PLANNED SUPPORT GUIDE

AN APPROACH TO CASE MANAGEMENT

QCOSS
queensland council of social service inc
WORKING FOR A FAIR QUEENSLAND

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03 ABOUT THIS GUIDE

This planned support guide is intended to help community sector workers understand and apply proven case management principles in their work with clients to improve long-term outcomes. It is intended to be useful to people working in any part of the sector where case management approaches could benefit clients.

The guide draws on a number of sources, including resources developed and used by Queensland services. It also incorporates evidence from research into good practice.

The guide was commissioned by the Queensland Council of Social Service (QCOSS) and its development was overseen by a reference group of sector representatives. Further information and resources are available at Community Door *www.communitydoor.org.au*

WHAT DO WE MEAN BY PLANNED SUPPORT?

Planned Support is an approach to case management that emphasises four key concepts:

Support: As the name implies, planned support involves proactively supporting clients to achieve their goals and negotiate the service system.

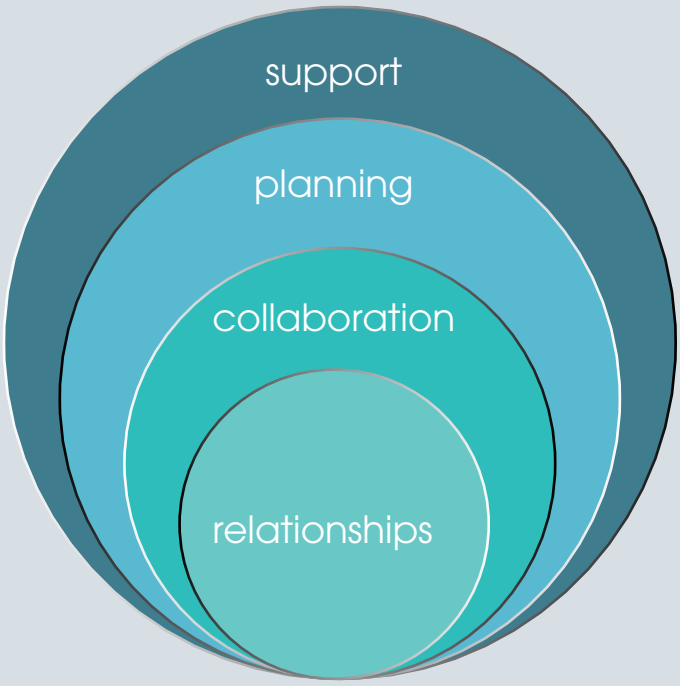
Planning: planned support ensures that support is purposeful by beginning with a plan that outlines the desired outcomes and how to achieve them

Collaboration: planned support is a collaboration with the client to work together. It also requires collaboration with other service providers to fulfil the range of actions outlined in the client's plan

Relationships: planned support depends on an ongoing trusting relationship between the support worker and the client to enable in-depth assessment of needs and help the client engage with the planning and action process.

The overarching goal of planned support is greater self-reliance in accessing short or long term services that may be needed.

Key Concepts



APPLYING PLANNED SUPPORT

This guide outlines the elements of Planned Support that together contribute to effective case management. This model can be adapted depending on the organisation's policies, procedures and guidelines.

Support Elements

WHY IS PLANNED SUPPORT EFFECTIVE?

Planned support may be labour intensive, but done well, research shows that it reduces the client's need to call on emergency and other services over the long term.
Planned support is effective because:

- the ongoing relationship between the worker and the client increases competence in taking action and accessing specialist support.
- the emphasis on support recognises the barriers many clients face and supports them to overcome these. The proactive approach emphasises direct service provision alongside referrals and advocacy as needed, rather than a "hands-off" referral-based case management approach.
- the individual support plan that forms the basis of the interactions between the client and the service system is directed at achieving the client's goals, broken into realistic steps to get there.
- the collaborative approach between worker and client encourages client engagement and self-reliance in the long term. Collaboration between the worker and other parts of the service system ensure the client can access as broad a suite of services as possible to achieve his or her goals.

WHEN SHOULD WE USE PLANNED SUPPORT?

Generally speaking, the more complex the client's needs, the more rigorous planned support needs to be. If a client has simple, short-term needs and no underlying issues are evident, there may be no need to embark on a planned support program.

Planned support may vary in intensity, with more regular contact at times of crisis or the beginning of the support relationship.

CULTURAL COMPETENCE

Planned support needs to take into account each client's situation including factors such as cultural and linguistic diversity or Aboriginal and Torres Strait Islander culture.

Workers need some understanding of the spiritual dimension entailed for some Indigenous clients resulting from separation from country and the radical disruption of culture and traditional kinship relationships. We also need to recognise the impact of personalised and systemic discrimination experienced by Aboriginal people and Torres Strait Islanders.

Cultural competence requires workers to have sensitivity to the diverse cultural beliefs and practices of others. Workers need to develop knowledge and understanding about the client's own culture while also understanding that the individual and his/her situation is always unique. (QCOSS, 2008, A Matter of Interpretation)

Some people may prefer workers who are specialists in their culture or area, others may be more comfortable with a mainstream service provider.

05 ENGAGEMENT AND INTAKE

WHAT DOES IT MEAN?

Engagement and intake occurs when you begin to establish a working relationship with a client. It includes accepting someone as a client, and establishing a relationship with them so that you can work together to achieve their goals.

For the consumer, engagement means feeling believed and respected, that their individual circumstances are understood, and that the worker is likely to be useful. For the worker, engagement means knowing enough of the consumer's circumstances and wishes to advise them confidently of their options and advocate on their behalf. (Opening Doors Framework, Victorian Government, 2008)

WHY IS IT IMPORTANT?

Intake isn't just a matter of checking that someone is eligible for your service and whether your service has the capacity to work with them. It is also a start to the support relationship. It's important to view the intake stage as an engagement process as much as a screening process.

This stage of the relationship is also a good opportunity to help people to clearly understand how your service can help them. It's a chance to begin to understand their needs and goals, particularly their most urgent issues.

Research shows that people go through a number of stages when contemplating change as shown below (from McCurdy and Daro in Cortics et al 2009 quoted in The Next Step Practice Manual).

Engagement is an important opportunity to help people shift from considering using the service, to readiness and then action.

HOW DO YOU DO IT?

1. Make sure other services in your area know what your service can do so that you receive appropriate referrals – you can do this by writing, ringing or visiting, having an up-to-date website, distributing service brochures and/ or participating in networks or inter-agencies.

2. When a potential client is referred to you, introduce yourself, try to put the person at ease and explain what your service does.

3. Seek the information you need to establish whether you will be able to help, including whether the client is eligible under your service's guidelines.

4. Clarify whether your agency is best placed to be the lead agency in a case work situation – if not you may need to establish a referral to another agency to take on that role, although you may still be able to help with part of the client's needs.

5. If you can't help, refer the person to someone who can. Some of the people who most need help can `fall through the cracks', disconnect from services or give up on help-seeking at this point. Increasingly, networks of services or consortia are working closely together to make it as easy as possible for a person to find themselves in front of a worker who can provide a practical response.

6. If you need to put someone on a waiting list, give them a realistic indication of how long they are likely to have to wait, and try to organise interim responses to their urgent needs until then.

7. Explain the process of working together, including your service's approaches to planned support. Provide information about any complaints or appeals processes available to the client.

8. This is also a chance to identify any special needs or requests the client may have – cultural issues, disabilities etc – so that your service can respond appropriately. For example, some people would prefer to work with someone from their cultural background if possible.

9. Depending on your organisation's procedures, gain consent from the client to provide services and to share information as appropriate. Be clear about what sort of information might be shared and with whom. This is important to establish a respectful working relationship.

10. Meet urgent needs fast by offering concrete assistance quickly, particularly where there is a crisis.

11. Use outreach where possible rather than expecting people to come to you. This is particularly important with hard-to-reach client groups.

12. If the referral has come from another agency, it may be appropriate to let that agency know about the outcome of the referral. This is courteous, it helps demonstrate your interdependence and accountability in the wider service networks and helps the referring agency know if the client's needs are being met.

Available evidence indicates that six months may be the minimum required duration to establish a working relationship with people experiencing homelessness and mental illness, and more than six months will be required for the most disengaged clients. (Gronda 2009)

HERE'S AN EXAMPLE ...

A family support service received a referral from the Department of Child Safety for a family considered at moderate risk of harm to children. The support worker contacted the family and arranged to meet them in a local park. She took afternoon tea and used the occasion to introduce herself and her service, to observe the family and to start discussions about what they thought they needed to cope better. Over a number of visits in the family's home and the park, the worker built a relationship which allowed the mother to confide her fears and hopes as the basis for starting to plan for change.

Tips from the field

- "Be honest about what you can do and don't make promises you can't keep. Say you are sorry if you can't meet their needs and start working on a creative solution with the family." (Homelessness to Home)
- If people have had bad experiences with services in the past this will affect how easily they will engage with you.
- Doing something practical to help demonstrates your service is relevant, and shows respect and empathy.
- Some of the most useful conversation and work happens while you are involved with a client in practical tasks – driving a person to their hospital appointment means they are accessing a health service but it is also invaluable time to talk and strengthen the relationship.
- Focus on engagement not paperwork the first time you meet a client – forms can be intimidating and impersonal. However good administration supports good outcomes!
- It can help to have a client information brochure about your service for clients and potential clients to take away with them - edit any brochure text to make sure it is plain English or accurate translations, and make sure you tell clients about their rights.
- Keep trying!
- Service users may have barriers to accessing your service – think about it from their perspective. Make sure your service is welcoming and that you have realistic expectations of clients' confidence or literacy levels. Consider meeting in a place where the client feels at ease.

Further resources ...

Community Door
www.communitydoor.org.au/voice/standard1-6
has examples of some relevant tools and resources including:

Defining eligibility: Many services have an eligibility/ access policy and prioritisation guidelines to help you be clear about who you can work with.

Entry/ screening tools: Some services have forms or procedures for accepting referrals to make the intake process easier. Sometimes these tools are shared across agencies.

Client information brochures: client information brochures tell clients what they can expect when they work with your service.

07 ASSESSMENT

WHAT DOES IT MEAN?

Assessment at the start of the service relationship focuses on preparing for the planning phase, as well as identifying and responding to any short-term crises. Ongoing assessment continues alongside actions and services over time as you work with the client towards achieving his or her goals.

In a planned support approach, service users are treated as full partners in the assessment process. This sets up the planned support process as shared work with them.

WHY IS IT IMPORTANT?

Like a medical diagnosis, assessment helps the service and the client work out what they need to do to achieve their goals.

Case management ... deliberately starts from the perspectives, interests, wishes, capacities, fears and desires of the person requiring care and their immediate 'others' (Moore and MacDonald, 2009)

Assessment is the chance for you and your client to understand the clients' strengths, needs, resources and goals as the basis to develop a plan. It is a useful opportunity for reflection for the client as well as for you.

Case managers emphasised the importance of flexible and creative interventions in response to a dynamic and ongoing assessment of the person and their situation, commenting that 'what works' will depend on the person (Gronda, 2009)

HOW DO YOU DO IT?

1. Establish the sorts of information you need as a basis for working with a client, thinking broadly about what aspects of a person's life will impact on his or her ability to achieve their goals. This may include information about health, housing, finances, skills, employment, literacy, social and family supports, relationships with other services, and cultural identity.

2. When a client is distressed or in a crisis, deal with the immediate issue first rather than expecting the person to participate in a comprehensive assessment.

3. Clearly explain to the client how the assessment process works and how it fits in the planned support process. The client needs to understand and support the purpose for your information gathering for this exercise to be successful.

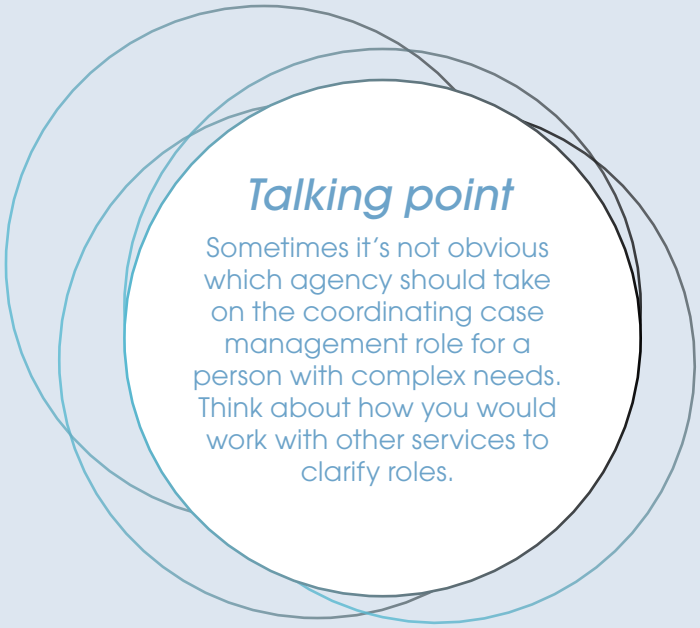
4. Work with the client using your assessment tools – this might be a form or checklist or another purpose-designed way to collect information and gauge the current situation.

5. Consider whether it is useful to access assessment information from other services with whom the client is involved (with the client's permission).

6. Part of an assessment is usually assessing risk, such as the risk of self harm or harm to children or family members. If such a risk is identified, you may be required by law to make notifications to relevant authorities. You may also need to access specialist help at this point.

HERE'S AN EXAMPLE ...

A mother in transitional housing is being supported to become less isolated, link with the play group and kids' swimming classes that cater for very young parents. She discloses that a former de facto partner is threatening serious violence. The housing worker contacts the regional domestic violence prevention service for help to create a safety plan and find out what legal and support options the woman has.



Tips from the field

- Don't get too caught up in getting an assessment in one session. It usually comes in bits and pieces as your relationship with the client develops. Add the information to the client's assessment file as it emerges.
- Focusing on the client's strengths as well as their needs is more likely to lead to a plan that is successful.
- If needed, allow time to set up the appointment with a qualified signer or translator present or on the phone. Anticipate how to cater for children who might be present.
- Assessments should take place in a quiet, private place.
- Allow enough time for the client to really consider the information without feeling rushed– this may mean an initial assessment goes over a number of sessions.
- Some clients will feel comfortable filling out a form independently, but many others will need the assessment to be collaborative with a worker.
- Be aware of your reactions so that you don't appear negative or judgemental when people disclose information.

Further resources ...

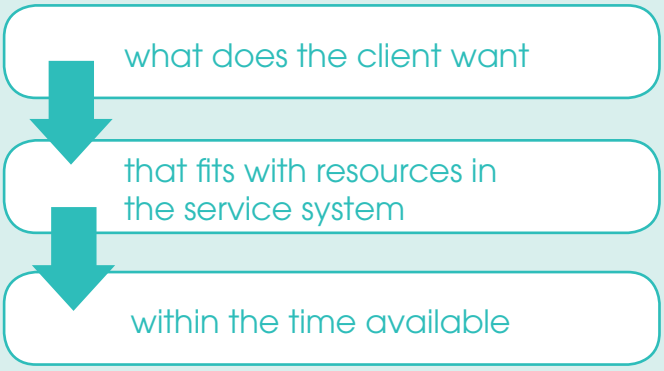
Assessment tools: there is a wide range of tools people can use, whether developed internally within organisations or shared from other services. An example is the "Outcomes Star" range of tools that allow client and worker to measure a person's current position on each of ten outcome areas relevant to their situation: www.outcomesstarsystem.org.uk/

09 PLANNING

WHAT DOES IT MEAN?

Planning helps the client articulate the goals they want you to help them achieve, and the steps or actions that will be needed to achieve these. The resulting Support Plan uses the information collected during the assessment process to help the client come up with a way forward. It is a tool that creates focus and sets some realistic boundaries around the work you can do together.

The Support Plan identifies the actions that your agency can help with, as well as support needed from other agencies. It matches the client's needs with the available resources.



WHY IS IT IMPORTANT?

It is easy to get caught up in day-to-day service delivery meeting people's immediate needs. Developing a support plan is a chance for you and your client to step back, work out what the end goal is for your work together, and think through the steps that are needed to achieve those goals.

Collaborative planning with the client helps them build self-reliance and play an active role in achieving the results they want.

Collaborative planning is partly to increase the client's engagement with the plan, but it is also a key tool in building trust by showing competence (Ballew and Mink, 1996).

HOW DO YOU DO IT?

1. If you are the overall coordinator for a client's planned support, your plan will be overarching and may include roles for other services or workers. If you are providing a service within a broader plan, your plan will focus on your specialist support but link with the over-arching plan.

2. Work with the client to identify their primary goal for their work with you – this goal should be measurable so the client knows when it has been achieved. (For example, to complete repayments of a particular debt by paying $100/month for six months.)

3. Think through the milestones or steps that may be required to work towards this goal.

4. Identify with the client any barriers to achieving the goal, and work through strategies to overcome these obstacles where possible.

5. Identify the actions that need to be taken, who needs to take them, and when they will be taken. This may include your service, the client and potentially other services with specialist roles.

6. Research the availability and capacity of other services that can support the client to achieve parts of the plan.

7. Give the client a copy of the plan, making sure it is written and presented appropriately.

8. Keep refreshing the plan as work with the client proceeds to make sure it stays current and reflects changes in the client's circumstances.

Case planning processes acknowledge the fact that client's needs are often best served via collaboration between specialised services. Case planning processes incorporate the coordination of specialist services where relevant to the clients' needs, and case plans and service strategies may be formally shared amongst one or more providers. (Mission Australia Case Management Approach 2010)

HERE'S AN EXAMPLE ...

A Gold Coast man with schizophrenia was sleeping rough after his condition worsened. When a support worker from a homelessness service worked with him to establish his goals, it emerged that his driving motivation to get secure housing was so that he could resume making art and get a computer to do design. With the worker, he identified steps including stabilising his mental health, finding supported accommodation, sorting out his income support, linking with social networks, improving his living skills, gaining part-time work and ultimately entering public housing and buying a computer. This ambitious plan had to be adjusted after the client's condition escalated again, and he adjusted his goal to doing voluntary graphic design work with a mental health organisation once his health stabilised. Art was his real driver, rather than ending his homelessness.

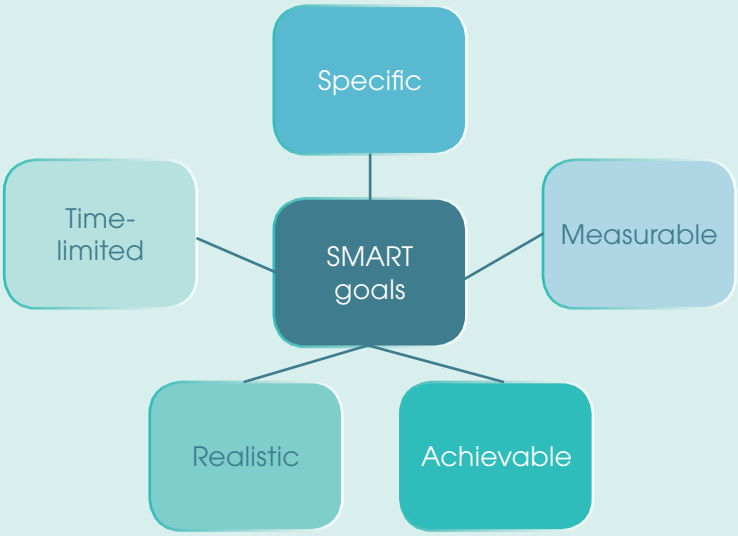
Talking point

Plans are more effective if they're shared by agencies and workers supporting a client. Think about how you can share support plans across agencies or workers.

Tips from the field

- Planning is mostly about listening and exploring so that it reflects the client's goals and motivations. They might need help to identify the driving motivation – listening respectfully will help you make suggestions to help.
- Goals should be achievable, broken down into small steps that can be celebrated along the way.
- Clients should feel ownership of the plan – it needs to be expressed in their language, or even pictorially if literacy is an issue.
- Expressing goals in positive terms changes the perspective completely (e.g. "Jon will not argue with his neighbour" vs "Jon will develop good relationships with his neighbour")
- If the client is not able to achieve a goal, the fault is likely to be with the goal – adjust the plan to make it achievable.
- As well as achieving the client's primary goal, the plan should include actions to encourage self-reliance, such as development of skills and resources.
- Planned support workers are regularly confronted with challenges in this work – it's important to remember to approach each person as an individual rather than a 'substance abuser' or 'mentally ill person'. It is equally important to have professional supervision and professional development to strengthen reflective practice and learn new skills.

Micah Projects uses the SMART goals acronym in planning with clients:



11 IMPLEMENTATION

Part A. Direct service provision

WHAT DOES IT MEAN?

Direct service provision means offering comprehensive and practical support and services to help your client achieve their goals and become increasingly able to manage their own circumstances.

Within a case work approach, the services you provide are based on the goals and needs identified in your planning with the client, along with the advocacy and referral work you do. At times, you may need to work with the client to overcome crises or barriers before they are able to "move on" with achieving their primary goals.

WHY IS IT IMPORTANT?

Sometimes case work has emphasised referral and brokerage – coordination rather than intervention. While these can be important, evidence suggests that the best results are achieved by providing direct support within the context of a sound plan and strong relationship developed over time with a client.

This may be supported by referrals to specialists for needs that your organisation is unable to meet.

Comparative studies have shown that case management is most effective when it provides direct assistance with practical and specialist support needs. (Gronda, 2009)

How do you do it?

1. During the assessment and planning phases you will have identified the support that you and your agency can offer the client.

2. Be clear with your client from the start about what you can and can't do. Include this in your client information brochure.

3. Keep the plan and the client's primary goals in mind, and focus your service provision on doing what it takes to achieve these goals.

4. Work as a team with the client whenever possible so that they remain in the driver's seat

5. Deal with crises as they arise to help mobilise the resources your client needs to stabilise their situation so they are in a position to continue to work towards their longer term goals.

6. Be flexible – build in opportunities for re-assessment of the client's plan so they can see how they are going and make changes as needed.

7. Keep good notes and records as you go to help assess progress and allow for continuity of service. These should be factual and concise.

HERE'S AN EXAMPLE ...

A regional domestic violence service worked with a woman and her three children. The case worker started by providing counselling for the woman, and included the children in the service's children's group program. As the client's confidence increased, she decided to leave the relationship. The case worker assisted her to take out an order against her partner and to move into a shelter with her children before finding permanent accommodation. The case worker still makes contact every two months to see how the family are going and actively assist if required.

Tips from the field

- Basic concerns such as safety, critical health care, food, income, and housing must be addressed first. Practical support can include assistance to obtain food, receive medical care, and access stable accommodation.
- Work as a team with the client or family, engaging and building their strengths and abilities as you support them.
- Outreach – visiting clients in their own environments – can help clients feel comfortable and in control.
- In a crisis or in the early stages of working with a client you may see them very frequently – be prepared to renegotiate this as you proceed

Further resources ...

Working within the rules: Direct service provision should be guided by your organisation's policies, procedures and guidelines.

Improving your practice: It's worth keeping in touch with good work in your field by joining a network or professional association, reading professional publications and attending conferences or other professional development when you can. Joining QCOSS is a good place to start.

13 IMPLEMENTATION

Part B. Referral and service coordination

WHAT DOES IT MEAN?

Planned support, or case management, is often broad, including a number of workers or organisations who are supporting the same client.

In case work, referral means helping a client to get a service they need from another organisation or from another part of your agency. Referral does not mean just telling a client about another service. It means making direct contact with the other worker, either with your client or on their behalf.

Making a referral is an active process which ensures that the client has been accepted for assessment by another service and is willing to become a client of that service. (Case Management Resource Kit for SAAP Services)

Service coordination means working with other workers or agencies to make sure a shared clients' needs are being met effectively. It includes sharing information (with the client's consent).

WHY IS IT IMPORTANT?

While research shows that direct service provision is most beneficial to clients, some people need specialist help, or could benefit from services offered by other organisations as well as yours. The aim is to make it easy to find the help that's needed - clients shouldn't need to be experts in the welfare system!

There is evidence that referrals without ongoing support, follow-up and coordination can undermine outcomes for clients. However, referrals can be effective when a needed service is available to clients, and when the referral is backed up by active, practical support that helps the client establish and maintain a working relationship to the service (e.g. providing transport to appointments) (Gronda, 2009).

There are often many structural and personal barriers for individuals or families accessing other services. An effective referral will identify and take action to reduce those barriers. (Planned Support and Advocacy Guide, Micah Projects Inc, 2008)

Service coordination is important to make sure clients don't fall through the cracks when more than one agency or worker is supporting them.

HOW DO YOU DO IT?

1. Identify appropriate services that your client needs to implement their plan or deal with a crisis, and discuss this with your client.

2. Identify how much support your client needs to access the other service. Initially many clients need you to work with them or on their behalf to secure the service they need. You may need to attend appointments with the client.

3. Discuss with your client how much information they are happy to share with the other service – it's important to respect their privacy and autonomy.

4. Establish clear arrangements with the other service and with your client about how the service can help your client, who is doing what and how you will communicate to make sure your client achieves their goals.

5. Follow up with the other service and/or with the client to make sure the service has been provided as agreed, and to check on progress.

6. If there are services you often collaborate with, consider developing streamlined procedures between your organisations for making and receiving referrals and for sharing information.

HERE'S AN EXAMPLE ...

A young client referred to a supported accommodation service was struggling to maintain stable housing because of her mental health issues and lack of income. During the client's stay in supported accommodation, the SAAP worker helped the client to link with the local youth mental health service to stabilise her condition. The SAAP worker drove the client to appointments with a psychiatrist until the client was able to make her own way there. Once her condition was stabilised, the SAAP worker made contact with an employment program that specialised in training and placing people with mental health issues. The employment service has begun working with the young woman to help her in an administration traineeship.

Further resources ...

Knowing who does what: Directories such as the Lifeline service finder, infoXchange service seeker and local service directories are a starting point. Local interagency networks help you make personal contacts with other services that can benefit your clients.
Try *www.serviceseeker.com.au/*
or *www2.lifeline.org.au/service_finder/*

Knowing how to share information: if your organisation doesn't have policies on client confidentiality and information sharing, refer to privacy laws in your state. The Case Management Guide for SAAP Services includes examples of referral and client consent forms. It's available from the National Homelessness Information Clearinghouse *www.homelessnessinfo.net.au*

Agreements with other organisations: Community Door *www.communitydoor.org.au/collaboration* has lots of examples and information about collaboration including guidance about Memoranda of Understanding and other collaboration tools.

Tips from the field

- Try to establish friendly professional relationships with workers in services where you refer clients. It's good to know their direct contact details and also to know the name of their team leader or manager in case things go wrong.
- Be really clear with clients about what the referral means. If it's the end of your provision of service for them they may feel "palmed off". Consider being open to ongoing contact (with clear boundaries).
- Keep in mind that some agencies, like Centrelink, are governed by legislation that may constrain information sharing. Formal approaches may be required and things may sometimes be slow to change.
- If the other agency and the client are willing to participate, a case conference can allow for collaboration and information sharing.
- You need to support referrals even when they are within your own organisation – don't assume another worker in your agency will automatically give the client the support you think they need without your proactive communication.
- Be honest – when you are making a referral you need to make sure the other service has the full story presented in a positive way, and also that your client understands the role, policies and criteria of the service you are referring them to.
- Skype can be a great tool for connecting with other service providers to review a client's progress.

Talking point

Sometimes there are no specialist agencies in your area that you can refer a client to. Think about creative approaches to this situation – what would you do?

15 IMPLEMENTATION

Part C. Advocacy

WHAT DOES IT MEAN?

Advocacy on behalf of a client means interceding so that your client receives access to a service or facility. It may be a follow-up to an unsuccessful attempt at referral.

Advocacy includes helping clients to develop the skills to advocate for themselves and negotiate to obtain the services or resources they need.

Advocacy can also refer to lobbying for better service responses or funding for a group of clients within the service system in your area.

Advocating for your client will require excellent knowledge of what is available within the service system and skills in networking and negotiating across that system.

WHY IS IT IMPORTANT?

Clients can face structural barriers to accessing their rights and entitlements. They may lack the confidence or skills to overcome these barriers, or they may have had bad experiences in the past. Advocacy can help them get fair access to things that might seem out of reach otherwise.

HOW DO YOU DO IT?

1. Get the client's written permission to advocate with or for them

2. Have your facts straight and your approach thought through before you make contact with your "target"

3. Find out who you need to talk to – who can make the decision you need made?

4. Contact the decision maker, ideally with the client there so they can hear the conversation

5. State the case for your client assertively and clearly, and be direct about what you want the other person to do

6. Follow up if required, for example by providing a request in writing or more information

7. If you are unsuccessful, you may be able to escalate. You could speak to someone higher up the hierarchy in the other organisation, check with someone in their funding body, or you could ask someone else in your own organisation to take up the case.

HERE'S AN EXAMPLE ...

A Youth Support Coordinator in a school was working with a student who had become homeless. The client was unwilling to approach Centrelink for income support, having been previously told by counter staff that he did not meet the criteria. The Youth Support Coordinator contacted the social workers in the regional office and restated the client's case. She attended an interview with the young person, helping him compile records and letters of support from the school to back up his case, which was successful.

Tips from the field

- Make sure you have the person's consent before you act on his or her behalf
- Your role is to ensure that your client's voice is being heard and considered.
- Try meeting in person – it makes you harder to say no to!
- Be persistent
- Don't create unrealistic expectations for your client

Further resources ...

Understanding your client's rights: you may need to check with funding guidelines or legislation to know what your client is entitled to.

Building your skills: Advocacy is largely based on assertiveness and communication. You might like to consider improving these skills as part of your professional development.

Changing the system: there are some useful guides to systems advocacy available. Check out Community Door *www.communitydoor.org.au* for examples.

17 MONITORING AND REVIEW

WHAT DOES IT MEAN?

Monitoring and review means evaluating progress on the support plan to determine whether it is effectively meeting goals or whether the plan needs to change. A plan will usually include review dates to ensure this happens regularly.

WHY IS IT IMPORTANT?

Regular and scheduled monitoring allows you and the client to celebrate achievements, review progress and plan the next steps. It's also a chance to begin to work towards exit planning once the client has made significant progress.

Monitoring is also a chance to check that the service system is working as it should. If a need is not being met because a service is unavailable or unwilling to help, then advocacy or a change of plans may be needed.

HOW DO YOU DO IT?

1. Review can take place one on one with the client or in a case management meeting including workers from other services that are working with the person.

2. Work with the client through a review of achievement against the plan.

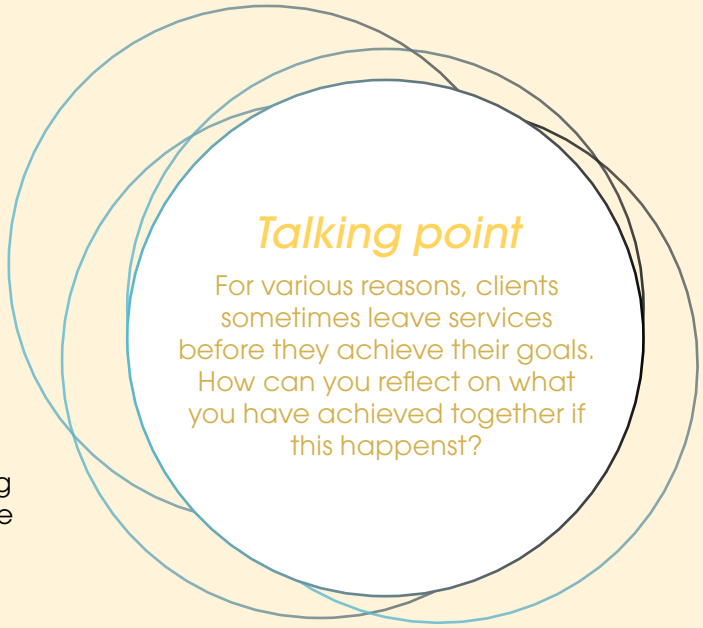
3. You may also work with the client through an analysis of change compared with the original assessment tool.

4. Reviews can be scheduled regularly (e.g. every four months) or triggered by a change in circumstances.

HERE'S AN EXAMPLE ...

A homeless outreach service has successfully engaged with a man with a mental illness who has been a rough sleeper for many years. He has made very minimal and reluctant use of services in the past. The support plan consists of a verbal agreement to attend a dental appointment on an agreed date, accompanied by the worker to receive treatment for severe tooth decay. The worker explains the situation and arranges for an understanding dentist to see the client outside usual hours to reduce the stress for the client.

When this is achieved, the worker congratulates the client on his follow through and encourages him to set another goal. Over a two-year period, and a continual process of setting, achieving, reviewing and re-setting goals, the man has begun to access several of the services he needs, some of them independently, and he is hopeful enough to set some longer term goals around becoming well and housed.



Tips from the field

- Reviews can be a reminder to both you and the client to "do your homework" so that you proceed with an agreed action – they can really help keep things moving along.
- For some clients, circumstances change fast and often. Never-the-less, keep your focus on the person and helping their self-reliance to grow and don't worry if last week's support plan looks suddenly outdated. There is no shame in reviewing and changing it when the dust settles.
- Good work is never wasted, even if people "drop out" from a program before they complete their plan.

18 EXIT PLANNING AND CLOSURE

WHAT DOES IT MEAN?

Exit planning is the process of helping a client prepare to maintain their progress without the support of your service. Research shows that the quality of the worker-client relationship is the most significant factor in successful planned support. (Morse, G., 1999 cited in Gronda p. 93). It follows that ending that relationship may well be a significant milestone bringing a sense of loss as well as an opportunity for the client to adjust and keep going forward.

Depending on the nature of your service, closure may involve a transition to more informal support, more remote monitoring by your service or a referral to mainstream organisations.

WHY IS IT IMPORTANT?

Exit planning is a supportive way to help clients prepare to continue without the service you have been providing.

Some services have guidelines that only allow service provision for a time limited period.

HOW DO YOU DO IT?

1. Exit and closure should be flagged at the assessment and planning phases so that clients do not feel suddenly "abandoned".

2. At each review, you should talk about the aim of independence from the service once goals have been achieved.

3. When you begin exit planning with the client, ask what support they will need to finish working with you, and work on a plan to access this support from your own or other agencies.

4. An exit meeting is a chance to review achievements and progress and adjust goals.

5. Provide information about how the client can access your service again should the need arise.

6. Follow the procedures of your service for exit documentation, file closure and secure archiving.

HERE'S AN EXAMPLE ...

Planned support ends with a client with a disability who has reached her goal of moving into her own unit with support services visiting to help manage some of the daily tasks. The worker and client have a final meeting to look back over the achievements and acknowledge the good efforts of both parties. They identify potential challenges that could arise and how the client could access the sorts of support needed to deal with these. The worker voices her respect for the client's determination and they both acknowledge the sadness of the end of the relationship as well as the happiness that the client's prospects are now much brighter. The worker explains what will happen to the client's confidential file.

Tips from the field

- Ensure the client does not feel "palmed off". Remain open to contact with clear boundaries, so that the client has a safety mechanism if they need it.

Further resources ...

Exit interviews: some services use an exit interview to review and celebrate with the client. See a sample exit review profile at Community Door
www.communitydoor.org.au/voice/standard1-6

19 EVALUATION

WHAT DOES IT MEAN?

Evaluation means measuring the success of your work with a client, from their perspective as well as from yours. Evaluations of each "case" can also feed into overall evaluations of a service or program.

Evaluation is likely to include:

- achievement of client outcomes
- client satisfaction with the process
- client satisfaction with the support worker's performance
- reflections from the support worker.

WHY IS IT IMPORTANT?

Evaluation of each case allows your service to identify things that worked and opportunities to improve. It also offers an opportunity for the client to reflect on their progress. Evaluation may be required by your funding body.

HOW DO YOU DO IT?

1. Ideally clients will provide feedback independently e.g. through a feedback form or interview that seeks their opinion about what worked for them and what improvements would have helped.

2. An exit interview allows your service to ask open-ended questions to get feedback.

3. It can be useful to seek quantifiable measures such as satisfaction ratings on a scale of 1 to 10, or measurable outcomes such as reduction in hospital admissions, depending on the nature of your service. Think through what measures will be most revealing and meaningful for your service.

4. Some services invite clients to forums so that they can provide input to service reviews or program design processes.

HERE'S AN EXAMPLE ...

An Aboriginal and Torres Strait Islander health service surveyed clients about whether they were satisfied with the services, what they liked about it and what this disliked. They outsourced the surveying to an employee from an Aboriginal and Torres Strait Islander service from a nearby town so that clients felt more able to disclose their views. It was explained that no names would be taken or passed on. The result showed that the lack of child-friendly offices and waiting areas was creating stress for parents needing services.

Tips from the field

- Evaluation can be simple – make sure you focus it on things you really want to know about your work.
- Evaluation can focus on effectiveness, processes, efficiency (or cost effectiveness), outputs or a combination of these.
- Plan what evaluation will look like and how to do it right from the outset – it is often too late to collect data right at the end of the financial year or the end of the project.

20 REFERENCES

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