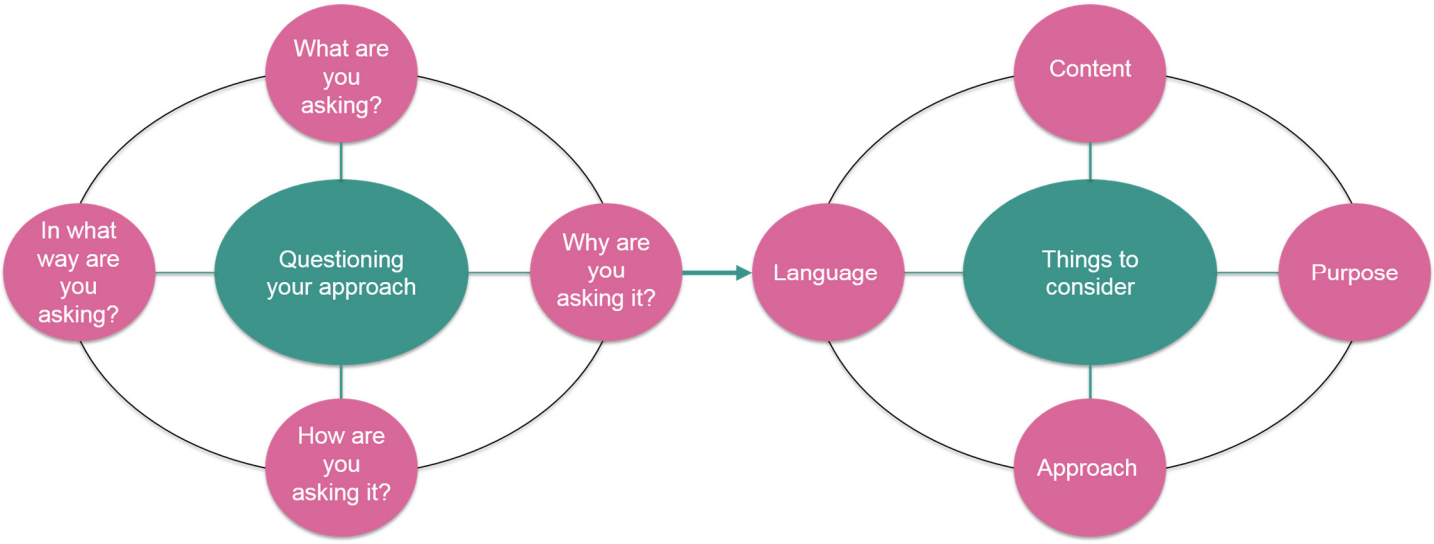
[32] Mulvey, E.P., Steinberg, L., Fagan, J., Cauffman, E., Piquero, A.R., Chassin, L., Knight, G.P., Brame, R., Schubert, C.A., Hecker, T. and Losoya, S.H. (2004) 'Theory and research on desistance from antisocial activity among serious adolescent offenders' in *Youth violence and juvenile justice,* 2, pp 213-236

[33] Paternoster, R. and Iovanni, L. (1989) 'The labelling perspective and delinquency: an elaboration of the theory and an assessment of the evidence' in *Justice Quarterly,* Vol 6 (3), pp 359-394.

[34] Klein, M.W (1986) 'Labeling theory and delinquency policy. An experimental test' in *Criminal Justice and Behavior*, 13 (1), pp 47-79.



We cannot hope to provide a comprehensive guide to re-doing your policies and procedures. We have instead included three detailed case study examples which demonstrate how this can be done and what it may look like in practice. Here are some things to consider when undertaking this task:

Organisational aims:

- What is our overall mission as an organisation? What are our values? What are our aims?
- Do we have a Theory of Change? What is this?
- How does each policy or procedure fit within these?

Organisational approach

- What is our overall approach? Have we adopted a newer approach of our own or do we aim to implement strengths-based practice, TIC or PIE?
- If we have made changes to our approach, how might this impact on policies or procedures?
- How does each policy or procedure complement our current organisational approach? Does it detract from this or support it?

Reviewing policies and procedures?

- What policies and procedures are currently in existence? When were they written/reviewed?
- Audit what you have already to get a sense of what most needs to change (but do not allow this to take so long that you are delayed in making changes!)
- Which policies or procedures can be updated reasonably quickly? Which will require a longer review and consultation period?

Prioritising

- Which policies or procedures do we think need changing most urgently? Which have the biggest immediate impact on the experiences of the people using our services?
- How much time can we set aside over the next quarter/year? Which policies/procedures can be tackled in this time?

Who should be included?

- This will depend on the nature of the policy or procedure being changed. Some smaller policies may be reviewed and adapted by a single allocated person. Others that are more fundamental will need

to include a broader design team and a full consultation. This would include referral and assessment procedures, support planning, eviction or barring procedures and anything else that has a fundamental impact on the people using your services.

Setting up your working group

- Who is best place within the organisation to lead on this work? How can you free up time for them to do this?
- Who needs to be included in the reviewing and design process? This may be a working group but should representatives of people using your services, managers, frontline staff and volunteers (where relevant).
- How and when will you meet? How can you make meetings meaningful and inclusive? This may include workshops and open discussion groups as well as formal meetings.

Designing your policy or procedure

- Start with considering the purpose of the policy or procedure? What was it originally? Has this changed in the light of changes in the sector or a new approach within your organisation? If the purpose has shifted, how can the policy or procedure be adapted to reflect this?
- Consider the original content and whether it achieves its original purpose? How should the content now be changed to reflect the new purpose?
- Look at examples where possible of how other organisations have adapted similar processes. This will highlight things to you that you might otherwise not have noticed.
- Think about language and wording. How should the policy/procedure be written to ensure it is easily understandable to everyone reading it. How can you best write the policy to reduce exclusion, disempowerment and to balance the power within the conversation? How can you avoid language that makes assumptions or stigmatises?

How should the policy or procedure be applied?

- Think about the approach that staff would need to apply to ensure that the policy/procedure is applied as intended. What principles/styles of conversation do they need to adopt?
- How can you support staff to ensure that they are able to do this?

Consultation

- Who needs to be included in the consultation process? For fundamental items such as assessments and support plans this should ideally include the whole organisation including frontline staff and people currently using your services, people who have used them in the past and people with experience of using other services.
- How can you do this in a meaningful way? This will depend on the size of your organisation and the systems already in place. If you are a very large organisation, you may need to have a generalised feedback process alongside more detailed consultation with groups representing Manager, frontline workers, people using services, volunteers etc. This may need to be done regionally.

Pilot

- Consider piloting the approach within one section of the organisation to see how it works. You can then make amendments as necessary before rolling it out further.

Guidance/training

- What training should be offered to ensure that all staff operate the procedure effectively? This is essential – if there is insufficient training or a false assumption that training to managers will 'filter down', the policy or procedure will not be applied as intended. It may then not have the required impact.
- How can you ensure that guidance you produce is read, understood and applied?

Iteration

- Keep the process of change open. Be open to ongoing changes and adaptation to make improvements. Many policies/procedures have unintended consequences – it is best to have an ongoing consultation as the approach is rolled out so that these can be addressed.

Developing new support plans – Evolve Housing transition to a strengths-based approach

How did we do this?

At Evolve Housing and Support, we launched our new approach to support in summer 2018. In the previous year we worked with staff and customers to review how the existing approach was going. Customers were happy with the support they receive and at the same time some areas for improvement were identified. Customers wanted a focus on what is strong and positive about them and on their relationship with the wider community, which led naturally into focusing on a more asset-based approach to working.

A working group of staff and customers was set up in late October to jointly create this new approach to support. As a group, we designed the new approach and the paperwork, made sure staff and customers could review and feedback at every stage and eventually agreed on what it would look like. The new approach, which focuses on a customer's wellbeing, their satisfaction with where they live, their community connections and their aspirations, is proving to have a positive effect after the initial pilot. One customer said about his experience of the new support plan: *"I have really enjoyed being able to take the time to complete this and I feel like it is mine and something I can work towards. I have liked looking at my strengths…"*

Customers and staff worked together to review the feedback from the pilot and to make any necessary changes. They also worked together to develop training for staff on how to work with the new approach which is in the process of being delivered. Over 60 staff and customers have been involved in this process with over half of these being our customers. The design, decisions and training work around the new approach have been done in partnership with our customers, and has resulted in a great new way of working for the organisation.

One of our managers said, *"Co-production allowed us to test ideas and bring current lived experience to the planning process. This is essential for any new support approach and invaluable to the ethics of design. By focusing on co-production, we have been able to get all parties to take ownership in its design and delivery and develop it into something that works for all and not something that is just implanted on our clients."*

What is the new approach?

The approach is community and asset-based. This aligns better with what both customers and staff wanted and fits better with the organisational approach. It also aims to have better and more positive outcomes. At Evolve there is a strong emphasis on co-production and this fits well with the approach.

The approach in practice has seven key strands. These are

- Creating positive expectations for and with your customers
- Building relationships and opportunity in the community.
- Customer involvement in your service.
- Shifting language.
- Adoption of four support planning areas (see image below).
- Ethos of reciprocity and partnership.
- Building better communities.

The new Support Plan

A full range of new processes have been and are being developed. One of the first to be launched is the new support plan. Support planning has adopted a coaching style and is no longer focused on deficits such as substance use or mental health. Instead, the customer identifies goals that they would like to achieve and works with the support worker to identify steps they may need to take to achieve this. Those people who have newly arrived in the service may adopt shorter term goals if they are in crisis, but over time it is expected that goals will become longer term. The different elements of the new support plan are detailed below.

Goals - what I would like to achieve is:

The aim is that the goals identified should be motivating. They should also be should be positive, manageable, realistic and achievable and challenging. We all have passions, dreams and aspirations that we aspire to in life. When having the conversation with the customer, staff try to find out what inspires them and what their beliefs and interests are. They ask questions that allow them to be creative and thoughtful in planning their goals.

Current strengths that will support this:

Strengths I would like to work on:

In order to achieve these goals, customers are asked to identify their strengths. Whatever we speak of most will be at the forefront of our awareness and the more it defines who we are. We want to develop a practice with our customers where they acknowledge what their strengths are on a regular basis. The strengths identified in this section should link to the goal that is being discussed.

Please note that the classification belongs to VIA and the images are the intellectual property of Evolve Housing.

The images above are included in the support planning booklet. They are based on the VIA classification with images designed by Evolve. They are used to support this conversation with customers. If a customer is struggling to identify any personal strengths, this provides an opportunity for support staff to feedback and highlight some of the customers, strengths.

The people and networks I would like involved are:		
		/ /
		/ /
		/ /

In order for a goal to be achieved, it must be broken down into manageable actions. These actions then become the driver for the goal. Actions need to be relevant and related to the goal in question. The role of the support worker is to help identify the necessary actions to achieve this.

Building strong connections to their local community enhances our customers' chances of success with fulfilling their goals. While the primary driver of any goal is the person who creates it, often it will only be successful if it utilises the support, guidance and coaching from others. Much support may come from staff, but it is essential to make use of all local resources including other services within Evolve, external services and community groups. These are identified within the support plan.

I will celebrate achieving my goal by:

When developing the new support model, customers said they wanted an opportunity to celebrate when they made progress. Focusing on what you have accomplished, rather than the long list of what there is still to do supports people to stay positive and motivated.

At the end of each support planning cycle, the project uses the Short Warwick and Edinburgh Mental Wellbeing Scale with some additional questions to measure progress and report to commissioners. It is a scale used across the sector and has been used in all Housing First pilots.

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last two weeks:

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future					
I've been feeling useful					
I've been feeling relaxed					
I've been dealing with my problems well					
I've been thinking clearly					
I've been feeling close to other people					
I've been able to make up my own mind about things					

This strengths-based document now makes up the entire support plan for residents at Evolve Housing. At the same time, the organisation has adapted new safety planning procedures, assessments and adapted our In-Form to meet our new needs. We have also introduced a five-day training course for all staff to fully understand the approach and how to apply it. It's a long process that is still ongoing but we are optimistic about the future and confident that our approach now fits with the aims and approach of our organisation.

Re-designing procedures – Genesis Housing Association Norfolk and Suffolk

We started this process last year. We had been working towards implementing strengths-based and person-centred approaches as part of our shift towards developing a psychologically informed environment.

A huge amount has been changed across the Homelessness services we run in this area. I have detailed a few of these changes here but this is part of a much wider process and is ongoing.

Referral and induction processes

We were unable to change our external referral process as this is standardised across the local area. However, our own internal referrals and assessments have been changed to enable more open conversations and to use positive language. This has enabled us to get to the root of issues that might previously have led to someone being considered high risk. For example, if someone has previously had repeated evictions from services, we would now talk to them in more detail about why that might have been and what could be done differently on this occasion. In the past, we might have automatically marked this down as a risk.

Below are examples from our guidance on the types of questions staff can ask as part of this conversation. Whilst the conversation starts with more positive strengths-based elements, you will see that we do go on to discuss issues such as substance misuse and mental health (and more topics that aren't included in the sample below). However, how we discuss these topics has changed significantly to a focus on gaining a better understanding of the strengths people use with this issues and why they engage in the behaviour.

MOTIVATION AND TAKING RESPONSIBILITY

- What would you like to achieve whilst here?
- What changes have you made already to achieve this?
- What do you think is not going so well?
- What do you think are the solutions?
- How do you think we can help with that?
- How do you feel about supported accommodation and working alongside the team?
- What is the one thing you think you are good at and one thing you would like to learn/change?
- Where would you like to be two years from now?

MEANINGFUL USE OF TIME

- Tell me about yourself?
- What are your hobbies and interests?
- What are you good at?
- Do you have any cultural/religious beliefs?
- Is there anything we need to consider/be aware of regarding these beliefs?

SOCIAL NETWORKS AND RELATIONSHIPS

- Do you have family/friends/significant others that you have contact with?
- Is there anyone who you would like involved with us?
- Do you have any concerns regarding moving into shared accommodation?
- Easy to make friends? Difficulty in talking to others?

ACCOMMODATION

- Review the reasons given in their application for maintaining/loss of their accommodation and expand focussing on:
- Are there times when you have successfully maintained accommodation/services longer than others- what was different?
- What do you feel are the key reasons for the loss of your accommodation/what have you learnt? What do you feel could prevent this from happening again?
- How do you feel we could help you with this?
- What would you do differently this time?
- Remember the 5 whys, it is important to not just document the first response, but to ask why they feel this each time to find solutions rather than focus on the problem.

DRUGS AND ALCOHOL

- How do you feel about your current drug/alcohol usage? Do you have any concerns?
- What do you think drinking/using drugs helps you with? How does it make you feel?
- Have you previously had periods of being abstinent? What enabled you to achieve this? What do you think caused any relapse?
- How does it impact on you?
- Is it impacting anyone else?
- How do we keep you safe in this environment in relation to your current usage?
- How do you think we can work with you to help you achieve what you want to achieve?
- How are external agencies helping you?

EMOTIONAL AND MENTAL HEALTH

- What helps you maintain your well-being? How can we help you to stay well?
- Do you know if you are becoming unwell?
- Is there anything that could help us identify if you are becoming unwell?
- Are there times when you have been able to overcome your feelings of depression, anxiety etc?
- Has your mental well-being ever caused harm to you or others?
- Have you or are you engaging with other services/support networks to support you with your well-being?
- How are external agencies helping you?
- Do you have a preference in your assigned team member in relation to supporting your well-being?

Our former induction process for new residents was a full day and involved going through and completing a huge amount of paperwork. It wasn't personalised to the customer and the risk assessment would ask about some very detailed issues that could be totally irrelevant to that person. The information in assessments and support plans often ended up being incomplete or even inaccurate as people didn't disclose all the information in that first meeting. As a result, when reviewed six weeks later, it could look as though the person's issues had escalated, when in fact they might be revealing the true picture for the first time.

We reviewed carefully what we actually needed to do so that we could scrap some of the paperwork. We then initiated a six-week induction process instead. Whilst some paperwork needs to be completed on that first day, we completed the rest gradually and only submitted our assessment paperwork in week six. As a result, information and goals are more honest and realistic.

We try to make people feel welcome on arrival. Everyone receives a Welcome Booklet on arrival with information about house agreements and positive information. There is less focus on 'rules' than previously' and language is more positive. We also have Welcome Packs for everyone who moves into our services consisting of a small toiletry kit. The pack can be expanded to include bedding or kitchen equipment if needed too.

Warnings and Evictions
Prior to working towards PIE we had already developed a new breach of license procedure but it was still very focused specific behaviours and their consequences with warnings leading to eviction. We have now introduced different levels and a range of support interventions that accompany them.

There are now three levels of 'breach'. Whilst previously any team member could give a warning, now it is a team decision if someone is to receive a level 1 or 2. If support is not successful and someone may be issued with a breach level 3 or NTQ, this can only be issued by managers following a reflective practice session. The aim is to prevent eviction as much as possible. There are still consequences for people who repeatedly breach the license agreement, but these aren't necessarily as black and white or authoritarian. Services are recognising that there are lots of alternatives to warnings and evictions.

For example, there was one individual who had a NTQ before Christmas last year due to aggressive behaviour towards another resident. Previously warnings would have required the individual engage with alcohol services but this was unrealistic and would have resulted in eviction. Instead the team took time to break down the issues in detail. They did some detailed work with him around his alcohol use. He was able to identify some triggers that lead to his drinking deteriorating and increased aggression. He was also able to avoid those triggers even though he did not wish to reduce his drinking. Staff also worked with him to identify the best ways to respond when he was feeling angry or aggressive. This particular person is still living in the accommodation nearly a year later. This is a good example of using Positive Behaviour Support (see below).

We have also changed how we notify residents about arrears. Language has changed to make them less aggressive. In an ideal world we would be able to separate support from housing management – however this is not realistic in our services. Instead we have adapted the process so that all arrears letters come from managers. This has enabled support workers to work collaboratively with residents to talk through the issues. In one service where this was piloted, there was a 27% reduction in arrears within the first month alone.

Key Features of Positive Behaviour Support:

The word 'positive' in behaviourial terms means 'adding to', so **PBS simply means supporting people to learn different behaviours**. It involves:

- Respecting individuality and how responses and behaviours are unique to the individual
- Identifying the function of behaviours to establish effective interventions
- Understand and recognise when certain behaviours occur
- Assessing the broad social and physical context in which the behaviour occurs - including the person's life history, physical and mental health, and the impact of any traumatic life events
- Planning and implementing ways of supporting the person to enhance quality of life
- Rejection of punishment as a response to behaviours
- Reduction of incidents through the development of adaptive behaviours
- Develops person centred risk management by involving customers in their own behavioural support plans, building skills and alternative approaches in adapting the behaviour

Staff training and support

Although it is important to change policies and procedures, a great deal depends on how these are delivered by staff. Staff need to feel supported to implement changes that can feel unnerving and can also take time to see results.

One solution to this is to develop a range of tools that can be used in different situations by staff. For example, rather than simply asking staff to use person-centred practice to work with customers after an incident, we have introduced the use of Antecedent Behaviour and Consequences (ABC) Charts and Wellness Recovery Action Plans (WRAP). These are both tools that have been professionally developed and, in the case of WRAP, extensively tested. They support staff to work through triggers, risks and incidents collaboratively with the resident.

The ABC helps staff to break down incidents. Although the ABC Chart itself is helpful, it is the accompanying information and guidance that demonstrates how staff can use this to gain a deeper understanding of the individual and the function of any behaviour that they are displaying.

WRAPs are designed for mental health wellness and are completed by the individual themselves. They detail information about how a person feels when things are going well and the different elements that are needed to make that happen (e.g. a good night's sleep, certain foods, exercise, seeing particular people). They also cover what might happen if things reach a crisis and how staff and others can intervene.

In addition to these tools, we have introduced Positive Behaviour Support Planning, Person Centred Risk Planning and have created a range of guidance and toolkits for staff to make use of. It is important that staff don't feel unsafe as use of previous tools (such as warnings and evictions) are reduced.

Although they had already done training, we felt that we needed to do more to support staff to deliver the approach. We have recently commissioned a five-day training course in much greater depth that will cover different aspects of the framework. Although we considered limiting this to managers, we felt it was essential for everyone to receive it if we want the approach to work. Every member of staff will be attending this course. Undertaking training on this scale can be expensive. However, the rewards come back in improving the quality and outcomes of our services.

We have also changed how we do our one-to-ones with staff. There was a level of fear that doing things differently would mean that they might miss targets at work. We have changed how we assess progress so that staff can meet their objectives in different ways. This should give them more confidence to try the new approach.

Making changes within strict constraints – Reading Borough Council Common Assessment Form

Background

Reading Borough Council has had a Common Assessment Form (CAF) for several years. The CAF is completed by any service wishing to refer someone into Reading's Homeless Support Services, which include supported homelessness accommodation, floating support and the rent guarantee scheme.

The previous version of the CAF had been in circulation for 4-5 years. Over that time, there had been significant changes across services who are now more focused on developing strengths and are more psychologically informed. Feedback from the weekly multi-agency referral panel and other partners was that the CAF was too negative. Individual forms were often simply updated meaning that information may no longer be relevant and risk profiles out of date.

Our brief

We took as our starting point the principle that it is not easy or fun to be assessed and talk about yourself to someone that you have just met for the first time. This can be a re-traumatising experience. We should be questioning why we ask people to complete so many assessments.

There were four main parts to our brief:

- Develop a strengths-based assessment tool.
- Focus on current information and relevant risk profile.
- Include the voice of the client and ask what they think works for them.
- Reduce duplication and the amount of assessments needed by making a Follow Me document that can be updated as people move between services.

Whilst we aimed initially to reduce the number of questions we were asking we found that we were unable to make cuts. Between the many services that used the CAF as a referral form, each question was a requirement for at least one service. As such our challenge was to make significant changes to the form, without changing the basic content.

What we did
We set up a working group of managers and frontline workers across our partnership and got feedback from service users. We also reached out to other areas to see what they were doing. We tried to match the CAF to the initial assessments that providers complete to reduce the need to repeat information at the referral stage and the providers' initial assessment.

What changed
We changed the language on the form to be more inclusive and strength orientated, with separate boxes for client and referrer comments. There were a lot of other subtle changes with the emphasis always on the client and what they think would/has worked for them. This allows the new provider to start risk management/support planning straight away. We produced new guidance and training for professionals completing the CAF. We also changed the front page to include all data we collect to make processing easier for us.

Guidance and Training
We recognised that how the CAF is used is as significant as how it is worded. We therefore produced guidance and training for professionals. The training includes a focus on things to consider which aims to ensure that the CAF is completed in a supportive way. This includes four key areas:

- Accessibility: we ask our referrers to consider their use of language, the level of literacy of the person with whom they are working, any mobility issues, risks and also the room in which the interview takes place. We recognise that the environment in which the assessment takes place is key to ensuring that the client has as positive experience as possible when completed the form.
- Existing information: we know that people find it frustrating and possibly re-traumatising to have to continually repeat information. We therefore ask in our guidance and training that staff pre-populate the form with information that has already been given. They can then use the meeting to check the details and support needs without forcing the individual to repeat information unnecessarily.
- Housekeeping: our training also includes a section on housekeeping as practical considerations can have a big impact. We ask referrers to book a room and allocate enough time so that they aren't hurried or interrupted. We also ask them to ensure there are comfort breaks and drinks offered. The aim is to create as comfortable an environment as possible.
- Consent: we also cover when to discuss consent and signing the CAF. It is important to get this right so that the person is confident about what will happen with their information and feels in control of the process.

Examples
Over the next few pages are extracts from our own and new forms, which demonstrate how we have made changes. As you can see, we are still seeking the same or similar information but there is a greater emphasis on hearing from the person themselves. The form is also designed to lead to a more conversational approach to each topic rather than asking direct questions and making assumptions from the outset.

OLD CAF Support needs section

LIVING SKILLS AND SUPPORT NEEDS

What are your client's primary and secondary support needs? exclude need to access accommodation	

Please summarise below how your client is able to manage with the following independent living skills including positive factors and give details if partner services will be putting support in place for them:

Living in shared or supported accommodation include history of rent arrears, any evictions or positive move-on	
Shopping, cooking and cleaning	
Emotional wellbeing health including social skills	
Budgeting and money management include payment of rent	
Personal hygiene	
Basic skills include literacy, numeracy and form filling	
Tenancy sustainment include antisocial behaviour issues, rent arrears and evictions	
Street-based activity include street drinking, begging or street-based sex work	
Other include any other addictive behaviour (for example gambling) or hoarding	

OLD CAF Support needs section

OFFENDING BEHAVIOUR

Offending history include dates	
Current legal status include whether on probation or police or court bail	
Details of any programmes attended to address offending behaviour	

SUBSTANCE USE

History of substance use include length of time using and amount/method of use	
Current substance use include amount used per week	
Treatment history include current prescriptions and motivation to change	

ALCOHOL USE

History of alcohol use include length of time drinking and impacts on functioning	
Current alcohol use include amount consumed on a typical drinking day	
Treatment history include work with treatment services and motivation to change	

OLD CAF Support needs section

MENTAL HEALTH

Details of any mental health diagnoses	
Current medication or treatment include dosages	
History of mental health and involvement with services include any hospital admissions and whether subject to s.117	

PHYSICAL HEALTH

Details of any physical health diagnoses	
Current medication or treatment include dosages	
History of physical health and involvement with services include any hospital admissions, whether registered with a GP and name of surgery	

LEARNING DIFFICULTIES AND/OR DISABILITIES

Details of any learning difficulties and/or disabilities	
Links with any LDD services	

OLD CAF Support needs section

	ADDITIONAL INFORMATION
Client comments include whether they agree with the information provided and whether they feel there is any further relevant information	
Strengths include what your client is good at and periods of their life when they have done well and achieved their goals	

New CAF strengths and support needs section

Strengths and Support Needs

Physical Health: Are you happy with your physical health? Do you have any current illness/conditions? How do these affect you? Are you on any medication? Do you generally seek and comply with medical advice? Include recent hospital admissions, risk information and GP details. Do you eat/sleep well?
Referrer's comments:

Tenancy Sustainment: What independent living skills do you have (cooking, cleaning, shopping, and paying bills)? Include any concerns about ASB, hoarding, evictions, previous stays in supported/shared accommodation
Referrer's comments:

Basic Skills/Training/Employment: Are you in employment currently or have you been previously? Do you have any training or qualifications? Do you need any literacy support? Have you ever had support for learning difficulties/disabilities?
Referrer's comments:

Finances: What's your income? Do you work/benefits? Do you have any debts and how did they occur? What are you like at budgeting? How can you be supported to manage your money? Do you have any repayment plans in place?
Referrer's comments:

Emotional wellbeing/mental health: Are you happy with your mental health? What impacts on your mental health? Can you identify any triggers? What helps you feel better? Do you have a formal diagnosis? Are you on medication? What should support providers do if you are experiencing mental ill health? Include information on self-harm and suicide (frequency, method) and current support or recent hospital admissions.
Referrer's comments:

Substance use/alcohol use: Do you currently use drugs (record the type(s) of substance, method, quantity, frequency length of use. Include any associated risks)? Do you want to make any changes? Has there been a reduction or cessation in use? How was this achieved? What are your triggers? What should support providers look out for? What should support providers do if they identify substance use or are concerned about it? Do you engage in any support? What is good/bad about it?
Referrer's comments:

Offending: What helps you to reduce your offending? What might lead to an increase? Are you currently on probation? Record previous convictions (type, frequency, date) any MAPPA, MARAC, DARIM, RSO details. Include any associated risk (domestic abuse, identify victims or perpetrators if appropriate).				
Is the client supervised by	**National Probation Service**		**Community Rehabilitation Company**	
Referrer's comments:				

Area-wide data management systems

This section grew out of a number of conversations with organisations and commissioners across four areas using shared data management systems. The content is based particularly on information from our three case studies, CHAIN (London), Mainstay (Merseyside) and GM Think (Greater Manchester).

A number of areas have developed area-wide systems for collecting certain types of information on people experiencing homelessness locally. Typically, a large number of services are able to input into these systems and view information. The systems are usually commissioned by one or more local authorities and delivered by a team within a local homelessness service.

The systems can make hugely positive contributions to tackling homelessness but they also come with challenges, some of which can be overcome with constant iteration but others are more endemic. The benefits and challenges vary greatly depending on the aim of the system and how successfully it is used. Some shared systems are designed to hold basic information only and others are designed to include full assessment information. Each model has different potential advantages and challenges.

Potential benefits of an area-wide recording system

- **Creating a comprehensive set of data on homelessness in your area** – as increasing numbers of services contribute information, a large dataset of information on people experiencing homelessness should develop. This level of data and information (if it is accurate and genuinely reflects the local situation) can be hugely useful for understanding needs and how to end homelessness in the area.
- **Reporting** – once you have a comprehensive dataset, it is possible to produce useful reports about homelessness in the area and support needs and to follow an individual's journey. This can flag up people who are circling around the system or where a particular service may be struggling. Being able to view homelessness from this broader perspective is enormously helpful for services and commissioners alike.
- **Identifying gaps and barriers** – having accurate data on people experiencing homelessness locally can help to identify unmet needs. Having clearer information on levels of substance misuse or mental health for example, demonstrates the level of need for these services. If it is also identified that particular groups are not accessing services, this can also support future commissioning. At the same time, you may also notice that certain groups are underestimated in your data which can suggest that those people are not accessing the services signed up to the shared system.
- **Mapping needs** – some systems are able to map where rough sleepers are located. This enables the area to create accurate 'hotspot' maps which can help to guide the work of outreach teams and commissioners.
- **Sharing information and avoiding duplication** – one of the most obvious benefits to an area-wide up data system is that services throughout the area can view up to date information on rough sleepers, their current support networks and their needs. This can avoid duplicate referrals and support work and ensure that there is continuity in the support that is offered to each individual
- **Avoiding repetition** – a related advantage is that the individual does not have to continually repeat their history to different workers. Information that has been shared in an assessment is already held on the system. It is clear from the input of people with experience of homelessness, that most people

prefer not to repeat the same information to different workers. A central source of information can prevent this. However, this depends greatly on the amount of information the system holds (in some cases systems intentionally only hold minimal data) and the accuracy of that information. It also depends on the number of services that have access to it. See case study on Mainstay for more information.

- **Consistency** – using shared systems can lead to a greater consistency in the types of questions that services ask across an area. The training that is received to gain access to the shared system can also ensure that services approach assessment in a more similar way. However, this will depend on the nature of the system – those that are designed to hold basic information only will have less impact on consistency as each service is likely to have their own assessment process separate to that related to the shared system.
- **Setting standards**– shared data systems can improve general record-keeping within services. In areas where services are included who previously kept only minimal 'tick sheet' type outcome data, using a shared system can lead to better monitoring overall. Ultimately having good information about the people using the service can ensure that it more effectively meets relevant needs.
- **Shaping practice** – shared data systems can improve practices such as joint working and referrals. Having information to hand about which services may be involved with the same individuals encourages contact and relationships between those services. It also encourages services to learn about one another and can lead to more appropriate referrals as a result.

Things to consider

- **Long assessments** – a potential risk of shared systems is that they can end up including a large number of questions in order to satisfy the needs of all the services involved. This is less of a risk in systems that hold basic information only and that sit alongside the support systems used within individual projects. Systems that take the place of referral forms for a variety of services are more prone to this. This can be minimised with different pathways being built into the system leading to different sets of questions depending on the referral. As a sector overall we are moving towards asking fewer questions and recognising that we should only ask what is essential to operate the service effectively. Care needs to be taken to ensure that shared systems avoid pulling in the opposite direction.
- **GDPR and data processing** – the more information a system holds, the more challenging this can be. This is particularly an issue if systems are set up to include support plans, written notes and attachments such as letters from GPs. Most systems can restrict access to an individual's profile to specific services but if that person is referred elsewhere and a new service gains access to their records, there is a potential risk. If the person in question gave their details to one service or groups of service, they may not have consented to sharing it more widely. While some information sharing by homelessness services may fall under a lawful basis for processing other than consent, it is not good practice to share data without the person's knowledge. In addition, consideration should be given to different types of data and special category data such as that contained in medical or other paperwork that may be attached within the system.[35,36]

[35] https://ico.org.uk/for-organisations/guide-to-data-protection/
[36] www.homeless.org.uk/introduction-to-gdpr

- **Data integrity** – a system that has several hundred users will inevitably have varied levels of consistency in terms of accurate data entry. It takes considerable effort to 'clean' the data by removing inaccuracies such as duplicate records. If this process doesn't take place the system becomes cluttered and full of inaccuracies. There is also an issue with missing or incomplete data. This is particularly significant if this data is key to understanding the particular case. As it takes time to build relationships with people who have complex needs, there may be missing information while a trusting working relationship is developed. However, it is important that this is continually monitored to avoid gaps becoming common and undermining the data set. See the case study on CHAIN for more information.
- **Inclusion / exclusion of services** – no system includes every service or drop-in within the locality. Inclusion is often limited to services commissioned by the local authority (where the authority is paying for the system) or to those that are better established. It is important to include only services that will comply with privacy policies and data protection. It is also important that services taking part have the time, equipment and training to enter complete and accurate data. Conversely, excluding services can be problematic as it can 'lock' particular organisations out of the broader referral and networking system. It can make it materially more difficult for smaller services to operate without duplication. In addition, it can be the case that well-established services are excluded from the system as they are differently commissioned or simply because the process for adding a new service is cumbersome. It is essential to consider the impact of including or excluding services when designing the system and to be continually reviewing this to ensure that people experiencing homelessness get the best possible service.
- **Facilitating or blocking access to the homelessness pathway** – a well-designed system can make it easier to access the homelessness pathway. Once information is held on the system, an individual can be more easily referred to services. However, if not working efficiently, a shared system can block access. This can happen if there are significant providers excluded from inputting data who work with client groups that are not accessing services elsewhere. It can also happen if there are barriers or thresholds to being added to the system that eligible people do not always meet (such as being seen by specific outreach teams or at certain times). If registration on the system is a condition for accessing the local homelessness pathway, a review should be undertaken to check for situations in which people may be unintentionally blocked from services. See case study on Mainstay for more information.
- **Designing your system** – it is hard to avoid being deficit-based in a shared system – as there is necessarily information that you want to include, you are guiding workers towards asking those questions. These topics usually include any risks, mental health needs or substance use. However some areas have made significant efforts to consult people with lived experience when designing the questionnaire and to be as person-centred and strengths-based as possible. See the case study on GM Think for more information.
- **Giving people access to their data** – it is worth considering whether people will be able to view their own records on the system. This can be complicated as all systems are password protected and it can be sensitive viewing notes made by a range of workers from different services. However, it should be considered good practice to make this option available for those who want it. See case study on GM Think for more information.
- **Buy-in from commissioners** – it is essential to have supportive commissioners who are prepared to fund the necessary staff to maintain the system successfully, and also use their influence to ensure

that information is consistency entered by services. They also need to be responsive in enabling change to happen as and when needed without unnecessary delays. All examples identified by this report are commissioned by a local authority or group of authorities. If a system were commissioned externally or funded through grant funding, the operator would need to work hard to ensure that services were fully engaged with the process.

- **Training** – all systems provide a form of training for new users. This training usually includes the practicalities of how to use the system alongside the basic principles and ideas behind it. In particular support workers should understand why certain data is essential and when making further notes is appropriate. Training may need to be updated and this is a consideration when designing a city wide system.

Mainstay – operated by YMCA Liverpool

Mainstay is a de-centralised gateway system across the Merseyside City region. All commissioned short term accommodation and floating support is accessed through the system. There is one common assessment that is completed and a prioritisation process is used to determine access to appropriate services. Services use Mainstay to complete assessments and also to record placements, support and outcomes. As such the system provides comprehensive data on needs, performance and demand to both services and local authorities.

Mainstay is currently in operation across six Local Authorities in the region. There are currently around 1150 users within 156 different services that are delivered by 55 providers. The system currently has information on 27000 clients of whom 9,000 are currently open. Approximately 300 new clients are added each month.

What is most unique about Mainstay is that it has created an unprecedented ability to access the homelessness pathway from any (signed up) service and at any time. Each day a number of services make themselves available for assessments. This includes a number of 24-hour services. As such someone finding themselves homeless should be able to have an assessment undertaken at any time of day or night. As there are multiple locations available, they can also go to the available service nearest to where they are or choose one that they feel most comfortable attending. In reality, assessments tend to fall to a smaller group of the better known services. Nonetheless, the ease of access to the homelessness pathway is unique.

Mainstay operates a matching system whereby services which are most suitable for the client will be allocated more points and therefore appear higher in the list of matches. Certain hostels are specifically for those with complex needs and certain groups such as rough sleepers may get priority. This has created a systematic method for allocating housing. It has also flagged up where there may be gaps in provision, for example for those with lower support needs or who may not be currently sleeping rough.

The system is also used to record comprehensive information on each client including information on support needs risks, referrals, support plans and case notes. To protect privacy, case notes are only visible to services working with the individual and the system will flag up a user attempting to view the notes for a client that is not working with them. Refuges have an additional option to protect the identities of those using their services. A huge range of reports can be provided giving data on all types of needs, referrals and outcomes.

There can be challenges with operating a large system. As with all the area-wide systems, it is necessary to ensure there is a consistently high quality of assessments and that data is entered accurately and comprehensively. It is difficult to avoid long assessments when the system functions as the assessment form

for so many different services although Mainstay has been set up to ensure that certain questions only appear if referring to specific services. The Mainstay team work continually to improve the service.

Some comments on Mainstay from those who have experience of it:

“I felt a little daunted as it was a big change. I would recommend that all Local Authorities adopt this method as it is a more streamlined method of meeting the needs of homeless people. It allows commissioners to collate more accurate and up to date quantitative data.” Area Manager for large provider.

“Previously I would have to complete many application forms and visit each service for a separate interview.”

CHAIN – operated by St Mungo’s

CHAIN is perhaps the oldest area-wide system in the UK, established in 2000. It is a system for recording information on rough sleepers and the wider street population in London, and is described as a key actions and outcomes system. It is explicitly not intended to act as a case management system or hold support plans.

CHAIN has approximately 800 users from around 70 different organisations. It is primarily used by commissioned outreach teams who input information on rough sleepers. This includes basic information including contact details and location and support needs. It is also used heavily by No Second Night Out teams who are working with those new to rough sleeping to find solutions to their homelessness.

A range of other services working with rough sleepers in London have ‘view only’ access. This enables them to look up information if a rough sleeper presents to their service but does not allow them to input information. This helps to protect data integrity whilst enabling them to contact appropriate support workers and avoid duplication.

CHAIN holds a comprehensive up to date information on rough sleepers within the London area. It includes details of street contacts and support workers involved, as well as referrals and stays in accommodation. As such it is an invaluable source of information about the changing needs of rough sleeping in the city.

In 2015 a mapping facility was added. This enables outreach teams to put a pin in the map where someone is sleeping (and if they are using the mobile version, it can automatically find their location). This allows the system to produce accurate maps of rough sleeping across the London area which is invaluable both for outreach teams and commissioners planning service provision.

CHAIN is also fully compatible with StreetLink, meaning that referrals received by StreetLink are automatically transferred onto the system including mapping information. This helps outreach teams to prioritise referrals and locate them geographically.

CHAIN has also recently developed a mobile interface to allow outreach workers to input information more easily during their shifts.

The database faces similar challenges to other systems. To tackle issues with data integrity, the CHAIN team creates monthly reports for each service giving them a compliance score. This flags up the percentage of missing essential data that is present across their entries. They also send each service a list of names for

whom different types of information is missing. This gives services the opportunity to complete missing information. Whilst the team understands that the nature of the client group means that complete data cannot always be obtained, it is important to continually strive to make data as accurate as possible.

GM Think – operated by Inspiring Change Manchester

GM Think (originally M Think) was created as part of the Fulfilling Lives project in Manchester. Its aim was to create a more joined up system and avoid people having to repeat their story to different disconnected services. GM Think aimed to help shape practice by improving information sharing, how services use data and by identifying gaps in service.

GM Think was developed around people and aims to have a person centred approach. A number of people were involved in its design including people with experience of homelessness. They talked about their experiences including missed opportunities and what they didn't want from a system. The system also aims to be values based with 'doing with, not to' at its heart.

As a result of this consultation, the system includes positive questions about an individual's ideas and ambitions and also uses inclusive language, asking questions of the individual rather than the support worker. It also includes safety plans rather than risk assessments. It does not include risk flags but rather uses a blue symbol to identify that a significant safety issue support need has been identified. The viewer can then click elsewhere on the system to see more information.

People are encouraged to have access to their own record. This would happen alongside a support worker and the individual would be able to view their front page plus any case notes recorded by that service. They can also see if case notes have been recorded by other services although not the detail. If they wish to view those they will be referred over to that service to have a look.
Training is a key part of GM Think and focuses on good practice, supporting users to understand how to share good information and why. Users need to gain an understanding of how their words may be viewed by another service in another context.

There are currently around 300 users of GM Think across 16 services. There are around 10,000 records on the system of which 3,000 are hidden (work undertaken by services working exclusively with sex workers remains hidden from other users). GM Think started as a system for Manchester and is currently being rolled out across the Greater Manchester area.

homeless link

What we do

Homeless Link is the national membership charity for organisations working directly with people who become homeless or live with multiple and complex support needs. We work to improve services and campaign for policy change that will help end homelessness.

Let's end homelessness together

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