

Specialist Homelessness Services Case Management Resource Kit

February 2012

Version 1

Foreword

Tackling the complex problem of homelessness is not just about providing a roof overhead. It is also about helping people get the support and skills they need to cope with the difficulties that arise in their lives, enabling them to stay in their accommodation in the long term and contribute to society. Case management is a key component in providing this support, by helping to address a wide range of client needs.

To effectively reduce homelessness we need an integrated and coordinated service system that puts people at the centre of what we do, supporting them to access a broad range of services.

Addressing homelessness means shifting the service system away from short-term and crisis solutions to providing long-term accommodation and support to people who are homeless or at risk of homelessness.

The NSW 2012 State Plan and the NSW Homelessness Action Plan commit NSW to reduce the number and rate of people who are homeless through the following targets:

- 7% reduction in the number of homeless people by 2013
- 25% reduction in the number of rough sleepers by 2013
- 33% reduction in the number of Aboriginal people who are homeless by 2013
- reduction in the number and rate of people experiencing repeat homelessness.

Effective case management is vital if we are to have an impact on reducing the number and rate of people who are homeless. This resource aims to help us work with clients in a way which respects them as individuals, ensures their particular needs are being met and assists them to achieve their goals.

Case management has clear benefits for clients and service providers. It means clients have better access to improved services and are empowered to make decisions about the support they receive. For service providers, case management reinforces shared responsibilities of clients and the services that work with them, and helps to identify the client's strengths.

Of course, case management requires a true partnership approach and a commitment to work across service boundaries – with clients and other homeless people, and specialist and mainstream services. This can cut across multiple areas such as health, income, legal or educational services, which help people to keep their accommodation and live independently or semi-independently, preventing them from becoming homeless or being at risk of homelessness.

There is a solid history of the government and non-government sectors working together to help people who are homeless. This resource kit was developed with the non-government sector and will be reviewed to ensure it continues to meet the needs of service providers.

Thank you to everyone who provided input, guidance and support in developing this key resource to support our work together to reduce homelessness in NSW.



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Section 1: Introduction

Case management is the key to assisting and working effectively with people who are homeless or at risk of homelessness and who have a range of complex needs.

If we are to achieve a real reduction in the number and rate of people who are homeless, we need to strive for effective case management. This resource aims to help us work with clients in a way which respects them as individual people, who have particular needs and goals that we can help them to achieve.

Effective case management can benefit our clients greatly. It improves the quality and range of services they receive and their access to them, which results in more successful outcomes. It enables more focused interactions between the client and the worker, and helps identify client strengths. If clients are involved in making decisions about their lives and the services they need we also empower them as people, assisting them to better manage their future.

Effective case management is about a true partnership approach with other providers and the client themselves. Case management requires a commitment to work across service boundaries – with clients and other homeless people, and specialist and mainstream services. This includes health, income, legal or educational services which all combine to help people keep living in their accommodation, either independently or semi-independently; preventing them from becoming homeless or being at risk of homelessness.

1.1 Overview

The Specialist Homelessness Services (SHS) Case Management Resource Kit 2012 builds on the 1997 Case Management Resource Kit developed by Lesley Gevers of Community Management Services. This new resource kit is designed to give SHS services up-to-date guidance on the delivery of case management that reflects evidence-based best practice and aligns with new Commonwealth and State policy directions in responding to homelessness.

The kit aims to provide caseworkers and casework supervisors across all SHS with knowledge and tools to work effectively with people who are homeless or at risk of homelessness.

The kit was developed with guidance from a panel of practitioners from a range of SHS across NSW, and also in consultation with both NSW government agencies and peak organisations. The kit draws on a number of information sources, including evidence from research on good practice.

The kit aligns with the NSW Government's policy directions on prevention, early intervention, long-term accommodation and provision of support. It reinforces the importance of cross-agency responses between SHS and mainstream services. This involves working together in flexible ways for as long as needed to meet the individual needs of people who are homeless or at risk of homelessness. The kit also draws on the *Good practice guidelines* developed by the Department of Family and Community Services which can help SHS organisations to meet their service agreement outcomes and facilitate good case management practice.

Specialist Homelessness Services (SHS), formerly known as the Supported Accommodation Assistance Program (SAAP) services, have expertise in supporting homeless people through

a range of services and support. They are 'needed to provide a crisis response to people who have no accommodation, to assist them with their transition to stable housing and to provide a source of expertise on homelessness...however, SHS services cannot be expected to deliver the entire homelessness response' (*The Road Home*, 2008).

Training will be available for SHS providers in case management and advanced case management, along with case notes training. This training can be accessed via the NSW Department of Family and Community Services, Community Services, SHS Learning & Development Program website at www.community.nsw.gov.au/training.

1.2 Background

The Supported Accommodation Assistance Program has operated since 1985 to assist people experiencing homelessness and those at risk of homelessness.

From January 2010, homelessness services operate under a new agreement between the Commonwealth, state and territory governments. The National Affordable Housing Agreement (NAHA) replaces the SAAP V Multilateral Agreement and the Commonwealth–State Housing Agreement (CSHA).

Consequently, the term Specialist Homelessness Services (SHS) replaces SAAP and is used throughout this kit to refer to homelessness funded services.

1.3 Some definitions of homelessness

While there is no one definition of homelessness, the Australian Bureau of Statistics (ABS) has adopted the Chamberlain and MacKenzie (1992) definition that divides homeless people into three broad sectors: primary, secondary and tertiary homeless. More specifically it is defined as:

- **absolute homeless (primary homeless):** people without conventional accommodation (living on the streets, in deserted buildings, improvised dwellings, in parks)
- **relative homeless (secondary and tertiary homeless):** people staying in boarding houses, people using SHS and other similar emergency accommodation services, or people with no secure accommodation staying temporarily with friends or relatives in private dwellings.

The *Supported Accommodation Assistance Act 1994* (Cwlth) defines a homeless person as having 'inadequate access to safe and secure housing' and 'places the person in circumstances which threaten or adversely affect the adequacy, safety, security and affordability of that housing and marginalises that person through lack of access to economic and social supports'.

1.4 Some causes of homelessness

The many and varied causes of homelessness are usually multifaceted and therefore one cause cannot be separated from another. Some of the causes (*The Road Home*, 2008) are:

- structural (e.g. declining housing and rent affordability, income support and employment)
- domestic and family violence continues to be the major driver of homelessness and safety is often an ongoing problem for people who are escaping violence
- long-term unemployment
- family breakdown

- mental health and substance abuse
- people leaving statutory care (i.e. health care services, child protection and correctional facilities).

A specific event can trigger homelessness. This may include losing a job, domestic/family violence, being evicted from stable housing or a period of high financial stress. Major changes and transitions, such as young people leaving home early, can place people at greater risk (FaHCSIA, 2008).

1.5 How to use the case management resource kit

The kit is designed to support the work of SHS organisations in implementing and maintaining effective case management services to clients. The kit provides examples of recommended best practices that apply to most SHS. However, there are many different service types, locations and models in place and in some cases what is recommended may not be appropriate. Therefore individual SHS organisations may choose to amend aspects of the kit to suit their specific context.

The kit is relevant for both experienced and inexperienced caseworkers. It is structured so that an experienced caseworker can reference a section based on a particular practice need, while providing more detailed information for those who may be starting out. It also has information to guide a caseworker from start to finish with a client and gives workers useful references to more information. Furthermore, it contains information and templates that caseworkers can adapt for use in their policy and procedures.

Section 1: Introduction

Provides an overview of the kit and how it can be used, as well as some brief information about homelessness.

Section 2: Case management in context

This section outlines the broader policy and legislative framework of case management in the homelessness sector in NSW. It provides a rationale for casework and an overview of some relevant practice models and theoretical approaches. There is also an outline of the practice principles that underpin SHS case management. These principles are then incorporated into and underpin Section 3.

Section 2 intends to help caseworkers understand that the casework services they provide are informed and guided by a broader policy framework that has an impact on funding, reporting requirements and service specifications. It also helps workers to appreciate the importance of evidence-based practice and the integration of theory into practice.

Section 3: Case management in practice

This section provides a detailed overview of case management in an SHS organisation. It outlines the core components of case management and how to put them into practice. It also includes some sample tools and advice on working with other services.

Section 3 aims to set benchmarks for quality of service and was developed with help from a range of SHS service providers. Information about reflective practice and how to work effectively with other services are significant additions since the previous resource kit.

This section is generic in nature to ensure it is relevant to all SHS types and has limited information about complex needs, client types and cultural considerations. Additional sections will be written at a later stage to provide information on these important areas.

Throughout the kit you will see information summarised in green, blue or orange boxes.



Where you see the tick icon with a green box, the text highlights important information or provides a practical example to explain a point.



Where you see the blue review icon with a blue box, the text summarises information from that section.



Where you see this orange magnifying glass icon with an orange box, the text outlines a case scenario to help explain information in that section.

These boxes give caseworkers the opportunity to quickly reference key information throughout the kit.

There is a list of acronyms and a glossary which provide a quick reference for any acronyms, terms or phrases used throughout the kit. The appendices include templates that can be adapted for use in different situations.

The following are some suggested ways that caseworkers can use the resource kit:

- orientation/induction tool for new caseworkers
- teach student caseworkers about case management
- assist caseworkers to critically reflect on their practice
- evaluation tool
- discussion starter in individual or group supervision
- training resource for new and existing staff
- writing or updating policy and procedures
- guide casework practice and give ideas for new ways of working with clients
- tools for identifying and developing partnerships.

The kit can and should be used in a variety of ways to enhance existing practice in SHS organisations. It is also intended to be a living and evolving document that Community Services will maintain and update as needed.

Section 2: Case management in context

2.1 What is case management?

Case management is a client-centred, strengths-based approach aimed at empowering and working in partnership with clients to effectively meet their individual needs and become self-sufficient. While there is no one definition of case management, the following are useful:

The Australian Housing and Urban Research Institute (AHURI, 2009) defines case management 'as an intervention which does not simply meet this or that need, but develops a person's capacity to self-manage their own access to any supports they need'.

The Case Management Society of Australia (2008) describes case management as 'a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes'.

The NSW Department of Family and Community Services, Community Services defines case management for early intervention, child protection and out-of-home care programs as 'the process of assessment, planning, implementation, monitoring and review. Case management aims to strengthen outcomes for both families and children and young people through integrated and coordinated service delivery'.

Case management involves skills and resources that are applied to meet the individual needs of the client who is being assisted. It is important to note that case management is not a linear process and that the elements overlap. Caseworkers must be able to move flexibly between the individual components of case management as needed, whilst remaining focused on developing the client's capacity to live and act independently of the caseworker.



In summary, case management:

- responds individually to the client's specific needs and issues
- looks at the client in an holistic way; not just their issues
- occurs with the client so that they can participate
- builds a client's knowledge and skills to enhance self-care, self-determination and independence
- provides continuity of care
- gives access to a wide range of support services
- coordinates existing resources and introduces new resources
- builds on the client's support network and links them to the wider community and its resources
- recognises social and personal contributions to a problem
- assists clients to navigate complex service systems
- gives clients information they can use again in the future to access support
- helps to prevent homelessness.

2.2 Best practice in case management

The term best practice is often used in delivering and evaluating case management services to clients. The following are some useful definitions of best practice:

Best practice is simply the best way of doing things. It is working for outcomes and empowering the workforce. It relies on problem-solving, objective-setting, planning and measuring at the operational level. It fosters the concept of continuous improvement as part of the organisational culture. Most importantly, it focuses on meeting the needs of the client (St. Clair, 1997).

The best practices in case management require organisational arrangements to support service delivery, staff who have been trained for the approach and its application to the particular practice setting and strategies to ensure that the organisation can be responsive to evidence from practice and advocate for systemic and policy change to support service delivery (CSMA, 2008).



Best practice summary

The term 'best practice' in case management refers to a way of working with a client that is considered to be the best way of providing support and which is underpinned by evidence.

Best practice therefore continues to develop and change over time.

2.3 New government policy directions

Case management in SHS sits within a broader policy framework that is set by government and based on research evidence. A policy framework is a way of outlining how SHS services are expected to work with homeless clients and those at risk of homelessness. Sections 2.3 to 2.7 outline a number of key policy frameworks that impact on SHS and practice.

An overview

The new directions in homelessness policy began in 2008 when the Federal Government released its Green Paper and then White Paper on homelessness. The White Paper details the Federal Government's vision for halving homelessness by 2020.

National Affordable Housing Agreement (NAHA)

At the same time, the Federal Government streamlined the instruments by which it funds states and territories. This led to the introduction of the National Affordable Housing Agreement (NAHA) in 2009. The NAHA replaced all previous housing and homelessness agreements, including the CSHA (Commonwealth–State Housing Agreement) and SAAP (Supported Accommodation Assistance Program). It now provides the overarching funding policy framework for Australia's response to homelessness.

The NAHA is a broad, high-level agreement, which incorporates the following initiatives:

- A Place to Call Home (APTCH)
- National Rental Affordability Scheme (NRAS)

- Housing Affordability Fund (HAF)
- First Home Owners Account (FHOA).

The NAHA also includes the national partnership agreements for social housing, remote indigenous housing, and homelessness.

National Partnership Agreement on Homelessness (NPAH)

The National Partnership Agreement on Homelessness (NPAH) is time limited and intended to promote reform of the homelessness service system. The Federal Government describes it as its down payment on achieving the vision of the White Paper. For NSW, the NPAH represents a financial commitment of \$100 million from the Federal Government and a \$213 million matching commitment from the NSW Government.



Underpinning the NPAH are targets the Federal Government and all states and territories jointly agreed to. They are:

- a reduction of 7% in the overall level of homelessness by 2013
- a reduction of 25% in the number of people sleeping rough by 2013
- a reduction of one-third in the number of Aboriginal people who are homeless by 2013.

The NSW Implementation Plan (IP) for the NPAH is structured in two parts:

- Year 1: includes a number of evidence-based initiatives established through a central process. The Year 1 IP and Report Card can be found on the Housing NSW website.
- Years 2–4: initiatives that aim to build on learnings of Year 1 and contribute to the development of regional homelessness action plans.

More information about the NAHA and NPAH is available at www.coag.gov.au.

Homelessness action plan (HAP)

The translation of national homelessness policy and associated strategies and actions for NSW is found in the NSW Homelessness Action Plan (HAP).

The HAP reinforces the NSW commitment to the NPAH targets and provides the direction for both new and existing efforts in NSW. It includes initiatives funded under the NPAH and through existing programs in NSW. Regional homelessness action plans were developed to express the strategies and actions required at a local level to achieve the targets of the HAP and its directions.

The governance structure set up to drive and oversee implementation of the HAP includes regional homelessness committees, which can escalate issues to a statewide Homelessness Interagency Committee and regional coordination management groups (RCMG). Both in turn can escalate issues to the joint meeting of chief executives of the Justice and Human Services departments and the NSW Premier's Advisory Council.

For more information about the NSW HAP go to www.housing.nsw.gov.au/NR/rdonlyres/...55E1.../ActionPlan2.pdf.

NSW policy direction

The new directions in homelessness build on the strategic priorities of the previous SAAP V Agreement.



NSW policy directions aim to:

- reduce the current level of high-cost crisis accommodation services and reconfigure these services into flexible support models
- improve client assessment processes so that clients are linked to the most cost-efficient service that meets their presenting needs
- increase involvement in early intervention and prevention strategies
- provide better assistance to clients who have a number of support needs
- provide ongoing assistance to ensure stability for clients post crisis
- improve service responses for Aboriginal and Torres Strait Islander people.

Improving the response to homelessness relies on a coordinated and collaborative approach between mainstream agencies, specialist homelessness services and other specialist services. Cross-agency collaboration is critical to ensuring better outcomes for people who are homeless or at risk of homelessness.

The new directions in homelessness policy in the HAP identify three strategic directions:

1. Preventing homelessness

For specialist homelessness services this is mostly about intervening early to support people at risk of homelessness from entering the supported accommodation service system. Early identification and response is central to effectively preventing people becoming homeless.



Preventing homelessness means understanding where people are coming from before entering supported accommodation services and considering how to support them beforehand to stem demand on the service system.

This may also mean advocating for greater support from mainstream services and linking people with appropriate services to stop them becoming homeless.

Strategies to prevent people entering the homelessness service system include supporting people in social and private rental housing who may be at risk of losing tenancies. They also include working with mainstream agencies to prevent exits from statutory care into homelessness (or more particularly into supported accommodation services).

To a lesser extent, SHS can raise awareness about the structural causes of homelessness (e.g. domestic/family violence) in the broader community.

2. Responding effectively to homelessness

Responding effectively to homelessness refers to situations when a person actually becomes homeless (e.g. within SHS supported accommodation, rough sleeping, couch surfing).

It is about fast tracking a client's path out of crisis towards long-term sustainable housing and social inclusion.



While it's not always possible to provide an intervention that prevents people from returning to homelessness, an effective response depends on a seamless service system that can respond to the diverse range of client needs; no matter how complex the need. It also requires post-crisis support to ensure clients maintain independence.

Responding effectively is about responses that build the resilience and self-reliance of people who are homeless and interventions that end their homelessness rather than perpetuate the homeless experience.

To a lesser extent, prevention is also about universal strategies aimed at the broader population to raise awareness about the structural causes of homelessness (e.g. domestic/family violence).

3. Breaking the cycle of homelessness

New innovative responses need to be developed for clients where the service system fails to engage them or provide an effective response.

Services need to respond to people who are chronically or long-term homeless because of complex or entrenched issues (e.g. co-morbid psychiatric illness or antisocial behaviour).



Breaking the cycle of homelessness is about finding out how the client became or remains homeless and helping them overcome their homelessness. It is also involves assisting clients to move quickly out of crisis and into long-term stable accommodation with new skills and knowledge to help them avoid a future crisis.

Key concepts within the new policy direction

Long-term sustainable housing

Concepts outlined in the new policy direction focus on pairing the provision of housing with ongoing support. This approach is also evident through new approaches such as 'Housing First' which aim to streamline the pathway of a client into long-term sustainable housing.

Client-centered support

This is often referred to as 'flexible', 'wraparound' or 'tenure neutral' support. Most simply it means providing the client with 'whatever' is needed, 'wherever' it is needed, 'whenever' it is needed, with 'whomever' is needed, for 'as long' as is needed; until a long-term sustainable outcome is achieved.

Integration and interdependency on mainstream service

The new policy direction recognises that mainstream services are often the first to realise a client is homeless or at risk of homelessness.

A 'no wrong door' policy for these clients focuses on the importance of mainstream agencies offering support and making relevant referrals to ensure that vulnerable people receive appropriate assistance.

The failure to recognise and address dependencies between mainstream agencies and SHS, and the flow-on effects for clients, can and often does have serious repercussions for vulnerable people. Accordingly, the new policy directions recognise the interdependency on mainstream services.

There is also recognition that SHS cannot address homelessness alone and need the support of the mainstream service system. This includes integrating police responses and improving decisions made in the justice system, particularly the Family and Children's courts, which are integral to addressing domestic and family violence.

The new policy directions include a strong emphasis on moving away from program silos, towards a more seamless service system response and apply equally to government and non-government services.

The links between education and training are vital to long-term sustainable employment outcomes for young people. Access to primary health, mental health, and alcohol and other drug (AOD) services, are also critical to the majority of target groups. An integrated service system can respond to a diverse range of client needs; no matter how complex they are.

New innovative models

Ultimately a broad range of flexible service models and responses are required across the entire homelessness service system (SHS, specialists and mainstream). They should be adapted to local need and embedded in local planning frameworks, to ensure effort is strategically targeted to stem demand and provide the most effective response within available resources.

In some cases, new innovative models may mean a significant change to the existing approach of an SHS. Often there are situations where there is a gap between what the service system provides and what a client needs.

Services can address these gaps by rethinking their parameters and/or creating new service models that respond to client need. New models may provide better approaches to assertively engaging clients that are reluctant to receive services, or better ways of working with difficult clients who display antisocial behaviour or have drug and alcohol or mental health issues.

This is not about a 'one size fits all' approach to the service system but about building on the strong foundation that already exists. It means being open to new ways of working and new models of service delivery for clients whose needs are not being met by the existing service system.

No access barriers

Clients should not have to bounce around the service system and jump through unnecessary hurdles before finding and accessing a service that meets their needs.

This builds on the concept of an integrated service system, however the emphasis is on a system that is easy to navigate and access.

Transition points

There needs to be a focus on preventing exits from statutory care into homelessness and transition planning for clients moving through or exiting SHS.

Effective case management aims towards an exit or transition plan that reduces the level of support the client needs and aims to help them live independently over time.

Transition planning should start at entry to SHS and is as much an early intervention as it is post-crisis support.

Understanding demand drivers

The new policy direction is focused on responding effectively to homelessness and understanding the points at which clients enter the homelessness system.

A greater focus on the demand drivers for supported accommodation in SHS is essential (i.e. a sharper focus on target groups that enter into crisis accommodation and frequent users of this service type).

Key examples include strategies that aim to prevent exits from statutory care into homelessness (e.g. from Juvenile Justice, Corrections and mental health institutions, and out-of-home care).

It is also equally important to understand where clients are coming from prior to crisis accommodation (e.g. private housing or social housing) and developing ways to engage and support people at risk, to sustain their tenancies and prevent them entering the homelessness system.

2.4 National quality framework for services to people experiencing homelessness

The Commonwealth, states and territories are working together to develop a national quality framework (NQF) to achieve better outcomes for people who are homeless or at risk of homelessness by improving the quality and integration of services they receive.

All governments have acknowledged that the best way to develop the homelessness national quality framework is in partnership with stakeholders through a two-stage national consultation process.

The objectives of the NQF are to:

- empower clients using a strengths-based approach
- provide assurance for clients, funding bodies and the community about the consistency and quality of services
- support service integration and collaboration
- ensure mainstream services recognise and respond to the diverse needs of people experiencing homelessness.

Once these objectives are achieved, the NQF will further inform SHS case management practice.



Key principles of the NQF:

- **Principle 1:** Services and governments will work together to develop a national quality framework and accept joint responsibility for quality service provision.
- **Principle 2:** Minimising red tape will be a key consideration in the development of a national quality framework.
- **Principle 3:** A national quality framework will build on and add value to existing quality systems.
- **Principle 4:** There will be a supportive and enabling approach to implementation.

For more information about the NQF go to

http://www.fahcsia.gov.au/sa/housing/progserv/homelessness/national_quality_framework/Pages/default.aspx.

2.5 Child protection reform (Keep Them Safe)

Keep Them Safe (KTS) is the state's new approach to child wellbeing resulting from the Special Commission of Inquiry into Child Protection Services in NSW. The central theme of the changes is that care and protection of children and young people is a shared responsibility.

The goal of KTS is that 'all children in NSW are healthy, happy and safe, and grow up belonging in families and communities where they have opportunities to reach their full potential'.

For an extensive range of up-to-date information, such as fact sheets and training materials that reflect the KTS changes in NSW, visit the Department of Premier and Cabinet's website at <http://www.keepthemsafe.nsw.gov.au/>.

A significant change to the child protection system is the change in the threshold of harm from **risk of harm** to **risk of significant harm**.

Mandatory reporting

Staff employed in non-government organisations (NGOs) will continue to make mandatory reports to the Community Services Child Protection Helpline if there is suspected 'risk of significant harm' (ROSH) as opposed to 'risk of harm'.

If reports do not meet the new threshold, mandatory reporters, where appropriate, will identify potential responses within their own agency or refer the family, with their consent, to other services that can provide them with support.

The NSW Department of Family and Community Services engaged the US-based Children's Research Centre (CRC) to develop the world's first Mandatory Reporter Guide (MRG). It involved extensive consultation with mandatory reporters from NSW Government agencies and NGOs.

The online MRG is a web-based interactive tool that assists frontline mandatory reporters, such as police officers, teachers, nurses, social workers and non-government service providers, to find out what to do if they are concerned about a child or young person.

The online MRG is available at <http://sdm.community.nsw.gov.au/mrg/app/summary.page>.

Legal framework for information exchange

Confidentiality and the exchange of information is an important aspect in working with children and young people. The legal framework for exchange of information allows organisations to share information about the safety, welfare or wellbeing of children or young people without consent. It takes precedence over the confidentiality of an individual's privacy. Consent is not necessary, however should be sought if possible.

The legal framework allows information sharing in specific situations, which are outlined in Chapter 16A and section 248 of the *Children and Young Persons (Care and Protection) Act 1998* (the Act).

Chapter 16A: allows information to be exchanged between 'prescribed bodies', despite other laws that prohibit or restrict the disclosure of personal information, such as the *Privacy and Personal Information Protection Act 1998*, the *Health Records and Information Privacy Act 2002* and the *Commonwealth Privacy Act 1998*. Under 16A, prescribed bodies may share certain information without having to rely on Community Services as an intermediary.

A prescribed body is any organisation specified in section 248(6) of the Act or in clause 7 of the *Children and Young Persons (Care and Protection) Regulation 2000*. Generally, prescribed bodies are:

- NSW Police Force
- a State government department or public authority
- a government school or registered non-government school or TAFE
- a public health organisation or private health facility
- an accredited adoption service provider
- a designated agency
- a registered agency¹
- a children's service
- any other organisation the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly to children.

A prescribed body may request information from another prescribed body about a particular child or young person and/or their family if it will assist the requesting prescribed body to:

- make a decision, assessment or plan relating to the safety, welfare or wellbeing of the child or young person

¹ Under clause 3 of the *Children and Young Persons (Care and Protection) Regulation 2000* a registered agency is defined as a 'Division of the Government Service or other organisation registered under clause 40G of this Regulation for the purposes of Part 3A of Chapter 8 of the Act'. Part 3A of the Act deals with voluntary out-of-home care, if an organisation intends to provide or arrange voluntary out-of-home care they may apply to the Children's Guardian for registration.

- initiate or conduct any investigation relating to the safety, welfare or wellbeing of the child or young person
- provide any service relating to the safety, welfare or wellbeing of the child or young person
- manage any risk to a child or young person that might arise in the recipient's capacity as an employer or designated agency.

The request must be clear about its purpose and how the information is expected to assist.

If you are unsure whether you work for a prescribed body or whether you are authorised by your organisation to exchange information under Chapter 16A, you should seek advice within your organisation or from a legal adviser.

Section 248: allows information to be exchanged between Community Services and organisations not covered by Chapter 16A, and where requests to access information under Chapter 16A have not been met. Requests made under section 248 are mandatory.

More information about the exchange of information can be found at http://www.community.nsw.gov.au/kts/guidelines/info_exchange/info_index.htm.

See Section 3.4 of this kit for more information on risk assessment and exceptions to consent; Section 3.5 for requests for information; and Section 3.6 for responding to a suspected risk of harm.

2.6 Key legislation

The following legislation influences the delivery of casework in SHS in NSW:

- Supported Accommodation and Assistance Act 1994
- NSW Community Welfare Act 1987
- Children and Young Persons (Care and Protection) Act 1998
- Children and Young Persons (Care and Protection) Regulation 2000
- Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009
- Crimes Act 1900
- Anti-Discrimination Act 1977
- Commission for Children and Young People Act 1998
- Child Protection (Prohibited Employment) Act 1998
- NSW Community Services (Complaints, Appeals and Monitoring) Act 1993
- NSW Occupational Health and Safety Act 2000
- National Privacy Principles 1998
- Commonwealth Privacy Act 1988
- Privacy and Personal Information Protection Act 1998 No 133
- Information (Public Access) Act 2009 (the GIPA Act)
- Freedom of Information Act 1989
- Health Records and Information Privacy Act 2002
- State Records Act 1998

NSW legislation can be found at <http://www.legislation.nsw.gov.au/>.

Commonwealth legislation is at <http://australia.gov.au/publications/commonwealth-legislation>.

2.7 NSW Government guidelines and plans

The following NSW Government guidelines and plans also influence the delivery of casework in SHS:

- NSW Department of Community Services: Multicultural Strategic Commitment 2008–2013
www.community.nsw.gov.au/DOCSWR/assets/main/documents/MULTICULTURAL_STRATEGIC_COMMITMENT.PDF
- Domestic Violence Interagency Guidelines
http://www.community.nsw.gov.au/DOCSWR/assets/main/documents/DV_guidelines.pdf
- Australian Domestic & Family Violence Clearing House
<http://www.austdvclearinghouse.unsw.edu.au/>
- NSW Domestic and Family Violence Action Plan: Stop the Violence, End the Silence
http://www.dpc.nsw.gov.au/data/assets/pdf_file/0005/93920/Stop_the_Violence_End_the_Silence_Domestic_and_Family_Violence_Action_Plan_-_Web2.pdf
- NSW Department of Community Services: Working with Aboriginal Communities: A Practical Resource
http://www.community.nsw.gov.au/docswr/assets/main/documents/working_with_aboriginal.pdf
- The Child Wellbeing and Child Protection – NSW Interagency Guidelines (the guidelines)
http://www.community.nsw.gov.au/kts/guidelines/info_exchange/introduction.htm
- NSW Department of Human Services, Community Services. Culturally-appropriate service provision for children and families in the NSW child protection system
www.community.nsw.gov.au/docswr/assets/main/documents/research_cald_families_summary.pdf
- NSW Department of Community Services: *Good practice guidelines for DoCS-funded services manual*
http://www.community.nsw.gov.au/docswr/assets/main/documents/good_practice_guidelines.pdf.

Linkages with Housing NSW strategies

Housing NSW (HNSW) is the lead agency in coordinating the whole of government response to reducing homelessness in NSW.

The social housing sector is expected to make a significant contribution to reducing homelessness through a range of strategies and initiatives. The new direction in homelessness policy emphasises collaborative and coordinated partnership responses between SHS and the provision of housing and tenancy products.

The recent injection of investment into new social housing under the National Building Economic Stimulus Plan is one such strategy. It has increased the number of properties, with the aim of building up available housing over time. Community housing providers provide

tenancy management services to tenants in these properties and also arrange support from relevant services to enable people to maintain their housing.

Another aligned strategy is Housing Pathways, which provides a single point of entry for people applying for housing, and where HNSW, a community housing provider or the Aboriginal Housing Office can make offers of housing.

Information about housing assistance products and services can be found at:

- Housing Pathways:
<http://www.housing.nsw.gov.au/Changes+to+Social+Housing/Housing+Pathways/>
- Rent It Keep It:
<http://www.housingpathways.nsw.gov.au/Ways+we+can+Help/Private+Rental+Assistance/Rent+It+Keep+It/>
- Nation Building Economic Stimulus Plan:
<http://www.housing.nsw.gov.au/Changes+to+Social+Housing/Nation+Building+Economic+Stimulus+Plan/>
- The Housing NSW Aboriginal Service Delivery Commitment and Action Plan:
<http://www.housing.nsw.gov.au/NR/rdonlyres/EBC517B2-4EC2-46B8-9E2F-B99110EDA307/0/CommitmenttoAboriginalService.pdf>
- Housing NSW Youth Action Plan 2010–2014:
<http://www.housing.nsw.gov.au/NR/rdonlyres/F612F189-4E34-457F-82B8-3AEAE8689E43/0/YouthactionPlan.pdf>

2.8 Evidence for case management

Case management has been central to homelessness assistance practice in Australia since at least the early 1990s, when it was adopted as a key strategy to enhance the SAAP (AHURI, 2009).

The AHURI research reported that while case management is a time and resource intensive intervention, it develops a person's capacity (through knowledge and skills) to access any supports they need. This is achieved through a relationship between the client and the case manager or case management team. This relationship has the qualities of persistence, reliability, respect and intimacy, and which delivers comprehensive and practical support. The report further stated that 'case management is most effective when it provides direct assistance with practical and specialist support needs'.

Sackett et al (1997) found that evidence-based practice is a process that considers 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals'. It also involves integrating individual practice expertise with the best available external evidence from systematic research, as well as considering the values and expectations of clients (Gambrill, 2003).

Case management is not always time specific and varies due to the client's individual needs and capacities. However, the evidence shows that six months may be the minimum time required to establish a working relationship with people experiencing homelessness and mental illness. It is likely that the investment of time will be lost if more than this period is not allocated to more complex clients (AHURI, 2009).

Similarly, professional supervision and multidisciplinary collaboration is needed to mobilise and manage the professional intimacy of the case management relationship. Case management outcomes were also found to be more effective; such as access to a range of

resources, including accommodation and specialist services, that may otherwise not be available to the client (AHURI, 2009).



AHURI (2009) identified specific conditions that enabled the case management relationship to deliver beneficial outcomes for people experiencing homelessness.

This includes:

- access to housing resources and specialist supports
- client-driven support durations
- highly-skilled caseworkers.

These caseworkers need to be able to:

- conduct advanced assessment
- have highly-developed communication and relationship skills
- engage in regular practice supervision
- access resources their client requires, e.g. housing and specialist supports
- develop a 'persistent, reliable, intimate and respectful relationship' to make the client 'feel like somebody'.

Case management is based in service provision arrangements requiring different responses from within organisations and across the service network that is client rather than organisationally driven (CMSA, 2008). It therefore relies on the SHS engaging with the client, adopting a consistent case management model and working effectively with its community partners to deliver better outcomes for the targeted population group.

Thus, case management becomes central in meeting NSW policy directions. It is a way of engaging with people, who are either currently homeless or at risk of homelessness, in a partnership approach that focuses on their goals. It also provides opportunities to exit homelessness at any stage, i.e. prevention, early intervention, supported crisis accommodation, supported transition accommodation and supported independent living.

It also enables SHS to work with other services as partners to provide a range of services that the client needs and that are not available within the SHS. The diagram below shows some of the wraparound services that clients require in addition to their housing needs. An SHS is unlikely to be able to provide all of these services effectively and will benefit from seeking partnerships to provide some of these for clients. More information about wraparound supports is found in Section 3 of this resource kit.

Diagram 1: Wraparound services



2.9 Benefits and challenges of effective case management

The purpose of case management is to enhance access to services required, improve the continuity and efficiency of services and maximise outcomes that build the client’s strengths and capacities. This approach depends on a systems coordination approach, i.e. effective coordination and collaboration across formal service systems and informal community supports.

Depending on the specific setting and locality, case managers are responsible for a variety of tasks, ranging from linking clients to services to actually providing intensive direct non-clinical services.

Gronda (2009) found that an effective case management relationship relies on highly-skilled staff and access to resources, particularly housing and specialist supports, e.g. specialist expertise in mental health and substance misuse.

Benefits of effective case management

For clients

The following are some benefits of case management for clients:

- improved coordination of services and reduced duplication
- improved outcomes due to clear assessment, planning and self-directed emphasis

- clients are empowered to address their own needs through active participation in positive decision-making and choice
- new knowledge and skills
- improved problem-solving skills
- increased resilience (ability to manage future difficulties)
- access to relevant services and entitlements
- needs are met.

For services

The following are some benefits of case management for services:

- increased client outcomes and satisfaction
- less repeat clients (they do not become dependent)
- interactions between clients and workers are more focused
- reduced worker burnout
- shared responsibility between services – reduced service duplication
- shared responsibility for client outcomes among a number of caseworkers and service providers
- caseworkers have a clearer sense of the direction they are taking with and on behalf of their clients
- improved coordination results in service gaps becoming more apparent
- more efficient use of resources
- client work is less crisis driven
- interactions are more purposeful and aim to address underlying causes of problems
- increased networks, partnerships, knowledge of and access to resources and services.

Some challenges of case management

Although effective case management requires genuine emotional connection (AHURI, 2009), it is the personal nature of the caseworker's engagement with the client that presents significant challenges to case management practice around power imbalances and professional boundaries. These challenges require SHS to have clear policies and procedures and clinical supervision available to staff (Boyer & Bond, 1999 in AHURI, 2009).

While the research about case management has found that having a primary worker within the team was important for providing continuity and personal knowledge of the individual (Krupa et al., 2005 in AHURI, 2009), this may not always be possible due to limited resources.

Similarly, in some regional areas, as caseworkers live in the area they work, clients can be family members or friends. To mitigate some of these challenges, SHS should have clear policies around boundaries and caseworkers should be given supervision to support them to meet these challenges.

SHS cannot deliver the entire homelessness response. The best outcomes for people who are homeless will be achieved if specialist and mainstream services work closely together (*The Road Home*, 2008).



A further challenge is the time needed to build trust and show benefits and outcomes to clients. This remains a challenge to SHS as service agreements require compliance with targets and there is often an unmet demand for services.

This is contrasted with AHURI (2009) which found that the active ingredient in the success of client outcomes was the time required to build a trusting relationship between the client and caseworker. If this was achieved within the first three months, better housing outcomes within twelve months were also achieved.

More information about the client/worker relationship is in Section 3.2.



Case management evidence, benefits and challenges summary

Case management is widely supported by research evidence and there are many benefits that include assisting clients to exit homelessness and improving client self-sufficiency.

There are a number of factors that support the casework process such as collaborative partnerships and access to resources and support.

There are also limitations to case management that include limited resources and time, and the emotional strain of working with complex needs.

2.10 Case management practice approaches

Case management can be applied in different settings and is informed by a variety of theories and practice approaches. The following outlines some of the practice approaches that are particularly relevant to SHS.

Social inclusion

While there are many definitions of social inclusion, the concept Monsignor David Capo describes (South Australian Government Social Inclusion Initiative, 2002) means:

- providing people with the fundamentals of a decent life
- giving opportunities to engage in the economic and social life of the community with dignity
- increasing their capabilities and functioning
- connecting people to the networks of local community
- supporting health, housing, education, skills training, employment and caring responsibilities.

This initiative has contributed to the social good of South Australia in its work on homelessness, drug abuse, Aboriginal health and wellbeing, school retention, youth offending, mental health and disability services.

For more information about South Australia's Social Inclusion Initiative go to www.socialinclusion.sa.gov.au.

Social inclusion means building a fairer Australia by targeting the problems that keep people in disadvantage and tackling the barriers that prevent them from participating fully in Australian life. The Commonwealth Government's social inclusion priorities are:

- closing the gap between Indigenous and non-Indigenous Australians tackling homelessness
- increasing employment for people with disabilities and mental health conditions
- assisting children at greatest risk of disadvantage
- supporting jobless families.

Mendes (2002) suggests that 'social inclusion is the process by which efforts are made to ensure that everyone, regardless of their experiences and circumstances, can achieve their potential in life. To achieve inclusion, income and employment are necessary but not sufficient. An inclusive society is also characterised by a striving for reduced inequality, a balance between individual's rights and duties and increased social cohesion'.

Strengths-based practice

Strengths-based practice (Buchwitz, 2001) assumes that people have strengths and resources for their own empowerment. Unlike other theoretical approaches, it focuses on the strengths that a client has rather than focusing on the deficits or things that they are lacking. The client is seen as the expert on themselves. The caseworker's role is to help them develop and use their strengths to overcome their particular barriers and prevent relapse.

A strengths-based approach is a philosophy for practice rather than a model. It primarily depends on positive attitudes about people's dignity, capacities, rights, uniqueness and commonalities. Applying a strengths-based approach is not meant to be a denial of a person's difficulties but a fruitful way to address issues and achieve change.

It is however important to recognise that the focus is on the person's potential for change. There should be a clear distinction between strengths-focused practice (identifying the client's past and existing strengths) and strengths-based practice (working with the client to openly explore the resources they have to create change). It is also important to ensure that motivation to change is assessed in strengths-based work, along with potential risks.

Strengths-based practice begins with the worker engaging with and assisting the client in a process of 'client-led' identification of needs and solutions and presumes that clients are the principal resource for change (NCPC, 2005). To achieve this, caseworkers should respect and work with the unique individual, cultural and ethnic realities that each client brings to the situation (Berg & Kelly, 1994).

This is also called 'client-centred' practice. In other words, clients, not workers, define goals, and identify and mobilise strengths and resources. This means that workers and agencies need to be ever mindful of the danger of inadvertently using their powerful positions to control the outcomes in their clients' lives.



In SHS, this means that a caseworker applies strengths-based practice in the following ways:

- establish and keep a client focus – listen to the client's preferred outcomes
- identify and acknowledge client's existing strengths, achievements and resources – build on these to find solutions by using the client's own words/images, as this will help the caseworker build on past successes (however small) and move toward solutions that are achievable and will last
- establish and maintain a partnership approach with the client and other services involved
- ensure solutions are decided by the client and caseworker working together collaboratively.

For more information about strengths-based practice go to <http://www.strengthsbasedpractice.com.au/>.

Following are some useful texts about strengths-based practice:

- Gambrill, E 2003, 'Evidence-based practice: implications for knowledge development and use in social work', in Rosen, A & Proctor, E (eds.), *Developing practice guidelines for social work intervention*, Columbia University Press, New York, pp. 37–58).
- Gibbs, L 2003, *Evidence-based practice for the helping professions*, Wadsworth, New York.
- Roberts, A & Yeager, K (eds.) 2004, *Evidence-based practice manual: research and outcome measures in health and human services*, Oxford University Press, New York.
- Sackett, D, Rosenberg, W, Gray, J, Haynes, R, & Richardson, W 1996, 'Evidence-based medicine: what it is and what it isn't', *British Medical Journal*, 312, 71–72, <http://cebm.jr2.ox.ac.uk/ebmisisnt.html>.
- Sackett, D, Richardson, W, Rosenberg, W & Haynes, R 1997, *Evidence-based medicine: how to practice and teach EBM*, Churchill Livingstone, New York.
- Simpson, G, Segall, A & Williams, J 2007, 'Social work education and clinical learning', *Clinical Social Work Journal*, (35), 33–36.
- Stout, C & Hayes, R (eds.) 2005, *The evidence-based practice: methods, models, and tools for mental health professionals*, Wiley, Hoboken, New Jersey.

A solution-focused perspective

Solution-focused approaches lend themselves to evidence-based practice (Miller, 2004). It involves a skilled caseworker engaging with the client and together defining the issues and their solutions. These solutions are defined in realistic, client-determined achievable terms and take into account the context in which the problem arises. The approach focuses on achieving a measurable outcome and values both the interpersonal relationships and the broader social context of the individual (Miller, 2004).

People, who experience traumatic events or a number of stressful life events, usually try to understand and reduce their symptoms to regain control of their environment and reach out

to their own support systems. It is also recognised that structural issues, e.g. lack of access to services can add to and compound these experiences. Sometimes the person's internal and external coping methods are successful, and an acute crisis episode is averted. At other times vulnerable individuals and groups do not cope and crisis episodes escalate.

Crisis is an event that can rapidly overwhelm the client's usual coping skills (strengths); consequently, these become inadequate to meet the challenge of the crisis. Providing services to clients in crisis is an 'opportunity' for them to learn new coping skills and further identify, mobilise and build on their existing strengths. It must also be recognised that there are many structural barriers that prevent the client from accessing supports they need, e.g. available and affordable housing, and access to mental health and AOD services.

Caseworkers who work within a solution-focused approach will help the client imagine a situation where their goals are achieved and describe what this will be like. They are then supported to lay out the steps that are required to reach that place. The caseworker then works with the client to put these into action. In the process, the client learns problem-solving skills and is empowered into action.

For more information about solution-focused practice go to <http://www.sfbta.org/>.

Following are some useful texts about solution-focused practice:

- Berg, IK & Kelly, S 2000, *Building solutions in child protective services*, Norton, New York.
- De Shazer, S 1985, *Keys to solution in brief therapy*, Norton, New York.
- Durrant, M 1993, *Residential treatment*, Norton, New York.
- Furman, B & Ahola, T 1992, *Solution talk: hosting therapeutic conversations*, Norton, New York.
- Hawkes, D, Marsh, T & Wilgosh, R 1998, *Solution focused therapy: a handbook for health care professionals*, Butterworth Heinemann, Oxford.
- Jackson, P & McKergow, M 2002, *The solutions focus: the simple way to positive change*, Nicholas Publishing, London.
- Lipchik, E 2002, *Beyond technique in solution focused therapy*, Guildford, New York.
- Miller, S, Hubble, M & Duncan, B (eds.) 1996, *Handbook of solution-focused brief therapy*, Jossey-Bass, San Francisco.
- O'Connell, B 1998, *Solution-focused therapy*, Sage, London.
- Walter, J & Peller, J 1992, *Becoming solution-focused in brief therapy*, Brunner, New York.

Resilience approach

Resilience refers to the ability of an individual, family or community to positively deal with difficult circumstances and bounce back from adversity. Key elements in resilience building are generally empowerment, efficacy and genuine opportunities for meaningful participation in their own lives and the wider community.

It is the capacity to cope with difficulties, to maintain functioning in the face of stress, to bounce back in the face of significant trauma, to use external challenges as a stimulus for growth, and to use social supports as a source of resilience (Du Plessis et al, 2001).



The resilience approach tries to identify risk factors and build protective factors so that clients are better able to face and respond to adversity within their own resources. Protective factors are generally seen as internal strengths/skills and external community networks of support.

For more information about the resilience approach go to

http://www.cyf.vic.gov.au/_data/assets/pdf_file/0006/15666/r-lemay-the-developmental-model-and-hope.pdf

<http://au.reachout.com/find/articles/what-helps-to-make-a-resilient-person>.

Trauma-informed care and practice

Trauma survivors are likely to have histories of physical and/or sexual abuse, chronic neglect and/or protracted emotional abuse, witnessing domestic violence, civilian involvement in wars and civil unrest, or refugee and combatant trauma. Such trauma frequently leads to mental health issues and other types of co-occurring problems, such as poor physical health, substance abuse problems, eating disorders, relationship and self-esteem issues and contact with the criminal justice system.

Trauma-informed care is based on an understanding of the particular vulnerabilities and/or triggers that trauma survivor's experience (that traditional service delivery approaches may exacerbate), so that these services and programs can be more supportive, effective and avoid re-traumatisation (MHCC, 2011).



Trauma-informed care is based on the idea that a client's past exposure to trauma can have an impact on their behavioural and psychological responses and may impair their cognitive or emotional functioning. Therefore a client's current life choices and behaviour may be linked to past experiences of trauma without this necessarily being a conscious process.

In SHS organisations, many clients have experienced a range of traumas and this gives caseworkers an opportunity to develop the client's insight into these. Caseworkers can help them identify links to past trauma and seek appropriate care for the client.

This theory also promotes the development of collaborative partnerships with a range of mental health services and/or GPs, who can provide specialist support as part of the client case management process.

For more information about trauma-informed care and practice go to

<http://www.mhcc.org.au/documents/TICP/TICP-Lit-Review.pdf>

<http://www.familyhomelessness.org/media/90.pdf>.

Assertive community treatment

Assertive community treatment (ACT) is a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to people with serious and persistent mental illness and provides a range of supports/services to enable them to live in the community successfully (ACT Association, 2007).

A multidisciplinary team from across the service system delivers ACT. It includes community and health professionals whose roles are interchangeable to ensure services are not disrupted due to staff absence or turnover.

It operates from a client-centred and strengths-based approach to plan and deliver services within a community setting over a long-term period. The team works collaboratively with the client and encourages community participation, such as employment.

Assertive community treatment is proven to be a comprehensive model (McGrew & Bond, 1995) that gives clients support across the service system. For example, supported accommodation housing has been effective in ending and preventing homelessness for clients with co-occurring psychiatric and substance use disorders, long histories of homelessness, and disengagement from traditional supportive housing services (Tsemberis et al., 2004).

For more information about ACT go to
<http://www.actassociation.org>
http://works.bepress.com/sam_tsemberis/3/.

Evidence-based practice

Evidence-based practice (EBP) is an approach to decision-making which is transparent and accountable. It is based on current evidence about the effects of particular interventions in the welfare of individuals, groups and communities. It also involves basing case management practice within an acknowledged body of evidence or theory that helps the caseworker understand, interpret and respond to the client's needs most effectively.

Evidence-based practice is a process that considers 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals' (Sackett et al, 1997).



There are a number of useful resources on the internet and in many libraries that can help caseworkers and managers work out the best theoretical approach or other evidence base. What is important about theory is that it:

- has an evidence base (a number of people write about it and have researched its validity)
- is relevant to an organisation's service context (the theory can inform interventions and decision-making in the organisation's case management process for its client group)
- is consistent with an organisation's mission and values (the theory supports what an organisation is aiming to achieve).

Some useful websites that will help to identify evidence-based practice are:

- Australian Housing and Urban Research Institute: <http://www.ahuri.edu.au/>
- Australian Institute of Family Studies: <http://www.aifs.gov.au/>
- Homelessness NSW: <http://www.homelessnessnsw.org.au/>
- Australian Institute of Health and Welfare: <http://www.aihw.gov.au/>
- NSW Council of Social Service: www.ncoss.org.au
- Social Policy Research Centre: <http://www.sprc.unsw.edu.au/>
- Australian Centre for Child Protection: www.unisa.edu.au/childprotection

- Communitybuilders: www.communitybuilders.nsw.gov.au
- Yfoundations (peak organisation that seeks to create a future without youth homelessness): <http://www.yfoundations.org.au>
- NSW Women's Refuge Resource Centre (peak organisation for women's specialist domestic violence services): <http://www.wrrc.org.au/>
- Local Community Services Association (peak organisation for community and neighbourhood centres): www.lcsa.org.au
- NSW Family Services Inc. (peak organisation in NSW for family services): <http://www.nswfamilyservices.asn.au/>.



Case scenario: Ruth

A mother, Ruth, and her two children have been at the SHS for several weeks after her third attempt at escaping domestic violence. The caseworker is not confident of Ruth's capacity to achieve her or her children's goals.

The caseworker is frustrated and to date has not recognised the achievements Ruth has made, such as enrolling the children at school and not having any absences and she is seeing a doctor to manage her anxiety.

The caseworker is struggling to make progress with Ruth so reflects on her work and considers alternate ways of working with her. After consulting with some of her colleagues, the caseworker realises that she has focused more on Ruth's faults rather than her strengths.

The caseworker then identifies Ruth has the following strengths:

- remained out of the abusive relationship
- acted to protect her children from harm
- children are attending school
- attending a GP for anxiety treatment
- participating in case management activities.

With her supervisor's help, the caseworker decides to focus on these strengths and empower Ruth to be self-directed and continue developing her skills.

Ruth soon shows improved self-esteem and takes initiative to apply for private rental properties near the refuge. The client develops new problem-solving skills and is able to invest more in her relationship with her children as her confidence grows as a parent.

Practice tips:

- Strengths-based casework is effective at empowering and motivating homeless clients when used correctly.
- Reflective practice helps the caseworker to consider alternate ways of working with a client.
- The caseworker is a facilitator who works to build up and bring out the unique skills and abilities of each client.

2.11 Integrating theory into case management practice

There are a number of theoretical approaches that can inform the practice of case management and there is no 'one size fits all' theory for specialist homelessness services. Each SHS organisation will need to select a theoretical framework that best suits their purpose and the client group they support. What is relevant to a women's domestic violence service will be different to a youth service for example. SHS may select more than one theoretical framework to inform their work. It may also differ depending on the geographical location and available resources in the surrounding area.

SHS organisations need to independently look at which theoretical approaches are likely to best compliment the type of service they provide. Other examples that can apply to SHS include:

- developing and writing policies and procedures that include the theoretical frameworks that underpin service models and interventions
- collecting and analysing relevant data that can be used in reflecting on practice and developing further knowledge about practice
- putting in place processes, e.g. supervision to reflect on and improve practice
- developing a research agenda and relevant partnerships to generate knowledge.

The rest of this section outlines just a few of the many theoretical approaches that specialist homeless services have used. They show how theory can and should be applied to casework practice.

Attachment theory

Attachment theory argues that the quality of attachment in our childhood and adolescent relationships will have a profound impact on our adult relationships and emotional wellbeing. If our experience has been of poor attachment then as adults we are likely to be more insecure and less trusting of others. If our attachment experiences are positive we are said to have greater confidence and social skills.

Bowlby's (1969) theory is that all people need to have an attachment to a care-giving figure that is reciprocal and predictable. This condition enables the child to establish a secure and trusting attachment that allows them to confidently explore the environment, safe in the knowledge that the care giver is available if needed. Insecure attachment occurs when the care giver is unavailable or unpredictable. This can lead to avoidant patterns, e.g. the child refrains from contact with their care giver.

Bowlby (1973) believed that a therapist would be seen as an attachment figure regardless of whether or not the client is aware of this fact. A similar attachment may take place between a client and caseworker.



A caseworker using this model will pay particular attention to the quality of the client's relationships with significant others and try to build on these as a safety network for the client. The caseworker may also work with the client to build trust and develop interpersonal skills.

For more information about attachment theory go to <http://psychology.about.com/od/loveandattraction/a/attachment01.htm>.

Feminism

Feminism is the belief that women should have the same social, political and economic rights and opportunities as men. Feminist movements aim to achieve these same rights and opportunities. Feminist theory provides a framework for analysis of and advocacy to address gender inequalities within society. Many women's services operate within a feminist framework and provide services to women by women only.

Many women's SHS services view family violence in the context of unequal power relationships between men, women and children. Feminism informs their work practices and governance structures. This approach is heavily influenced by advocacy and often tries to raise awareness about inequalities and seek social change through the casework process.

For more information about feminism go to <http://www.wrrc.org.au/aboutus/principles> or <http://www.feminist.com/resources/artspeech/genwom/whatisfem.htm>.

Developmental theory

A developmental approach involves adjusting supports to match the developmental stage of the client. It generally applies to children and adolescents but also to adults in some circumstances.

Children develop skills in five main areas of development, which are:

- **Cognitive development:** The child's ability to learn and solve problems, e.g. an infant learning to explore the environment with hands or eyes or a five-year-old learning how to do simple math problems.
- **Social and emotional development:** The child's ability to interact with others, including helping themselves and self-control, e.g. a six-week-old baby smiling, a ten-month-old baby waving bye-bye, or a five-year-old boy knowing how to take turns in games at school.
- **Speech and language development:** The child's ability to understand and use language, e.g. a one-year-old saying his first words, a two-year-old naming people or a five-year-old saying 'feet' instead of 'foots'.
- **Fine motor skill development:** The child's ability to use small muscles, e.g. hands and fingers to pick up small objects, hold a spoon, turn pages in a book or use a crayon to draw.
- **Gross motor skill development:** The child's ability to use large muscles, e.g. an infant is able to sit up with some support, a one-year-old able to pull up to a stand holding onto furniture and a five-year-old learning to skip.

For more information about childhood development go to www.earlychildhoodaustralia.org.au/.

Young people's psychosocial development is influenced by their environment and the support they receive from family, peer group, school and the wider community, as they transition to adulthood.

A successful transition involves a young person being able to support themselves financially, engage in healthy family and other social relationships, and participate in education/employment opportunities and the community. Research (CYD, 1991) has found that a young person must be provided with an environment that promotes healthy physical, social, emotional and cognitive development that builds a wide range of skills and competencies to positively engage in adulthood.

Key areas of development:

- **independence** from parents and other adults
- development of a realistic, stable and **positive self-identity**
- formation of sexual identity
- negotiation of peer and intimate **relationships**
- development of realistic **body image**
- formulation of their own **moral/value system**
- acquisition of skills for future **economic independence**.

However, the onset of mental health problems, if left untreated at this time of life, can have a significant impact on the development of important life skills.

For more information about adolescent development go to

<http://www.headspace.org.au/parents-and-carers/find-information/adolescent-development>.



Practice approaches and integrating theory into case management practice summary

There are a wide variety of practice approaches and theoretical models that can inform and guide casework practice. These play an important part in maintaining evidence-based, best practice in case management.

Each SHS will make independent decisions about which approaches and models they choose to use. This will depend on the target group and expertise of the casework staff.

The information in this section is not exhaustive and caseworkers must further investigate the information available on casework practice and community service theory.

2.12 Practice principles

Practice principles are used to set the standards by which workers operate in a particular setting. The National Practice Principles and the SHS Practice Principles for Case Management are practice principles that affect caseworkers in SHS and are outlined below.

National practice principles

Case management principles were identified in the 1994 Case Management Discussion Paper that led to the development of the National Practice Principles in SAAP Case Management in 1997. It is important to note that 'principles' may often be accurately described as 'process' standards. They outline the good professional or organisational practices necessary to deliver quality services. They are focused on maintaining and promoting the civil, economic, political and social rights of clients.

Principles should be the overarching, guiding basis for practice. Within this, the development of more specific, measurable standards, which relate to the impact of the service on

individuals, is essential. The following principles were developed for use in SAAP (SHS) organisations.

Principles underlying SHS (formerly SAAP) service delivery

(i) **Protection of human rights and freedom from abuse.** This includes:

- legal and human rights of each client and worker are upheld in relation to the prevention of sexual, physical, financial and emotional abuse within SHS services
- each client is provided with opportunities for enhancement of dignity and a positive self-image
- each client receives the least intrusive, appropriate intervention from a SHS service
- SHS services ensure duty of care in all service delivery practices.

(ii) **Confidentiality, privacy and access to personal information.** This includes:

- each client's right to privacy and confidentiality is acknowledged and maintained
- each client is informed about confidentiality policies and practices at every stage of service delivery
- information about each client is collected by lawful, fair and non-intrusive means
- only information which is necessary for the delivery of the SHS service is sought from clients
- each client is advised of the purpose for which information is requested, the type of information kept, and the person(s) to whom the information will be made available/disclosed
- each client has the right of access to personal information held by the agency/service, and is informed of steps to take if he/she wishes to obtain access
- clients are advised of the limitations of the service's confidentiality policy, e.g. subpoena to court, child protection notifications.

(iii) **User rights upheld.** This includes:

- utilisation of a dispute process which does not jeopardise the right to service
- each client is made aware of, is supported in, and has access to complaints and dispute resolution procedures
- each client is provided with information about the nature and choice of available services, rules and conditions
- equity of access within what the service offers is assured.

(iv) **Client self-determination.** This includes:

- each client is supported and encouraged to achieve the maximum possible degree of independence and participation in the community that the client desires
- each client receives service which aims to enhance his/her self-reliance
- each client receives service which is client focused and client directed, within the parameters of SHS
- each client participates in all stages of the case management.

(v) **Needs-based service delivery.** This includes:

- each client has access to service based on assessment of relative need and available resources

- each client receives a service which is designed to respond to his/her individual needs, which is timely and relevant, and which is planned with the individual
- each client receives a service which is holistic in approach and focused upon client
- strengths, successes and achievements, and present and possible future needs
- each child accompanying adults to SHS services is provided with support, protection and services based on assessment of her/his individual needs within the family context
- each service will develop appropriate external networks to enhance positive outcomes
- SHS will offer flexibility within service models, and all aspects of service delivery, and responsiveness to individual need.

(vi) **Non-discriminatory access and non-judgemental support.** This includes:

- each client is provided with non-discriminatory access to SHS services, within the service scope and target group
- each client receives non-discriminatory support and response to needs, provided in a non-judgemental manner within the scope, target group and capacity of the service
- each service will be provided in settings which are comfortable and non-threatening to the client, and which encourage client participation.

(vii) **Culturally-appropriate service provision.** This includes:

- each client receives a service that is sensitive to and respectful of his/her cultural and linguistic background and values, including the importance of preserving significant networks and/or relationships.

(viii) **Effective and efficient management.** This includes:

- service management which is efficient, transparent and accountable to all stakeholders
- service management which ensures coordinated, planned and reliable service delivery
- each client is provided with genuine opportunities for participation in consultation and planning of services
- each client receives services from trained and skilled service providers, delivering services in an ethical and professional manner
- each client receives predictable, consistent service provision based on articulated principles and standards.

(ix) **Duty of care.** This includes:

- service management which exercises reasonable skill and competence
- the adoption of appropriate standards of care
- the development of guidelines/protocols and provision of opportunities for appropriate intervention to protect and assist the client
- safety and security procedures are implemented to ensure the safety of staff and clients.

For more information about the National Practice Principles in Case Management go to

http://www.fahcsia.gov.au/sa/housing/pubs/homelessness/saap_er_publications/saap_case_mgmt_resource_kit/national_practice_principles/Documents/Practice_Principles_case_mgt.pdf.

SHS case management good practice principles

The following good practice principles were developed in consultation with a Practitioner Advisory Group. They aim to provide a set of principles that can underpin all SHS case management in NSW. They are further supported by the NSW Department of Family and Community Services, *Good practice guidelines* and are embedded throughout this resource kit.

Principle 1: Social justice and human rights

- 1.1 Access: All clients have access to services, information, advice, resources, support and opportunities regardless of ability.
- 1.2 Equity: All clients are treated fairly and equally with regards to service provision and allocation of agency resources.
- 1.3 Rights: The rights of all clients are protected through informed consent; confidentiality (within legislative limits); right to service, protection of human rights, respect, safety, access to the complaints process and the right to service while the complaint is processed.
- 1.4 Participation: All clients are active participants in the decision-making processes that impact on their lives and not to be excluded, i.e. case plan driven by client's needs, issues and aspirations versus worker's expectations.
- 1.5 The legal, human rights and dignity of each client are preserved and supported.

Principle 2: Client-centred practice

- 2.1 All support revolves around the needs of the client.
- 2.2 Clients are empowered to make decisions regarding their own care plan.
- 2.3 Children are recognised as clients in their own right and have an individualised case management plan.
- 2.4 Clients are invited to join the case management process through informed consent and participation in decision-making processes.
- 2.5 All actions support the wellbeing of the client.
- 2.6 All clients are respected for their intrinsic worth and right to self-determination.
- 2.7 Caseworkers maintain effective and timely communication with the client.
- 2.8 The caseworker maintains dynamic and flexible responses.
- 2.9 Active engagement and sustained attention/effort into building relationship with client.
- 2.10 Client/caseworker relationship built on trust and respect.
- 2.11 Caseworkers engage in respectful interactions.
- 2.12 Provide opportunities that result in client empowerment and independence.

Principle 3: Strengths-based practice

- 3.1 Caseworkers recognise and acknowledge client's strengths and achievements.
- 3.2 Caseworkers provide support for client-generated solutions.
- 3.3 Clients are encouraged to utilise their strengths to overcome adversity.
- 3.4 Achievements are emphasised over failures.

Principle 4: Enhance client self-sufficiency

- 4.1 Case management builds the client's capacity to become self-sufficient.

- 4.2 Case management builds the client's social and community networks.
- 4.3 The client's life skills and knowledge of community resources are enhanced.
- 4.4 Caseworkers seek to end or prevent homelessness for all clients.

Principle 5: Professional practice

- 5.1 Caseworkers consistently engage in ethical practice including establishing boundaries, maintaining consistency and reliability.
- 5.2 Caseworkers engage in reflective practice through supervision and peer engagement.
- 5.3 Caseworkers actively participate in evidence-based practice which drives continuous quality improvement.
- 5.4 Caseworkers participate in ongoing learning and development to help understand and address the causes of homelessness.
- 5.5 Caseworkers participate in and contribute to individual and group clinical supervision, staff/team meetings, case reviews and training.
- 5.6 Caseworkers maintain high levels of accountability and reliability through accurate records and workplace safety.
- 5.7 Caseworkers observe a duty of care towards clients and colleagues across the service system.
- 5.8 Engage in power sharing through collaboration and inclusion.

Principle 6: Social inclusion

- 6.1 Caseworkers engage in culturally- and religiously-informed practice, i.e. access to the service, interpreters and translated material, and adjusting practices to suit the cultural and religious framework in which the client exists.
- 6.2 Caseworkers make reasonable adjustments to practice to incorporate individual differences and beliefs amongst clients.
- 6.3 Caseworkers ensure inclusiveness and respectful approach for:
 - Aboriginal and Torres Strait Islander peoples
 - people from a culturally and linguistically diverse background
 - people from all faiths
 - people with a disability
 - gay, lesbian, transgender, intersex and bisexual people
 - people experiencing social, economic disadvantage and/or geographic isolation.

Principle 7: Multidisciplinary approach and collaboration with other services

- 7.1 Caseworkers build collaborative partnerships with government, non-government and specialist services that are client-based, activity-based and/or service-based and that enable:
 - referral pathways
 - planning, delivery and coordination of multidisciplinary practice, e.g. participation and contribution to case management, i.e. service delivery and case conferences
 - provision of activities, opportunities and community linkages
 - contribution to a more streamlined and integrated approach to service delivery.
- 7.2 Caseworkers maintain open and honest communication with service partners within the context of the National Privacy Principles.
- 7.3 Caseworkers seek to enhance access to services for their clients by seeking to work in partnership with mainstream and community services.

Section 3: Case management in practice

3.1 When and why to apply case management?

Case management is a process that occurs throughout a client support period and can begin from the first time the client is met. Case management is best suited to situations where a client needs help to work towards agreed goals. This may involve practical assistance with food and shelter, providing information, advocating for the client or helping them to negotiate their way through diverse and complex service systems to get adequate support.

Some clients will not want this assistance and may refuse to accept support. Others will only access SHS support for a brief period or specific purpose where formal case management is not required. Others may have external organisations providing case management services. In these situations, informal casework support should be provided that follows the same practice principles.

According to the NSW Homelessness Action Plan, there is a clear expectation that all SHS clients will be offered case management and should be encouraged to accept the support. However, some will not and access to services must not be refused on this basis alone. Even when case management is not formally provided, the principles of case management still apply to any service provided to clients and records should still be kept about support they receive.

Case management is therefore a key function of a SHS provider. The NPAH identifies that SHS providers must work towards breaking the homelessness cycle and intervene early to prevent it in the first place. Case management enables workers to support clients to create changes in their lives that will help to break the cycle of homelessness or violence. It also helps empower clients to exercise their rights and effectively problem-solve future circumstances that place them at risk of homelessness.



When and why to apply case management summary

- Case management is suitable for all SHS clients.
- Case management includes a range of activities to support clients to reach agreed goals and to access support.
- Informal casework is appropriate if the client doesn't want or need formal case management support.
- All SHS clients should be offered and encouraged to accept case management support.
- Services cannot be refused on the basis of a client refusing case management.
- Case management includes advocating for the client's rights.
- Case management is ultimately aimed at building client capacity and preventing or reducing the risk of homelessness.

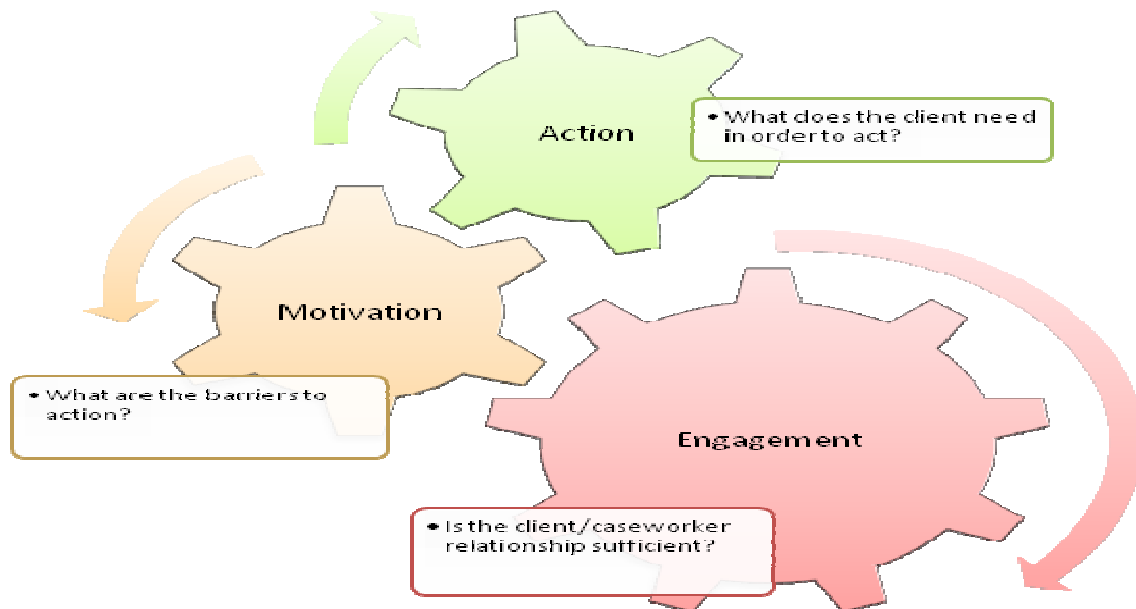
3.2 The client/caseworker relationship

The client/caseworker relationship is extremely important in ensuring the ongoing success of any case management process (AHURI, 2009). A critical aspect of the relationship is the level of engagement and respect achieved throughout the case management process and this starts from the first meeting.

Engagement includes getting to know the client's interests, what motivates them to action and what barriers they perceive. It is also about building trust and mutual respect so that the relationship stands up in times of conflict or when there are 'road blocks' preventing the client from moving forward. This is particularly relevant to clients with complex or multiple needs.

The diagram below illustrates the components of the client/caseworker relationship. It shows that an effective caseworker needs to invest heavily in the relationship with the client, to motivate them towards action. If there is not a sufficiently strong relationship (trust, knowledge and respect) the caseworker is less effective at motivating a client and supporting them to act on their goals.

Diagram 2: Client engagement



The diagram also acts as a useful self-reflection tool for caseworkers to identify potential blockages in their client relationship and why a client may be lacking progress in a particular area of the case plan.

There are three key questions that can be asked in this situation:

1. **What does the client need to act? (Action)** Sometimes clients may need something else to be in place or to happen before they can act on a particular goal or issue. The client may need additional support to take the first step or more information to help them work out the best way forward.

This can involve helping a client to attend the first few appointments with a counsellor, showing them where to find information or helping them to go through the process of registering with Housing NSW. Caseworkers therefore need to get

to know their clients well enough to understand these factors and be able to talk openly about them.

2. **What are the barriers to action? (Motivation)** There are multiple barriers to action for clients that can include internal and external factors. A client's internal barriers are most likely to impact on the client/caseworker relationship and include a client:

- doubting their ability to reach their goal
- being afraid of rejection
- not knowing how to go about meeting their agreed actions
- being anxious about an anticipated outcome of an action
- having a developmental delay that causes emotional or cognitive immaturity
- having a mental illness
- being under the influence of alcohol or another drug.

External barriers are less likely to affect the relationship but can demotivate the client and include:

- long-term unemployment due to job shortages
- having friends or a partner that is having a negative influence
- lack of access to services and support that the client needs
- lack of education.

Clients become unmotivated for a number of reasons that are often connected to misinformation that can cause them to experience a lack of confidence.

A caseworker may need to use a strengths-based or solution-focused approach to revisit with a client what their hopes and aspirations are, to remind them of their strengths and abilities to achieve these, and help them to work out the steps to get there in more detail.

Sometimes the case management process can become overwhelming for the client and the caseworker can help break it down to a more achievable level.

An effective relationship with the client will enable these issues to be identified and responded to more effectively.

3. **Is the client/caseworker relationship sufficient? (Engagement)** It is critical that there is a relationship of trust and respect, so the caseworker can ask tough questions or encourage the client to share their inner thoughts and feelings about issues. The caseworker must also have sufficient knowledge about the client to help them explore these thoughts and feelings.

It takes time to develop this kind of relationship so caseworkers must allow time for this in the early stages and throughout the case management process. This will be affected by the caseworker's case load and the type of support they receive.

At difficult times in the case management process, the caseworker should consider if there has been a break down in their relationship with the client and, if so, what needs to be done to rebuild it.

Furthermore, the client/caseworker relationship is to be client centred. Client-centred practice involves placing the client as the central focus of case management. It is an act of client participation where power is shared equally in the relationship, so as to empower the client to become self-sufficient.

Client participation

One way of strengthening the client/caseworker relationship is to ensure the client is empowered to be a decision maker in the relationship and is invited to be an integral part of their support plan.

According to Spall, Testro & Matchett (1998), participation is the act of taking part in and sharing in the processes. Participation also refers 'to the process of sharing decisions which affect one's life and the life of the community in which one lives' (Hart, 1992).

Client participation is not simply consulting with clients about their views but rather taking those views and incorporating them into planning and evaluation processes. It is also about inviting clients to take an active and legitimate role in delivery of support services to them.

These concepts should guide the client/caseworker relationship, as they will help to ensure that the client remains central to the process and develops the skills to be self-sufficient.



Examples of client participation include:

- developing a client council to advise on service delivery issues
- providing opportunities for clients to have some say over how the SHS they live in, or receive support from, is operated
- inviting clients to be involved in decisions about changes to service delivery
- inviting ex-clients to join the management committee of your service
- inviting clients to develop their own holiday activity program.

For more information about client participation in homelessness services see the Consumer Participation Resource Kit on the Council to Homeless Persons' website http://www.chp.org.au/public_library/cpkit/index.shtml.

Maintaining professional practice

Case management involves supporting clients with some very personal issues at times when they may be at their most vulnerable. In these circumstances, the caseworker and client can become very close and this can lead to a blurring in the professional relationship between them. This can lead to all sorts of unintended consequences such as:

- showing favouritism
- developing personal relationships outside of work
- worker burnout
- co-dependency of the client with the caseworker
- supporting clients outside of work hours or going beyond the levels that are normally expected for client support.

Therefore caseworkers must be careful to guard against situations that may cause their professional practice to come into question. This can be done using reflective practices and ensuring appropriate professional boundaries are in place.

Professional boundaries

Boundaries are acceptable and ethical lines that are drawn between the professional and private spheres of the caseworker. As a caseworker spends more time with the client, the relationship can become more complex and there is an increased risk of professional boundaries being compromised.

These boundaries are crossed when the relationship moves beyond appropriate professional standards of practice and blurs into the private life of the caseworker. It can also occur when the client's or caseworker's expectations become more than what would normally be expected in a professional relationship.



Some examples of crossing the line include:

- a client starts to become physically and emotionally attracted to their caseworker or vice versa
- a staff member giving gifts to one client and not others
- a caseworker becoming friends with a client on Facebook on a private account
- exchanging messages outside of work on a mobile phone
- a client visiting a worker at their home.

Clients and caseworkers do not generally deliberately move across these boundaries; they often involve a gradual process of crossing the line. Reflective practice, supervision and colleague feedback are often the best ways to detect boundaries that are becoming compromised. Caseworkers must never be convinced that it will not happen to them.

Organisations must have systems in place to set up and maintain appropriate boundaries and for managing compromised relationships professionally and ethically.



To avoid inappropriate professional conduct a caseworker should:

- establish clear roles and responsibilities for staff and clients in the service at the start of the support period (Appendix 1 can be used to help set out rights and responsibilities for clients)
- maintain clear distinctions between work and private life
- remind clients that the relationship is professional only when you feel that it may be getting blurred for the client (i.e. when they expect you to act as a friend)
- reflect regularly on your emotional responses to clients as a way of self-checking and encourage colleagues to point out if they see the relationship changing between you and the client
- make supervision a priority and use it to reflect on your relationship with clients and to discuss concerns.

Conflict of interest

Conflict of interest is a particularly relevant issue in rural and remote and some cultural communities, if there is limited separation of individuals, the wider family and social connections. However, it is also relevant in metropolitan locations from time to time. It is important to have clear policies and training about identifying, declaring and managing a conflict of interest.



A conflict of interest occurs when your decision-making capacity as a professional is compromised by a personal interest. For example:

- a client needs furniture for their new unit. The caseworker's brother is in the furniture business and expects them to give him the business
- a caseworker realises that their new client is related and certain family members want the client to get special treatment
- a caseworker finds out that their service has received a referral for their cousin and it is the only suitable service in town.

A conflict of interest does not mean a caseworker cannot work with a client but it does mean that the conflict needs to be declared or put out in the open, to avoid being unethical or having their professional judgement compromised or questioned.

In some cases, it may mean that it is best for another worker to take the case or the caseworker needs to run decisions past their manager. Most conflicts of interest can be managed but they must first be identified and declared.

Sometimes there are no options to avoid a conflict of interest, such as re-allocating workers or avoiding certain decision-making processes. If so, the caseworker must develop strategies to ensure they continue to make ethical decisions and remain client-centred. This may involve:

- running all decisions past a supervisor
- ensuring that actions and decisions are in the interests of the client and not yourself
- encouraging the client to make decisions for themselves
- discussing the conflict of interest with the client and jointly developing strategies to manage it
- ensuring that clients are presented with a range of options to choose from and providing information about each option so they can make an informed decision
- maintaining public and transparent practices and records of the casework process to provide evidence of ethical practice
- familiarising yourself with the agency or industry code of ethics.

Code of conduct

SHS organisations must have clear policies and procedures about what is appropriate and what is not in the client/caseworker relationship. This is usually in the form of a code of conduct or code of ethics (see sample code of conduct in Appendix 4). It may also be incorporated and cross-referenced into other policies about working with clients.

If a caseworker is unaware of their agency policy about client and caseworker relationships, or have not read a code of conduct, they should speak with their manager about it.



Caseworkers should familiarise themselves with their agency code of conduct and use it as a guide for client/caseworker relationships.

Typically a code of conduct should provide guidance about appropriate standards of practice on:

- how to deal with gifts to or from clients
- contact with clients outside of work hours
- appropriate dress code
- behaviour or conduct when with clients (e.g. language, smoking, etc.)
- consequences of breaching the code of conduct
- use of alcohol or other drugs at work
- conflict of interest
- contact with the media.

What goes into a code of conduct?

The code of conduct and other agency policies must also reflect the principles of case management that are outlined in Section 2.4 of this kit. The key principles about the code of conduct are:

- treating clients equitably and fairly
- remaining focused on the client's needs rather than the worker's
- respecting client rights including the right to self-determination
- respecting client's identity, i.e. culture, religion, sexual preference, ability/disability
- focusing on strengths, achievements and abilities rather than deficits
- ensuring self-care for staff.

Please see Appendix 4 for a sample code of conduct that can be adapted for your organisation.

Secondary or vicarious trauma (self-care)

There is an increasing body of knowledge and evidence about caseworkers and other helping professionals experiencing secondary or vicarious trauma, as they are regularly exposed to the trauma stories of their clients.

The effects of trauma exposure on professionals were first observed formally in the late 1970s in emergency and rescue workers, who displayed symptoms similar to the trauma victims they were helping. This prompted investigation of other people working with victims in various capacities, such as disaster relief workers, nurses, and crisis and hotline workers.

SHS caseworkers are regularly exposed to the trauma experiences/stories of their clients and therefore at risk of experiencing vicarious trauma and its negative effects. Caseworkers can avoid these effects by understanding and responding to the warning signs and taking preventative action.

Symptoms

A caseworker can suffer trauma due to prolonged exposure to it through hearing about and witnessing trauma in their clients' life circumstances. While trauma symptoms need to be recognised as culturally diverse, trauma reactions are generally divided into three categories:

- **intrusive reactions:** dreams/nightmares, flashbacks, obsessive thoughts, physiological reactions and other persistent re-experiencing of the traumatic event
- **avoidant reactions:** general numbing in responsiveness and avoidance (particularly of things related to the traumatic material)
- **hyperarousal reactions:** hypervigilance, disrupted sleeping patterns and difficulty concentrating.

Prevention

The effects of vicarious trauma can be prevented or minimised through a combination of self-management strategies, organisational policies that encourage an appropriate work/life balance and reflective practice through supervision.



The ABCs of preventing or minimising secondary trauma are:

- a. **Awareness** – being attuned to your own needs, limits, emotions and resources
- b. **Balance** – maintaining balance among activities, especially work, play and rest
- c. **Connection** – connecting to oneself, to others and to something larger.

A useful resource on vicarious trauma is:

Richardson, JI 2001, *Guidebook on vicarious trauma: recommended solutions for anti-violence workers*, Centre for Research on Violence Against Women and Children in London, Ontario for the Family Violence Prevention Unit, Health Canada.

<http://www.crvawc.ca/documents/guidebook%20on%20vicarious.pdf>.

This resource from the Australian Centre for the Study of Sexual Assault is also useful http://www.aifs.gov.au/acssa/pubs/wrap/acssa_wrap4.pdf.

Supervision

Supervision is a key tool for caseworkers and casework supervisors to use as a way of avoiding or minimising the impact of vicarious trauma in an SHS. Supervision enables caseworkers to:

- develop reflective practices – by encouraging the caseworker to stop and reflect on what they are trying to achieve, why and how, and look at alternate ideas for intervention
- identify areas for professional development – by identifying training needs and allocating resources to support training
- review work performance – by providing and seeking feedback on work tasks

- seek help with challenging clients – by getting ideas and suggestions from a more experienced supervisor
- raise support needs – by making the supervisor aware of areas of difficulty and negotiating a solution or additional support needs.

Supervision is a process of meeting with another professional (usually a supervisor) for the purposes of administrative review, professional development and self-care. Many supervisors struggle to get past the administrative part; however caseworkers should help their supervisor to make sure that professional development and support needs are also discussed.



Kadushin (1992) identified that supervision involves three core components:

1. **Administrative** – the promotion and maintenance of good standards of work, coordination of practice with policies and procedures, and the assurance of an efficient and smooth-running office
2. **Educational** – the process of educating the worker with new knowledge and skills; helping them to realise their full potential; and developing reflective practice
3. **Supportive** – the maintenance of harmonious working relationships and flexible work practices.

The AHURI synthesis paper (2009) for the NSW HAP points out that ‘high workloads and scarce resources can impact on workers’ capacity to maintain respectful, ethical practice.’ These are things that many workers feel in their work; not enough time or money and too many people needing your help.

Caseworkers must prioritise regular supervision and encourage their supervisor to do the same, so that professional and ethical practices are maintained and workers are not burned out unnecessarily.



The Wood Special Commission of Inquiry into Child Protection Services in NSW (2008) highlights that supervision should occur at a minimum of one hour per month. It recognises that supervision is a key factor in maintaining quality casework services when working with clients who have complex needs. It highlights that the FaCS (formerly DoCS) policy set this standard and suggests that supervision should include:

- debriefing (discussing recent experiences)
- reflection (considering the impact of interventions)
- development of skills/knowledge (discussion of recent literature, strategies, alternative approaches)
- professional development (progress with any agreed development plans)
- constructive feedback (meaningful feedback on work performance and areas for further development)
- recording of information (tasks and activities to be used as a reflection tool for the next supervision session).

Supervision should occur in a private place and made a priority regardless of whether it is felt that it is needed. It must be part of a culture of continuous improvement and wellbeing rather than one of compliance and discipline.

It is a good idea to use a template for supervision discussions and have a supervision contract in place. This ensures that supervision remains supportive, educational and administrative. Supervision is not only the responsibility of supervisors and must be planned for and contributed to by both parties.

A sample supervision record (Appendix 2) and a sample supervision contract (Appendix 3) are included in this kit as suggested templates. They can be used as a basis for reviewing or establishing a professional supervision relationship in the workplace.

The supervision record includes a number of prompting questions that the supervisor can use during supervision or help the caseworker prepare for their meeting.

The supervision contract sets out the frequency, privacy and terms of the supervision relationship. It helps the caseworker and supervisor to agree on the minimum frequency of their meetings.



Client/caseworker relationship summary

- The client/caseworker relationship has a critical impact on the likelihood of successfully reaching the client's goals.
- The client/caseworker relationship takes persistence, time and involves building trust and respect.
- The client/caseworker relationship is client-centered. Client-centered practice involves providing clients with the opportunity to participate equally in the casework process and become self-sufficient.
- Caseworkers must maintain an appropriate and clear distinction between their professional and private life from the start of the support period.
- Reflective practice, supervision and feedback from colleagues help caseworkers to manage this distinction and recognise when it is being blurred.
- Caseworkers must take care to protect themselves from burnout and secondary trauma when supporting clients by maintaining an appropriate work/life balance and participating in supervision.
- Supervision is a critical part of self-care and professional development. It should involve administration, education and support for caseworkers.
- A conflict of interest may occur in casework if the personal interests of the caseworker cross into their work role. These must be declared and avoided where possible.
- An agency code of conduct provides a guide for developing and maintaining professional practice in casework.



Case scenario: Matt

Matt has been a dedicated SHS caseworker with young people for three years. Young people find Matt approachable and reliable. His colleagues and supervisor have commented on his dedication to clients and the service.

In the last three years, Matt has had four weeks annual leave and he doesn't claim time in lieu. Matt often works back late with clients as many of them have experienced past trauma and he feels that they have had a rough past and need his support.

Recently, his colleagues have noticed he is becoming a bit forgetful, not turning up to team meetings and appears increasingly irritable. Matt has also taken sick leave for the first time in two years and been complaining of headaches.

When his colleagues try to suggest that he may be too stressed and should take a break, he reacts by suggesting that they do not appreciate all the work he puts in and that the clients need him around.

Matt's supervisor has tried suggesting to Matt that he may be experiencing some secondary trauma as a result of all the time he spends with his clients at work. He has been minimising the problem in supervision even though his health and mental wellbeing have been deteriorating.

Matt is eventually told to take some compulsory leave to avoid further harm to himself. He reluctantly accepts and takes a week off. He is instructed not to have contact with work.

When he returns to work he has a meeting with his supervisor where he discloses that he has realised he is over committing himself to his work and needs some help to set better boundaries with these clients. He puts together a plan with the help of his supervisor containing some strategies he can put in place to better separate his work and private life.

Matt also realises he was not helping himself or the clients effectively, as they were becoming dependent on him and he was starting to lose his objectivity. After a few weeks of following his plan for better boundaries, Matt's health has improved and he is working more effectively with the clients. He is now more focused on the case plan and helping clients take charge of their situation.

Practice tips:

- Professional boundaries help caseworkers to remain effective support workers.
- Supervision plays a key role in self-care and reflective practice.
- Caseworkers can benefit from taking time out of their work to reflect on their practice and recognise where they may be stepping outside of the expectations of their role.
- Maintaining a healthy lifestyle helps to ensure mental and physical wellbeing.

3.3 The elements of case management

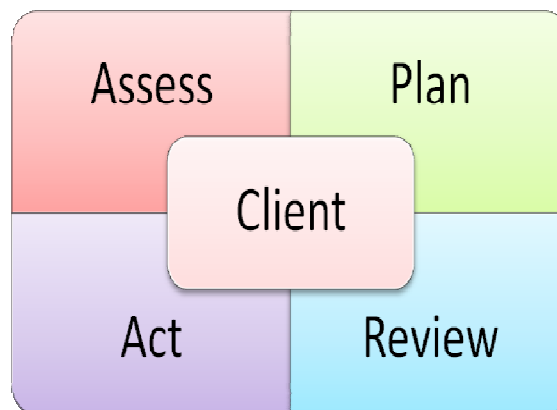
Case management is not a static, step-by-step process, but rather it consists of a number of elements that work together according to the needs of the client and the type of support provided. These elements can overlap or be undertaken simultaneously.

The elements of case management can be summarised under four headings:

1. Assess
2. Plan
3. Act
4. Review.

The following diagram shows these four elements as a process that continues as long as the client needs it and which places the client as the central focus point. The ultimate goal is that the client's capacity to self-manage is developed by linking them with appropriate supports, providing information and helping them to develop new skills.

Diagram 3: The elements of case management



At times the elements will overlap into each other and at other times they will be distinct. Each element is equally relevant from the first time you meet the client until the last. For example when a client first presents at a SHS service it is likely that the caseworker will be aiming to meet the client's basic and immediate needs, as well as assessing ongoing needs and developing a case plan to agree on a way forward.

The rest of this section will expand further on each element.

3.4 Assess

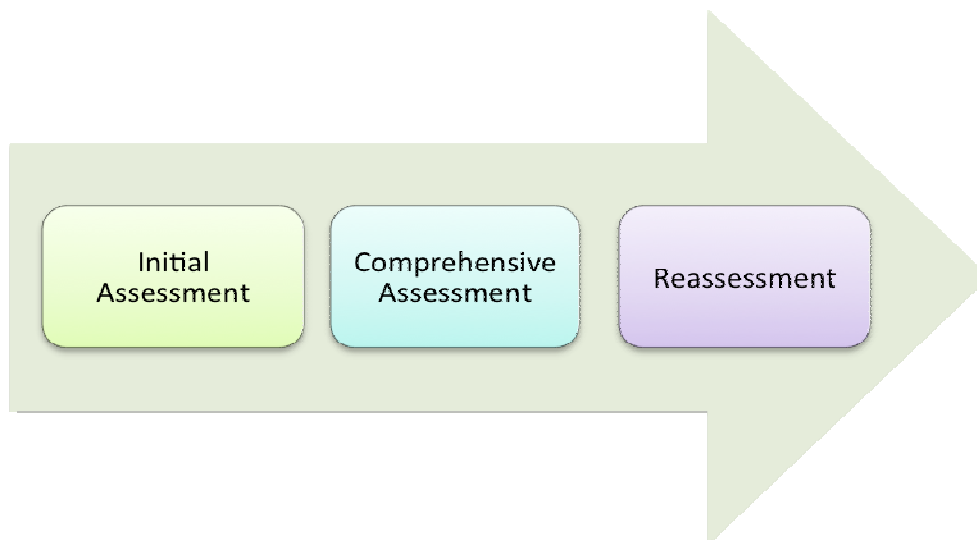
Assessment can be defined as the process of discovering the short- and long-term needs of a client and considering these against the skills, resources and capacity of the service to meet these needs. It is not simply about comparing the client to a set of criteria but rather a process of identifying the most appropriate interventions for them and how to address these in an efficient and constructive way.

Assessment occurs from the first point of contact with a client and continues throughout the support period. Assessment involves a variety of skills and knowledge about the client, their needs and what works to address their needs.

The assessment process

Assessment can be thought of in three stages: initial screening, comprehensive assessment and reassessment. The diagram below shows that assessment is not something that happens at a single point in time or only at the start of the support period. Assessment is ongoing throughout the case management process. Every interaction, intervention and observation accumulates to provide an informed perspective about the client and his or her needs and strengths.

Diagram 4: The assessment process



3.4.1 Initial assessment

At initial assessment the caseworker will gather information about the client's range of needs and put together an initial case plan. This may be just a list of actions that need to be taken in the first few weeks of support and will contribute to the formal case plan.

Initial assessment involves:

- screening for suitability
- identifying client needs
- assessing risk
- considering the agency's ability to meet those needs alone or in partnership with other organisations.

The caseworker should apply the SHS Risk Assessment Tool (Appendix 5 & 6) or a similar tool to help assess and minimise any potential risks to staff or clients. The SHS Risk Assessment Tool provides a useful and comprehensive assessment of potential risk factors and supports caseworkers to consider appropriate risk management strategies.

More information about this tool can be found in this section under the heading Risk Assessment. See Section 3.5 for information about case planning.



An effective initial assessment will consider the profile of the clients that your organisation has chosen to focus your service delivery on.

This may be young people, families, adult males, single women or other target group you choose, together with funding providers, and based on the skills and resources available to your organisation.

Initial assessment must also be timely and remain client-centred. The client must therefore get a response to their request for service as soon as possible and be kept informed of the process along the way. They must also be told the outcome of the initial assessment and advised of more suitable services if your organisation is unable to assist.

Initial screening (eligibility criteria)

Eligibility criteria are the factors that help caseworkers to determine the particular clients they can help based on the skills and resources available to your service. They are not a means to exclude particular subgroups of homeless clients and should therefore not be too specific. Each client should be individually assessed to work out if they can be supported.

For example, it would be inappropriate to have criteria that specify your service does not support clients with drug and alcohol addiction. There is a big difference between a client who has an addiction and is unwilling to change compared to one who is seeing an AOD counsellor and actively avoiding drugs. There is also a difference between regular and casual users and are clients who smoke cigarettes considered to have a drug addiction?

Each SHS will need to consider basic universal factors like age, gender, relationship status, income and reasons for becoming homelessness. Some of the more specific criteria to consider may include:

- Will you accept accompanying children?
- Do you have access to specialist assistance to enable your service to target special needs groups (e.g. mental health issues, violence, disability, alcohol and/or substance misuse or sexual assault)?
- Will you target people from a specific geographical area or a particular sociocultural group?
- Are there particular gaps in the service system that your service can help to fill?

When considering eligibility criteria it is also important to research what other SHS and non-SHS services are available in the area and what support they provide to people who are homeless or at risk of homelessness. This information should then be compared to local demographic and statistical information to help identify any potential service gaps that your organisation could fill.

It is important that services in a particular area try to cover a broad range of needs in that community rather than targeting just a few subgroups of homeless people. This is a responsibility of all funded services.

Furthermore, it is critical that the criteria developed for your organisation or program do not allow discrimination by becoming a rigid list of criteria that all prospective clients must meet to be accepted. If this is the case, then some clients who can potentially be assisted will be excluded because of these criteria.



Eligibility criteria are simply a guide for potential clients and referring agencies about the target group your organisation helps and specialises in. Once a referral is received the client should be individually assessed based on whether your organisation has capacity to address their needs and they sit broadly within the target group.

For example, if an organisation has a client with some complex and difficult needs that take up more resources than usual, it may decide not to accept another person with the same level of needs.

However, if you mostly have clients with lower support needs you may be able to work with a client who has higher and more complex needs.

Essentially assessment should never be about ticking a set number of boxes but rather it should be a flexible and adaptable process that looks at each case on its own merit. This principle flows through all aspects of assessment in case management.

Entry to the service

Once an organisation accepts a client for support it is necessary to gather more information about them to fulfil its duty of care and help move the assessment process forward.

Information collected at this point will vary depending on the client and the particular supports your organisation will be offering. For example, the information required from a client will be different depending on whether they are receiving residential support or going to a drop-in centre with case management support.



Information collected at the client's entry to the service will build on information given in the initial screening. It can include:

- personal contact information for self and significant others
- critical health information, e.g. allergies, illnesses, medications
- details of client's activities, e.g. education, employment
- details about any legal issues
- Medicare number and emergency contact numbers
- information about any other services they are involved with.

This information must be collated into a client file along with all other information collected about the client so far. This information must therefore be kept secure and locked away when not in use in line with privacy principles. More information on privacy principles is in Section 3.6 under the heading Privacy.

Informed consent

Informed consent refers to the right people have to be told about the supports they will receive, what will happen to information collected about them and what the likely outcomes of the support may be. Staff do not have the right to make decisions for clients without their consent, even if their desire is to protect or assist a client, unless there is a risk of harm to the client or others. The preferred option, however, is always to seek consent first.



Permission from the client must be given before any information about them or their child is given to another agency. If possible this consent should be in writing but if not, for instance when the client is supported by telephone, the worker should make a note in the case file recording the conversation and the client's response.

Caseworkers must also consider that in some cases consent may be more difficult to get or required from a legal guardian. For example, a person with an intellectual or learning disability, a child, or a person who is mentally unwell.

When a client enters a service they should be made aware of the agency policy on informed consent. It is important that the client gives informed consent for the exchange of information between the caseworker and others, at the start of the support period. Some organisations may get consent at the initial interview and then more detailed consent when support starts. Either way, the caseworker must have consent before they can proceed further with the case management process.

See Appendix 7 for a sample consent form that caseworkers can use and some suggested text to help the client understand what they are consenting to.

More information about informed consent is available in the new SHS Data Collection Training Manual which can be found at <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737419123>.

Exceptions to consent

There are some exceptions where client consent is not required to share information with others. These are usually situations where there is a risk of harm to the client or another person, or if the law requires the exchange of information.



Examples of exceptions to client consent:

- a child is at risk of harm from a parent or other individual
- the client is at risk of self-harm or suicide
- the client has threatened to harm another person
- the client needs medical treatment due to an overdose
- the police produce court papers requesting information from your service
- a client provides information about a serious crime
- a client requires immediate medical assistance
- a client is unable to give informed consent (in this case there may be a guardian available).

In situations involving client safety there is a duty of care to involve others who can help ensure the safety of the client and others, with or without the client's permission.

If practical and possible the situation should be discussed with your supervisor before any action is taken. The client should always be given an opportunity to make the choice for

themselves. If action is taken without the client's consent they should be told as soon as possible afterwards.

Establishing immediate needs

At initial assessment and screening it is important to identify the immediate or presenting needs. These will be the issues that the client/s first presents with and those most important to them. They may include safety, housing, financial support and relationship or food assistance.

It is useful to identify any needs/wants that you can address fairly quickly because if you resolve some of these immediate needs promptly, this can quickly build trust and engagement with the client.

These immediate needs will be the basis of engagement with the client in the first few days or weeks of support whilst a more comprehensive assessment is done.

More information about assessing needs is found in Section 3.4.2 Comprehensive Assessment.

Risk assessment

In 2004, the NSW Ombudsman's report, *Assisting homeless people – the need to improve their access to accommodation and support services* identified issues that the office believed were hindering homeless people from accessing services.

The report concluded that some client exclusion policies and practices were in place in homeless services that may contravene anti-discrimination legislation. These practices included blanket restrictions on certain types of clients and inadequate risk assessment processes.

In response to this report, funding was made available to develop a risk assessment tool for homeless service providers in NSW. This tool is found in Appendix 5 and the guidelines for using it are in Appendix 6.

The SHS risk assessment process tool is based on five steps that start when the SHS service considers accepting a new client for support. The five steps are listed below and shown in Diagram 5:

1. **Asking open-ended trigger questions** in identified areas of client risk at point of contact or intake.
2. **Asking follow-up questions to gain further information** to learn more about the person's experience with the issue, if needed.
3. Establishing **how severe the risk is** and its potential for harm, if an issue of client risk is identified.
4. Considering **management strategy options** that could lessen the risk.
5. **Balancing severity of risk with the potential to manage the risk, in the decision whether to accept the client.** Then, if accepting the client, developing a risk management strategy as part of the case plan or, if not accepting the client, working with them to make an effective referral.

Diagram 5: SHS risk assessment process



Risk assessment should be completed as part of the screening and entry process as it helps to inform the client's support needs. It should also be revisited as necessary throughout the support period to further assist the caseworker to make decisions about safety for staff and clients.



It is important to remember that risk assessment is not intended to create reasons to exclude but rather its focus is on identifying risk management strategies that can be used to minimise or eliminate risk.

It is good practice to review these risk management strategies as circumstances and needs change throughout the support period.

An assessment template and guidelines are in Appendix 6 which explain the process for using the SHS Risk Assessment Tool included in Appendix 5.

Another tool that may be useful in services that respond to family and domestic violence is found at <http://www.tafe.swinburne.edu.au/CRAF/resources/MCHN%20handbook.pdf>.

See also the information about mandatory reporting in sections 2.5 and 3.6 of this kit.

What about when needs do not match service capacity/resources?

Sometimes the needs of a client will not match with a service's capacity to meet those needs. In these cases, rather than simply rejecting the request, it is best to try to match the client with a more appropriate service and give them information that may help them to manage in the meantime.

The client and the referring agency or individual also has a right to know why the request for service was rejected. If a referral is made on the client's behalf, it is best practice for the assessing worker to give reasons in writing as to why the client was refused. If the client referred themselves it is best practice to explain to them directly why their application was

refused and help them to access a more appropriate service. In some high-volume services it may be more appropriate or practical to give verbal feedback to all referrers.

Helping clients to access other services may include contacting another organisation on their behalf (with their prior consent); giving information about emergency accommodation options; and information about other supports such as counselling or legal assistance. In some cases, your organisation may assist with the cost of a hotel overnight or can advocate for support from a government agency.

Every contact a caseworker has with a potential client is an opportunity to intervene in their situation, regardless of whether they become a formal client or not.



Initial assessment summary

- Assessment involves gathering information about the client's needs and goals.
- Assessment involves the caseworker engaging with the client and inviting them to work together to develop skills and knowledge that will help them to meet their goals.
- Initial assessment involves matching client needs with service capability on a case-by-case basis.
- Eligibility criteria should be based on data about local needs and disadvantaged groups and negotiated with the funding provider.
- Initial assessment must be timely and client-centered.
- Informed consent involves giving clients a clear explanation about what will be collected, why and what will be done with their information.
- The caseworker should quickly establish the immediate needs of the client and try to address some, or all, of these needs as soon as possible to help build trust.
- During the initial assessment the caseworker should collect basic information to help develop an initial case plan.
- The caseworker must use this initial contact to invite the client to participate in the process and to build trust and respect.
- Information gathered in the initial stages contributes towards a more comprehensive assessment that will be completed later.
- Risk assessment is a key part of initial assessment as it helps determine if the agency has capacity to work with the client's needs and to ensure safety for clients and staff, as well as non-discriminating practice.
- Risk assessment is aimed at risk reduction rather than exclusion.
- Clients must be told about the outcome of their request for support.

3.4.2 Comprehensive assessment

The real nuts and bolts of assessment begin when a client is accepted for a service and starts to receive case management. Assessment at this point builds on information gathered in the screening and entry processes. The primary purpose of assessment now moves to the development of a planned approach through an agreed case plan.

Therefore comprehensive assessment requires the gathering of further information about the client through observations, discussions with other workers/support people and more interviews. The caseworker must try to get to know the client better so they can help them to work out a suitable action plan (or case plan).

One of the primary tools that caseworkers use to help work out the best course of action is a theoretical framework. These help to provide a way of understanding and interpreting the specific needs and behaviours of clients. There are a range of theoretical approaches and each offers useful insight into the needs and actions of clients. It is important that caseworkers do not simply rely on their own knowledge and life skills alone, but rather base their actions within an evidence base (see Section 2.3.2 Integrating theory into case management practice).

The assessment process

Assessment involves an ongoing process of observation, information gathering, reflection, engaging and partnering with the client and analysis of that information. It involves engaging the client in a process of self-reflection and self-discovery. It is challenging and stretching the thoughts and self-beliefs of clients and it is never finished.



Assessment does not happen in one sitting with the client. It is not something that a caseworker does from behind a desk or to a client. It is not simply filling out a form or talking with some other workers or individuals about the client. It is an interactive and educative process for both client and caseworker.

As shown in Diagram 4, the assessment process is easiest thought of in stages that build upon each other. At the start of the casework relationship the emphasis is on eligibility criteria and the ability of the agency to meet the needs of the client. As you get to know the client better and they are more comfortable with you as a caseworker, a comprehensive assessment can take place and work can continue on developing a case plan.

As the caseworker keeps working with the client their needs will change. There will be a need to reassess the case plan based on new information that is available and the client's growth through the casework process. Caseworkers should aim to formally assess client needs at least every 3–6 months. Any less and the case plan may become ineffective and irrelevant.

What to ask in an assessment

It can be useful to have some forms or templates to assist with the process of assessment. Templates ensure that a consistent approach is used to assess client needs and helps the caseworker to have some prompting questions to ask. They can also act as a reminder of the range of issues to be considered in an assessment.

However, templates can cause caseworkers to conduct an assessment like a job interview. Caseworkers should avoid working through forms or templates in a step-by-step or linear format. The best assessments are those that are conversational and natural in their progression. Caseworkers should have some starter questions from which they build on according to the information that the client provides.



If the caseworker starts with a question about what the client would like to achieve by the end of the support period and the client talks about getting a job, then the caseworker can naturally lead into more questions about employment and educational needs/desires.

Whilst listening to the client talk about their situation and desires, the caseworker should keep some basic notes about what they say. The caseworker should stay with one topic at a time rather than jumping around from one to the next. This breaks the flow of conversation. The caseworker should take note of things that are said so they can refer back to these issues if necessary.

For example, the caseworker may say 'you mentioned before that...can you tell me more about this?'

The best way to work out what to ask is to focus on the main life domains that will form part of the case plan. These include but are not limited to:

- accommodation
- finances
- legal and justice
- family and relationships
- recreation and leisure
- religion and culture
- emotional and psychological
- education and employment

The caseworker should explore the needs of clients in each of the above domains and keep in mind that assessment informs the case plan. Find out what support the client wants and work out how you can best provide that support.

The discussions during assessment are a great way to build a relationship with the client by discovering their hopes and desires and their likes and dislikes. It is also an opportunity to invite the client to partner with you in the case management process by helping them to realise their own potential to help themselves with your support.

The caseworker does this by describing what to expect and helping the client to see how the process can help them to reach their goals and point out their strengths. It is also achieved when the caseworker talks to the client with respect and in language that is appropriate to them.

Recording assessment information

It is best practice to formally write up the information you find out during an assessment. An assessment report is basically a summary of the key bits of information gathered in an assessment process.

It is a useful document kept on the client's file so that other workers and new staff can refer to it when working with the client. It can also be shared with other services if the client gives consent. This reduces the need for the client to repeat their story to other support workers.



There is no universal format for an assessment report but it should include the following:

- an introduction stating the purpose and context of the report (i.e. why it is being written and how it will be used)
- a background summary of how the client came to access support from your service, why they need it and what other supports they have or had
- a summary of the client's current needs
- an analysis of the client's needs, including causes of homelessness and the rationale for support.

An assessment report should be written in line with the case planning process, i.e. at initial assessment and each case review.

A sample case assessment report template is included in Appendix 8, as a guide for caseworkers writing an assessment report.

In some high-volume or emergency-oriented services, an assessment report may be unnecessary or impractical; however the information gathered about a client must be recorded on their file so that other workers can access and understand it easily.

A combination of case notes, forms, letters or reports from third party support workers can be used to record information on the client file. If there is a lot of information, it is useful to have a basic assessment report with a quick summary of the main issues that informed the case plan.

Assessing and prioritising needs

When assessing needs in a SHS program it is important that the caseworker considers needs holistically rather than focusing on the presenting issues alone. A holistic approach considers the whole person and the range of needs they present with rather than just one aspect.

It can be useful to consider needs within the framework of human motivation theories such as Reiss' 16 basic desires or Maslow's hierarchy of needs.

For example, Professor Steven Reiss (2004) has found 16 basic desires that guide nearly all human behaviour. The desires are:

1. acceptance, the need for approval
2. curiosity, the need to learn
3. eating, the need for food
4. family, the need to raise children
5. honour, the need to be loyal to the traditional values of one's clan/ethnic group
6. idealism, the need for social justice
7. independence, the need for individuality
8. order, the need for organised, stable, predictable environments
9. physical activity, the need for exercise
10. power, the need for influence of will
11. romance, the need for sex

12. saving, the need to collect
13. social contact, the need for friends (peer relationships)
14. status, the need for social standing/importance
15. tranquility, the need to be safe
16. vengeance, the need to strike back/to win.

In this model, people differ in these basic desires. They represent intrinsic desires that directly motivate a person's behaviour and therefore influence what a person considers important. This then has an impact on how a person perceives their needs.

Similarly, Maslow (1943) identified a range of motivating factors or needs that were ranked in a hierarchy of needs as follows:

1. physical needs
2. safety and security
3. love and belonging
4. self-esteem
5. purpose and meaning
6. self-awareness and freedom.

These theories both centre on the idea that motivation is linked to needs – the greater the need the greater the motivation to satisfy that need. These needs, and therefore sources of motivation, will vary depending on the client's circumstances.

Homeless clients may hold any number of these needs or desires as important and they may not always be what is expected.



For example:

- A young person living on the streets may be driven by their desire to get shelter and food. This desire will likely overtake other needs such as education, work and relationships.
- A person who has been living on the streets for years may be less concerned about shelter than remaining with their friends on the streets where they get their sense of self-worth.
- A parent may have a greater need to protect their children's safety and wellbeing above their own.

Assessment is very much about working out what these needs are and how they relate to each other and the causes of their homelessness. Caseworkers must be able to distinguish between short- and longer-term needs so that a client's needs can be prioritised and targeted appropriately. The caseworker must also review these needs regularly as they will change as circumstances change.

One of the risks in case management is that the caseworker always remains focused on the crisis of the moment. This means no work is done on the longer-term needs of the client and therefore the underlying causes of their homelessness do not get addressed.

Clients may present with a different crisis every day or every week that they want help with. Just focusing on these will fail to make an impact on taking them out of the homelessness cycle.

One of the values of separating out immediate and longer-term needs is that it enables the caseworker to plan and focus on the whole range of needs, rather than just the presenting immediate needs. It also helps caseworkers put the daily crisis situations in the context of longer-term needs.



Short-term needs are generally those concerned with safety or that are most important to the client.

Longer-term needs are generally those that can wait while other needs are addressed. It may include needs that the client has not yet recognised.

Some examples of short- and longer-term needs are:

Short-term needs:

- secure, safe housing
- food assistance
- health check
- legal protection through an apprehended violence order (AVO).

Longer-term needs:

- finish a qualification and get a job
- get some exercise through a sport
- sort out belongings.

The underlying causes of homelessness

It is important to dig deeper beyond the presenting issues to identify some of the reasons why a client may have become homeless or remains homeless. This involves a process of trying to find out the underlying causes of homelessness and ensure they are addressed appropriately. Failure to do this will mean a caseworker does little to stop the client from becoming homeless again in the future.

There are many reasons why a person or family may be homeless. Some reasons involve:

- personal trauma and/or struggles
- social and community factors outside the client's control, e.g. structural barriers (lack of affordable housing, access to a mental health or AOD service, poverty or overcrowding).

What is important is that the caseworker tries to identify why the client became homeless and how they can work effectively to prevent them from becoming homeless again. This involves looking beyond the presenting and immediate circumstances of the client.



For example:

- If a client becomes homeless due to an abusive relationship and financial problems and the only focus is on their need for housing rather than addressing their self-esteem issues and protective skills in relationships, then the client may end up in the same situation again.
- A middle-aged man becomes homeless after being retrenched and then unable to find work again. He loses his home and gets a bad credit rating meaning that he cannot get private rental. This man's homelessness is connected to his social circumstances rather than personal difficulties and needs advocacy assistance.
- A young mother becomes homeless because she is escaping an unsafe home environment. In this case, the cause of homelessness is outside the control of the young person.
- A young person goes to a SHS program after being kicked out of home. If the caseworker focuses simply on the need for housing they will fail to address the real reasons why he is homeless. When the caseworker investigates further it is clear there have been long-term communication difficulties between him and his parents. He has begun to misuse drugs and no longer attends school. The caseworker may dig deeper still to find that he has depression that is undiagnosed and untreated.

Capturing this additional information enables the caseworker to help the client address the range of issues and hopefully develop the client's capacity to overcome their need for housing/homelessness assistance.

The NAHA has a significant emphasis on breaking the cycle of homelessness. This can only be done if each casework intervention is seen as an opportunity to address the underlying reasons why a person has become homeless or continues to do so.

This includes engaging the client in discussions about their background and the circumstances around their homelessness. This will be more involved if the client is long-term homeless rather than for the first time. It may take a few conversations, as well as talking to significant others with the client's consent.

It is not only important that the caseworker tries to understand these issues but it is also critical for the client to be engaged in understanding these causes and their triggers.

Theoretical frameworks are useful at this point as they help to understand the behaviours and cognitive processes of clients. Evidence-based theories help caseworkers determine what interventions will work best depending on the client's circumstances. See Section 2.3 in this resource kit for more information on these theories.



Comprehensive assessment summary

- Gathering information about the client from a range of sources including the client, family members, other support workers and observation.
- Building a relationship with the client as you seek to understand what is important to them and work out how to best support them.
- Assessment questions should reflect the broad life domains that are addressed in a case plan.
- A range of factors motivates clients. What is most important to a client will generally be the greatest need at that point in time.
- Needs change regularly as circumstances change.
- Client needs should be separated into short- and longer-term needs so the caseworker can move beyond crisis-oriented practice.
- Assessments must be appropriately recorded in the client's file and should include an analysis of information and a rationale for support.
- Considering the underlying causes of homelessness in the client's life will help the caseworker to ensure the client does not become homeless again.

3.4.3 Reassessment

The concept of reassessing is similar to that outlined in the previous sections on assessment, except that it includes the reviewing (and reassessing) of client needs and circumstances. Reassessment is necessary as client needs do change regularly and caseworkers must keep exploring how to best support them as they develop their skills and knowledge.

When things don't work out as expected

It is highly likely that the client's needs will change throughout the course of supporting them in case management. In fact, caseworkers should expect things to change and therefore develop a flexible approach to case management to manage this. Effective caseworkers are able to update and adapt their work as the needs of the service and their clients change.

When adapting to the changing needs of a client is no longer possible, the service your organisation provides may cease to be suitable for them. Alternatively, a client may stop progressing towards their goals and be resisting casework assistance.

In these cases, it is useful for the caseworker to find out the reasons for the change and evaluate what may need to be done differently to get things moving in the right direction again. Sometimes there may be things getting in the way of the client moving forward that is causing them to avoid certain situations or aspects of the case plan. Sometimes it may be the caseworker themselves that is causing the blockage.

This should be seen as an opportunity to reassess the client's situation, including their needs. Perhaps inviting the client to review their needs, issues and aspirations at this point may be necessary; as a change in approach is probably needed.



When things do not work out as expected it is useful to spend time reflecting on the following questions:

- Is there anything that you find challenging about the client?
- Are there particular aspects of the case plan that the client is resisting?
- Is the client or caseworker trying to avoid something?
- Could the client's behaviours be disguising their underlying fear or anxiety? What will help to get to the heart of that fear or anxiety?
- What alternate explanations can you identify for the situation?
- Could your actions or words be contributing to the client's actions?
- Is there a communication problem such as literacy or language issues?
- What alternate approaches could you try with the client?
- What else could you try?
- What are some possible explanations for why things have not worked out as expected?
- Is there something that you need to do differently as the caseworker?

It may also be helpful to consult with colleagues and a supervisor for feedback on the issue and to see if you may be contributing to the problem.

Section 3.6 on strategies to assist with challenging clients may be useful if the support relationship is becoming unworkable.

Services should never be refused just because the client does not want to participate in case management.

Ongoing assessment

Assessment is an ongoing process of identifying and re-evaluating the needs of clients and should never become a static process. In some ways, caseworkers are best to expect and plan for the unexpected in their work with clients. This can be done by building in regular review processes and working with the client to develop their problem-solving skills that they can apply in a variety of situations.

Caseworkers should never stop assessing the needs of their clients. The information a caseworker gathers from ongoing discussions and observations helps to inform the planning, action and review components of case management.

Ongoing assessment has the same function as reviewing in case management. See Section 3.7 on review for more information about ongoing assessment.



Ongoing assessment summary

- Regularly check with the client about their needs.
- Consider reasons for 'road blocks' in the case management process.
- Review progress of goals in the case plan.
- Update the case plan goals in light of progress and changes in circumstances.
- Check on the client/caseworker relationship.

3.5 Plan

Planning involves setting goals in partnership with the client and developing a list of strategies and actions to reach these goals. Information gathered in assessment will inform planning. Planning is also about ensuring that there is a planned and deliberate approach to the support given to clients. Furthermore, it is a process of engaging the client in developing their own solutions and learning the skills along the way to do it for themselves in the future.

The planning aspect of case management is where the case plan is developed and maintained together with the client. Caseworkers should ensure that their work with a client is not ad hoc and has some clearly identified goals or outcomes that the client would like to achieve.

For example, a planned approach will ensure that each crisis is used as an opportunity to learn new skills and insights that help to achieve one of the agreed goals in the case plan. Alternatively they may trigger the need for a review of the case plan.

Finally, planning is also about ensuring that roles, responsibilities and expectations of the case management process are clear and unambiguous. Often the case management process includes working closely with other support workers and service providers, both internally and externally to your organisation. Good planning and communication also ensure there is no duplication and that the client receives seamless service provision.

When to develop a case plan?

Caseworkers should make a basic plan on the first day that a client is accepted to the service to guide initial work with them. Ideally a formal case plan for a client should be developed within 4–6 weeks of starting the support period or as soon as possible.

This time frame is a suggestion to enable sufficient time for a more comprehensive assessment of needs and engage the client further in the case management process. After this the case plan should be reviewed formally at least every three months and informally on a regular basis.

See Section 3.7 on reviewing for more details about the review and monitoring process and how it supports the planning process.

Where to start?

The assessment process informs the case plan. During assessment the caseworker should develop rapport and a partnership with the client to try to address their needs and aspirations. This partnership culminates in the case planning process as both caseworker

and client work together to plan for action. The case planning process will struggle if the client is not in agreement or sufficiently engaged.

Caseworkers should not limit themselves to meeting with clients formally in an office. Caseworkers may consider taking the client out for a drink or some food to discuss their goals or choose to informally discuss goals with them during an outing.



The role of the caseworker is to bring their professional expertise and observations from assessment to the table for discussion and help the client determine goals and strategies that are right for them.

This does not mean that both caseworker and client need to agree about everything, but that some common ground should be found and an agreement made about the way forward; who will do what and by when.

Remember that case management should be client-centred. This includes acknowledging the client as an expert on themselves and inviting them to choose their own goals and strategies in the case plan.

There are a number of tools that can be used to assist a client to develop their goals. Some clients will be able to think abstractly about their goals and others will work better with stories or visual material. Some visual goal-identification tools are included in Appendix 9. It is best to think first about the client's communication skills and the way they think about things; then adapt the approach to suit.

For example, a client may find it easier to draw a pathway of their life journey and where they would like to end up. They can then look at what steps are required to move from one point to another.

Another client may find it easier to reflect on what their life would be like if they did not make some bad decisions. Then with help they can work out what would need to change to get them back on track. Use whatever tools are appropriate for encouraging discussion about their goals.

Developing a strengths-based case plan

A case plan may vary from service to service but at its most basic level it is a document that outlines the agreed goals/outcomes that a client hopes to achieve and the actions and strategies to work towards these goals.

A case plan should therefore include:

- a list of goals
- a list of actions or strategies to achieve these goals
- who is responsible for each action
- the date when each action needs be completed.

Case planning is goal-oriented and involves the caseworker helping the client to set goals that are SMART (see Appendix 10) and work out how to reach them. Goals are the things that clients hope to achieve or want to see changed in their life. Strategies are the steps needed to reach the desired goal.



It is important that caseworkers try to develop a case plan around the strengths of a client rather than the problems. Case plans can be overwhelming for a client when they present a whole range of problems and lots of actions that seem impossible to them. Some strategies to achieve a more strengths-based case plan are:

1. **Reframe items from the negative to the positive** – e.g. instead of ‘reduce the number of behavioural incidents at school’, it could read ‘increase the number of rewards for positive behaviour’ or ‘increase the number of incident-free days at school’.
2. **Build in opportunities for success** – e.g. ensure there are items in the case plan that are easily achievable for both the caseworker and the client, so that achievements can be celebrated and used to reinforce strengths.
3. **Identify strategies that use the client’s strengths** – e.g. if the client has strong communication skills then build in strategies that encourage them to make self-referrals and self-advocate and then use and further build these skills. This reinforces their strengths and helps them build confidence to use these skills in different circumstances.

A case plan is a fundamental tool of case management and must be used in some form. A sample case plan template can be found in Appendix 11. It has the following key elements:

- a section with information about the client and other support workers involved
- a section for goals and strategies for each of the life domain areas
- columns for who is responsible for each action and by when
- a place for the caseworker and client to sign.

An example of a filled-out case plan is also included in Appendix 16.

What about when client and caseworker disagree?

When the client and caseworker disagree it should not be a case of who has the final say. Differences of opinion can arise from different information, insights, life experiences or ideas about what will help. If there is a disagreement it is best to try to negotiate an agreed outcome. The caseworker can share their ideas and reasons and then invite the client to do the same. If a disagreement still exists it is best to go with the client’s choice and note the caseworker’s alternate view in the case plan where appropriate.



In most cases an agreement on a case plan can be reached. In some cases the client may need to act on their own idea before using the caseworker’s approach.

For example, a client may want to treat a drug and alcohol problem via a traditional cultural-healing practice but the caseworker would prefer that the client get specialist support and possibly detox. The caseworker may agree together with the client that they can try their own choice of treatment first, but if no improvement is made within a certain time then an appointment will be made with a drug and alcohol counsellor.

It is usually best for both caseworker and client if they can reach an agreement and to see the case plan as belonging to the client; for the caseworker it is useful and a requirement. The only time the caseworker should override the plan is where there is a clear safety issue placing the client or someone else at risk of harm. In these cases, there should be a clear risk assessment to consider the risks in a proper and objective way.

Flexible and client-centred planning

Case management is not a precise science that works in a predictable format and sequence. Clients change, circumstances change and support workers change. Therefore, case management needs to be flexible and allow room to change and adapt as circumstances change and the client develops.

Caseworkers need to be comfortable with the idea that things can and do need to change along the way and therefore so does the case plan. The reviewing part of case management, as well as engaging regularly with the client, plays a key role in supporting this process of change and adaptation.

Caseworkers need to regularly check progress with clients and if a change is needed then it should be made. It is not critical to wait for a formal case review.

Equally important here is the need to remain client centred. When a caseworker is client centred they try to build support around the needs of clients rather than their own.

Focusing on the client's needs and their progress towards their agreed goals assists flexible casework practice. Case management is not for the caseworker, but rather it is for the client's benefit.

For example, when developing a case plan a caseworker may not want to work with a client on a particular issue due to their lack of confidence or the perceived level of difficulty. Client-focused practice means that the client sets the goals for their case plan in partnership with the caseworker. These factors should be included even if the caseworker does not end up supporting those issues.

This does not mean that a caseworker cannot disagree with the client. However the reasons for disagreement should be explored, discussed and negotiated with the view to finding common ground. The caseworker is therefore adviser and facilitator in the planning process.

Transition planning (formerly exit planning)

Transition planning is linked to the principle of enhancing client capacity or self-sufficiency. It ensures the case management process includes planning for the client to transition out of both the case management relationship and the homelessness system and onto independence. Effective transition planning ensures clients do not end up becoming dependent on the casework relationship and are helped to leave the homelessness support system permanently.

Therefore, transition planning involves working out the skills and resources that a client needs to move out of the homelessness system and the steps they need to take along the way. It is also about setting realistic time frames in which to achieve this.

Transition planning will vary between services; however it must start from the beginning of the support period. For example, in an emergency accommodation service transition planning may involve resolving the immediate crisis and setting the client up with the skills

and resources to move into longer-term housing within 4–6 weeks. A youth service may work to restore the relationship with the client’s family so that they can return home with some case management support. Alternatively in an outreach service, it may involve developing the client’s life and problem-solving skills and enhancing their support network, so that they can manage their tenancy and finances on their own.



Some tips for a successful transition include:

- find opportunities for clients to experience the reality of a tenancy and bills whilst in the safety of supported accommodation
- ensure the client has the knowledge and skills to access local support systems when needed
- identify the clients transition goals early in the support period and use it as a motivator
- work at resolving factors that made the client homeless so they will not become an issue again or if they do that help is available
- try to normalise the client’s experiences within the casework service so they develop effective problem-solving and self-management skills
- ensure the client has core life skills such as budgeting, cooking, cleaning, knowing their rights and how and where to get help
- have two or three transition options for each client as some things do not work out as planned
- promote the transition as proof of the client’s skills and achievement.

What is important is that a time frame for working with the client is set up and there are clear expectations about what the caseworker and client will aim to achieve by the end of the support period. Effective transition planning also aims to work towards breaking the cycle of homelessness in the client’s life.

Transition planning is best included as an item in the case plan so the client and caseworker are clear about the expectations of the relationship and the time frames. Also see Rent It Keep It at

<http://www.housingpathways.nsw.gov.au/Ways+we+can+Help/Private+Rental+Assistance/Rent+It+Keep+It/>.



Plan summary

- Setting goals and associated actions to help ensure that client needs are appropriately met and support is coordinated.
- Planning is informed by assessment.
- Planning must be flexible and adaptable to changing circumstances.
- Client and caseworker disagreements can be opportunities to work through an issue in more detail and help the client or caseworker develop new insights.
- Transition planning starts from the beginning of the support period and aims to ensure that the client can avoid homelessness again in the future.
- A case plan is the primary tool for a caseworker to use as a guide for their work with a client. A case plan must cover the main life domains and provide information about the client and other support workers involved.

3.6 Act

Acting means providing direct support to the client. Acting is a really important part of the case management process as it is where caseworkers share their professional expertise and power with the client. It is also where the client/caseworker relationship is strengthened and the client's capacity to help themselves is increased.

Acting includes a whole range of supports including help with referrals, incidental counselling, life-skills development, developing problem-solving skills, providing information and rebuilding a positive social and community network for the client. It is also a time where caseworkers can test things with the client, stretch their comfort level and build their self-confidence.

What happens whilst caseworkers act becomes useful information for future assessment and planning.

Providing targeted support, information and resources

A significant part of acting in case management is providing specific information and resources in line with the case plan. Giving clients information improves their ability to be self-sufficient. Caseworkers have a unique opportunity to intervene with clients to help them gain insight into their situation and to develop knowledge about how to respond to it effectively.

A large variety of useful resources are available from the internet or other services that can help inform both caseworkers and their clients. Caseworkers should find out what is available so they can quickly get information on specialised topics as needed.

Facilitating agreed outcomes (client empowerment)

Empowerment is both a process and an outcome. Clients are initially empowered when the caseworker engages them in developing their case plan and enables them to 'drive' the process, i.e. the caseworker works with the client rather than for them.

Empowerment means the client increases self-knowledge about the issues and conditions that led to their current circumstances, and what prevents them from acting to meet their own goals. It also sees the client develop/enhance their self-knowledge, knowledge about other

services and ability to advocate on their own behalf, as they acquire new skills and are better placed to manage tricky issues. In other words, their capacity to be self-sufficient is built up.



Highlighting a client's strengths can give them a sense of how things might be as well as ideas about how to bring about the changes they want rather than creating or continuing discouragement.

A strengths-based approach can therefore help build confidence and empower a client to make positive changes. It also assists the caseworker to work with rather than for the client.

'Acting' in case management is about facilitating agreed outcomes for the client based on the case plan. It is useful for caseworkers to regularly remind themselves that the ultimate purpose of case management is to enhance the client's capacity to be independent of their caseworker.

It is a delicate balance of leading the client and supporting them to do it for themselves. If the caseworker does too much then they risk the client becoming dependent and if they do too little the risk is the client becomes overwhelmed.

It is important when forming a case plan to consider what skills development is needed so the client can self-manage; what tasks the client can do well now; and where they will need some help.



Every activity that the caseworker does with a client is a potential learning opportunity. Encourage clients to try things for themselves; help them understand how you do it and teach them the skills they need.

For example, if the client needs help to get a Centrelink benefit but are unsure, encourage them first to have a go at approaching the counter and tell them how to ask for an appointment to speak with a social worker.

If the client lacks confidence to do it themselves then go with them to support them through the process. If the client then succeeds they will have a sense of achievement and new skills they can use next time they need to deal with Centrelink.

Finally, using a strengths-based approach will help clients to develop confidence and new insights into their skills and how to use them.

What to do if you suspect a child is at risk?

The Mandatory Reporter Guide (MRG) is a resource caseworkers can use to help them decide whether to report concerns they have about a child or young person they meet through their work, who is being, or likely to be, abused or neglected.



The Online Mandatory Reporter Guide (MRG) was developed to help workers identify a potential child at risk of harm and determine the right action to take.

The Mandatory Reporter Guide is available at <http://sdm.community.nsw.gov.au/mrg/app/summary.page>.

Mandatory reporters are encouraged to use the Online Mandatory Reporter Guide to help them decide whether or not a report to the Child Protection Helpline is appropriate under the new risk of significant harm reporting threshold.

The guide is intended to complement rather than replace critical thinking and does not prohibit a mandatory reporter from any course of action they believe is appropriate.

The MRG helps a reporter identify their risk concern using seven areas and then guides them through a decision tree to work out the action required. The areas are:

- physical abuse
- neglect
- sexual abuse
- psychological harm
- relinquishing care
- carer concern
- unborn child.

The decision types and actions include:

- immediate report to Community Services
- report to Community Services
- consult with a professional
- document and continue the relationship
- make a referral to other services.

How to use the MRG

Caseworkers should start on the first page and select the main decision tree that most closely matches their concerns. If there is more than one concern, start with the most serious concern. The decision tree leads workers through a series of questions. It is important to read the definitions to complete a 'yes' or 'no' answer until a final decision is reached.

A decision report can be generated with an explanation of the outcome based on how the decision tree was completed. This should be printed and/or saved on the service's records.

If concerns do not fit any of the decision trees, it is probably not reportable, but caseworkers can consult their organisation's Child Wellbeing Unit (CWU) and/or supervisor.

Caseworkers can call the Child Protection Helpline to report directly; however they should use the MRG first to see if their concern meets the threshold for statutory child protection reports (i.e. whether or not to report to Community Services).

For up-to-date information about Keep Them Safe (KTS), see the Department of Premier and Cabinet's website <http://www.keepthemsafe.nsw.gov.au/>.

The website includes:

- interagency guidelines
- workforce development and capacity building
- NGOs and the new system
- information and training.

Free child protection training is available through the Community Services NGO training program at

http://www.community.nsw.gov.au/for_agencies_that_work_with_us/home_training/ngo_training.html?s=2045613566.

Please also refer to Section 2.5 for more information about child protection reform.

Creating a healthy casework environment

Effective case management needs an environment which is engaging, inviting and safe. This is done through the client/caseworker relationship (see Section 3.2), but also influenced by where and when case management happens.



Some environmental factors to consider are:

- Is there an area where a confidential conversation can happen between the client and the caseworker without interruption (i.e. somewhere quiet and away from others who may hear or interrupt)?
- Is the environment safe and secure (i.e. no risk of an abuser coming home or finding you with the client)?
- If working with children or young people are the surroundings appealing and comfortable for them (i.e. toys for children or an informal location for youth)?
- Is the environment culturally appropriate (i.e. anything offensive or culturally inappropriate or consideration needed for male/female roles)?
- Does the environment indicate equal power relationships (i.e. not interviewing from behind a desk or over a counter)?
- Is there inviting information on the walls about client rights and access to additional support services (i.e. information about rights, legal assistance, how to complain, interpreter services, etc)?
- Is the environment welcoming and safe (i.e. the property is well maintained, comfortable, secure and OHS compliant)?
- Is the property accessible and non-discriminatory (i.e. the environment shows that the service is equitable and accessible to all types of clients within the target group, such as wheelchair access or adjustment for cultural and religious practices)?
- Are clients given a real voice (i.e. invited to participate and make a joint decision about services – see client participation in Section 3.2)?

Multidisciplinary casework

Multidisciplinary casework is when more than one support worker is involved. The workers can come from multiple professional disciplines, e.g. social worker, psychologist, youth worker, childcare worker, teacher or AOD specialist. Each professional provides support relevant to their particular expertise. They are coordinated through a central case manager who maintains a seamless approach for the client.



For example, a client with a mental illness may have a psychiatrist, counsellor and community nurse when referred for housing after discharge from hospital.

The psychiatrist will focus on medication and mental wellbeing; the counsellor on long-term coping and causes of the illness; and the nurse on maintaining their medication in the community.

This work may include some psycho-education and support for the client's family but is unlikely to support community reintegration and housing support needs. In this case, the SHS worker can focus on these areas and work with the other professionals to maintain a consistent front for the client.

Multidisciplinary casework helps improve outcomes in the case management process as it reduces:

- the risk of people getting lost in the system
- client's feelings of frustration
- duplication of information, forms and services.

Clients can have a single intake interview and just one assessment. They have one case manager who has access to all the professionals involved in service delivery.

This approach is particularly effective for clients with complex issues who need help from several professionals. It brings specialists together, with mutual responsibility to help the client, particularly in understanding the role of other services and negotiating complex systems.

Difficulties may arise when other partners do not agree, when the case manager and/or the specialists have too heavy a case load, or when resources are insufficient for the services needed (Yarmo-Roberts, 2007).

Multidisciplinary casework is also about seeking out partnerships with other professionals to access supports for clients. Find local organisations that provide counselling support, social activities to link them to the community, financial support or education/employment support, so clients can get help from a range of other professionals depending on their needs. Be careful however not to overwhelm clients with too many people.

An example of a multidisciplinary team is one that can include 'social workers, psychiatrists, vocational trainers, substance abuse counsellors, nurse practitioners and housing specialists' (Tsemberis et al., 2004).

The AHURI (2009) found a successful multidisciplinary approach provided case management services together with permanent housing and that 'multidisciplinary case

management teams are more cost-effective for working with people requiring complex service responses’.

Find out more about working with other services in Section 3.8.

Working with additional needs

Some clients will have additional needs due to illness, language barriers or disability. In these cases, there are additional support services available such as interpreting services, multicultural services and specialist disability support services.

The law requires caseworkers not to discriminate on the basis of these factors, so clients with additional needs should be given the same opportunities to access support.

Caseworkers may need to make reasonable adjustments to their work with the client to help them get through the case management process successfully.



Adjustments caseworkers may need to make include:

- arranging for interpreters for key meetings. All government-funded organisations can access the free Translating and Interpreting Service (TIS) in NSW on 131 450 (organisations must first apply for an exemption from the fee). Download the TIS form from http://www.immi.gov.au/living-in-australia/help-with-english/help_with_translating/pdf/exemption-tis-charges.pdf
- allowing clients with a physical disability access to a downstairs bedroom depending on their mobility
- making arrangements for a seeing eye dog if the client is vision impaired
- assisting clients to complete and understand paperwork if they struggle with literacy
- training staff in basic sign language to help them support hearing-impaired clients.

More information about supporting clients with additional needs will be included in future sections of this resource kit.

Recording your work

Writing down what you do is a key part of effective casework as it helps you to make good choices about what to do and how to do it. It also helps the service when it comes to asking for money to run programs. Much of the evidence to support your work with clients is in your case files if good records are kept.

Clients are entitled to read the notes that caseworkers write about them so they should always be written in a way the client would find acceptable but remain true to what happened. Clients should be made aware of what records caseworkers are keeping about them, where they are kept and who has access to them.

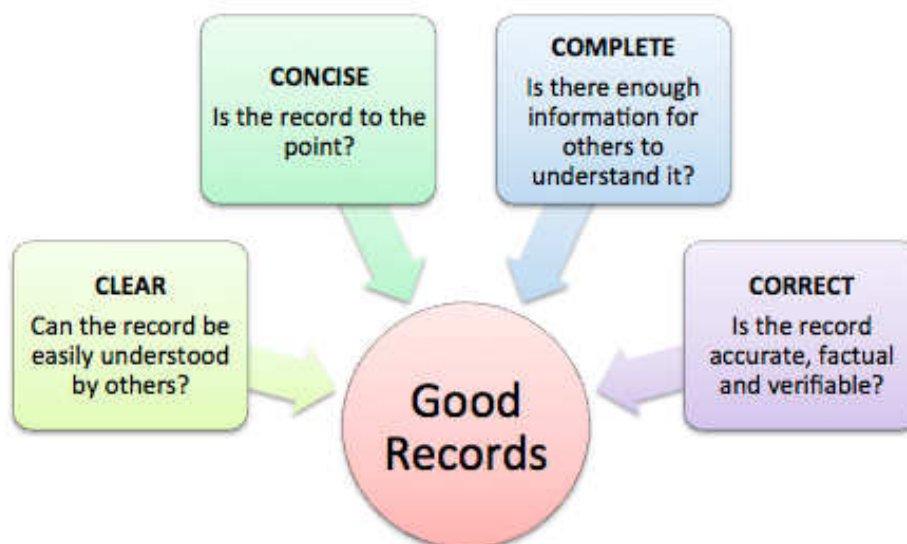


Write facts only; if writing an opinion the caseworker should make sure it states that it is their opinion, e.g. 'in my opinion...' or 'the client has stated...'. Describe observations as they were experienced, i.e. instead of saying 'the client was angry' state 'the client yelled abuse, shook visibly and had trouble controlling their breathing'.

Caseworkers must also ensure they keep notes according to the law and agency policy and procedures. All records should include your name, date and signature.

The principles of effective record-keeping can be summed up with the four Cs as follows:

Diagram 6: Record-keeping principles



When caseworkers record their work with a client they must try not to compromise their relationship or make them feel uncomfortable if they struggle with literacy and numeracy.

The AHURI synthesis paper *Evidence to inform the NSW homelessness action priorities 2009–10* (2009) warns 'Administrative systems can inadvertently humiliate or degrade people experiencing homelessness'. Paperwork should be something that enhances casework rather than something that inhibits it.

Training on writing effective case notes is available from the Community Services, SHS Learning & Development program. For more information see www.community.nsw.gov.au/training.

Security and storage of client files

Client information must be kept confidential at all times. This includes:

- ensuring client records are only accessible by people authorised to see them
- keeping records in a secure location
- ensuring files are not left out in an area where other clients or visitors can access them.

All client records should be kept neatly in a client file and stored securely in a locked filing cabinet in a staff-only area of the building. When a caseworker needs information from a client file they should use it within a staff office area and return it to the secure filing cabinet when finished. Files should not be left out on desks or in public areas where they may be seen by others.

Client records should not be removed from the site where they are stored unless a supervisor authorises that it can be moved to another storage site or to respond to a subpoena.

Failing to keep client records secure can result in a breach of privacy legislation.

Subpoenas

A subpoena is a court order that requires a record or person to be presented to the court by or on a specific date. An SHS may get a subpoena to provide a copy of a client file, an organisational record such as a log book or diary, a record within a client file or any other record that the organisation is believed to hold. A subpoena may also be issued for an individual to give evidence in court.



There are three types of subpoena. Each will usually specify what is required and by when:

- **Subpoena for production** – this subpoena requires that documents be provided to the court. Usually an SHS will need to produce the documents by the set date rather than attending court.
- **Subpoena to give evidence** – this subpoena requires the recipient to attend court on the day specified to give evidence in the witness box.
- **Subpoena for production and to give evidence** – this subpoena is a combination of the above two subpoenas.

A subpoena remains in force until:

- it is complied with
- the issuing party or the court releases you from your obligation to comply
- the trial concludes.

Sometimes a service can reclaim reasonable costs incurred in providing the required evidence. Failing to comply with a subpoena is a serious offence. A caseworker can be found guilty of contempt of court and an arrest warrant issued. It is therefore imperative to respond to the subpoena within the time allowed. This may include contacting the lawyer for the party that issued the subpoena to discuss compliance. Sufficient time should also be given to allow for a caseworker to comply with the request.

If a caseworker receives a subpoena for documents they should refer it to their supervisor. SHS caseworkers and supervisors should seek legal advice about how to respond to a specific subpoena. This includes checking what information must be supplied and what may be omitted (e.g. confidential information about other clients).

Requests for information

Under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*, prescribed bodies are enabled to share information, without consent, if they deliver services and supports to promote the safety, welfare and wellbeing of a child or young person. SHS organisations that provide care to children are included as prescribed bodies.

The purpose of information exchange is to help protect children and young people from harm and identify potential risk of harm. Information must not be exchanged unless it is relevant to the reasons for the request. Whilst clients are not required to give consent they should be told that the information has been or will be shared.

SHS caseworkers should seek legal advice if they are unsure of their responsibilities under Chapter 16A of the Act or if they do not feel there are sufficient grounds to warrant sharing the information against the client's will. More information about exchange of information under Chapter 16A can be found at http://www.community.nsw.gov.au/kts/guidelines/documents/info_exchange_factsheetfactsheet.pdf.

See Section 2.5 on child protection reform (Keep Them Safe) for more information about information exchange.

National data collection

All SHS must collect data about their clients, the services and supports they provide and the outcomes of their interventions. The Commonwealth and state/territory governments have agreed to a National Minimum Data Set (NMDS) which includes data on:

- agencies or services that provide specialist homelessness services
- the types of support or services that are provided
- the clients, including adults, children (who are recognised as clients in their own right) and young people; who they are; and what their circumstances are before, during and after receiving support
- their previous experiences of homelessness
- their outcomes or achievements as a result of the supports and services they receive
- their case plans and how successful they were in achieving the goals set out in their case plans
- people who present to specialist homelessness services and are unable to be assisted.

Data must be collected for each client who is supported and throughout the entire case management process. Data needs to be reported monthly and caseworkers must allocate regular time to data collection and entry into the online data system.

The online data system provides tools to record all the types of support and services given to individual clients; record case plans; and report progress on achieving goals.

Confidentiality

All clients have a right to confidentiality. This means that information a client gives to a service worker is only shared with other people if they give permission.

This can be more complicated in a setting where a client deals with a range of workers within one service, as in a SHS. For example, in some residential programs, confidentiality needs to be between the client and the team rather than an individual worker. This is because there is a different support worker each day and all workers need to have the same information.

It is important clients are given clear information about confidentiality and what will happen to the information they share, from the start of the support period. This should include information about limits on confidentiality.

Caseworkers must get informed consent from a client each time they wish to share or obtain information from or with another person. They can use a generic consent form, such as the one in Appendix 7, or get written consent each time information is shared. If a generic consent form is used then caseworkers must still verbally tell the client each time that they wish to share information, who they wish to share it with and why. Caseworkers must also regularly review any consent agreements to ensure that they are still okay with the client.

More information on informed consent is in Section 3.4.1.

Privacy

The National Privacy Principles (1998) set out how organisations should collect, use, keep secure and disclose personal information. The principles give individuals a right to know what information an organisation holds about them, the purpose for which it is being collected and stored, who will have access to it and the individual's right to correct information if it is wrong.

Clients have a number of important rights in relation to their personal information. They have the right to:

- be told about how information will be collected and used
- decide for themselves whether to give personal information
- be assured that they will get the same service no matter what they decide
- have their privacy protected if they give personal information
- be able to talk in a private space
- have information kept confidential and only used by people who need the information
- have any form of information containing their personal details kept secure.



Summary of national privacy principle obligations

1. Only collect personal information that is necessary for your functions or activities.
2. Use fair and lawful ways to collect personal information.
3. Collect personal information directly from an individual if it is reasonable and practicable to do so.
4. Get consent to collect personal information.
5. If it is lawful and practicable to do so, give people the option of interacting anonymously with you.
6. At the time you collect personal information, or as soon as practicable afterwards, take reasonable steps to make an individual aware of:
 - a. why you are collecting information about them
 - b. who else you might give it to.
7. Take reasonable steps to ensure the individual is aware of this

information even if you have collected it from someone else.

8. Only use or disclose personal information for the primary purpose of collection, unless you have consent or there are specified law enforcement or public health and public safety circumstances.
9. Take reasonable steps to ensure the personal information you collect, use or disclose is accurate, complete and up to date. This may require you to correct the information.
10. Take reasonable steps to protect personal information from misuse, loss and unauthorised access, modification or disclosure.
11. Take reasonable steps to destroy or permanently de-identify personal information if you no longer need it for any purpose.

More information on privacy principles can be found at <http://www.privacy.gov.au/materials/types/infosheets/view/6583>.

Strategies to assist with challenging clients

Challenging clients are those who are, for whatever reason, not progressing as expected towards their agreed goals or distracted from them. Challenging clients can also be people who are difficult to get along with and have complex or difficult behaviours.

These clients require additional persistence and creativity to engage or re-engage them in the casework process. Sometimes there will be a need for repairing the relationship with the client and starting over. This work is difficult for a caseworker, as it requires some critical self-reflection and considering alternate ways of working that may not be their usual approach.

In some cases, a caseworker may have tried a number of ways of working with the client but feel that the support is no longer helping them achieve their goals. This may be for a number of reasons.



Caseworkers should attempt the following process if they are considering ending support or there is a significant problem in the relationship that may lead to ending support.

1. Consider if your concerns are likely to have a critical impact on the future supports you provide to the client.
2. If they are likely to then you must consider what conditions will be required to see the concerns resolved and enable you to continue to provide support. You must also consider what conditions will lead to ending support.
3. Discuss your concerns with the client and outline the reasons. The caseworker should tell them what needs to change and any possible consequences if these concerns are not resolved. Do this from a position of concern for the client's wellbeing and their ability to achieve their goals rather than with accusation.
4. Invite the client to explain their view on the situation and suggest their own strategies to resolve the situation. Try to come to an agreement and document any agreed actions.

5. If the client and caseworker disagree then the caseworker should consider the client's viewpoint and prepare some conditions in writing. Discuss the concerns again with the client and give them a copy of these conditions. Repeat the reasons for your concerns and invite them to work with you to find a common solution to the issues/concerns.
6. Remember that these situations are an opportunity for the client to learn and develop personal insight. Always look for ways to reconcile rather than ending support. It is also useful to link concerns to the impact on the client's progress towards their goals as it helps to make them less personal.
7. If you have given the client the chance to reconcile, invited them to work towards a solution and still feel no progress is being made, then it may be time to end support. If you reach this point you must be clear about why and what you have done to avoid it and explain this to the client. Give them a time frame for ending support and help to find alternate supports. Also tell the client of any conditions for re-entry to the service. You should not ban the client from future support.
8. You should always keep a focus on safety. In some situations, if safety is compromised it may be necessary to end support sooner.
9. Try to always be prepared for an alternate explanation for problem behaviour.
10. Document everything along the way.

When caseworkers are working through this process they should also keep in mind that the policy directions for SHS funded programs include making an effort to preserve long-term sustainable housing and prevent a return to homelessness where possible.

The above steps sit within this policy directive and aim to help a caseworker follow a restorative justice approach to client problems. If a support period needs to end the caseworker must still aim to prevent the client from returning to homelessness in the process.

See Section 3.4.3 for more information on when things don't work out as expected.

If a client is avoiding casework contact it may be worth adopting an assertive community treatment approach (see information on ACT in Section 2.10). This involves seeing the client in their own environment. It may mean taking the focus off the client achieving particular actions or goals and just spending time re-establishing the relationship and finding alternate ways of working with them.

Challenging behaviours often result when the client avoids particular issues that they may or may not be aware of. These opportunities, whilst difficult and frustrating, can become real breakthrough moments if the relationship can be maintained or rebuilt and the client develops insight into their situation.

Finally, if these things still do not work, it may be necessary for a different worker to try to help the client or they are not ready to receive the support being offered. Whatever the outcome, it is important that caseworkers persist with challenging clients. They should take a

restorative approach and give the client opportunities to develop insight, rejoin the process and start over.

See the last part of Section 3.4 for strategies to help address client concerns that are having an impact on the continuation of support.

Duty of care

Duty of care means that people have a responsibility to avoid doing or failing to do things which could reasonably be foreseen to cause injury or harm. In organisations, this means employers (management) and employees (workers) need to be aware of their responsibility to take reasonable steps to prevent injury.

They have a duty of care to other workers, clients, volunteers and visitors. If someone is injured and takes court action, they will need to prove to the court that the service or their actions were not negligent or failed to take reasonable care. Duty of care also relates to client's children; if you know that they are vulnerable to abuse or exploitation and at risk of significant harm.



Act summary

- Providing targeted support, information and resources to clients to help them to work towards their goals.
- Continuing to build the client/caseworker relationship.
- Working in partnership with support workers in other professions helps create a more seamless support network around the client.
- Good casework has good records. Good records are clear, concise, complete and correct.
- Clients have a right to privacy and national privacy laws require records to be kept secure. Clients can access records if they want to read them.
- Data collection is a requirement of funded SHS services and they must regularly gather data and appropriate consents.
- Caseworkers must access other supports when clients have special needs that are outside of their organisation's scope.
- Clients are empowered by giving them new skills and knowledge and standing by them as they develop the confidence to do it themselves.



Case scenario: Zoe

When Zoe and her two children first arrived at the service, she had low self-esteem and little confidence in her ability to manage her day-to-day affairs. Zoe experienced difficulties in managing daily tasks with her children and at home. She also had difficulty making appointments and negotiating with other services, including communicating with her children's teachers.

Zoe is like a lot of other clients who have been in an abusive relationship. She is used to being told what, when and how to do everything, which means her ability to trust her own judgement is at an all-time low.

To assist her, Zoe's caseworker, Sally, worked with her to formulate a case plan. However, as Zoe was unable to manage many basic tasks, Sally advocated for her and helped her with everything; such as organising the children for school, helping her cook meals and making all the phone appointments for her.

Sally's supervisor became concerned about the amount of hands-on tasks that Sally was doing for Zoe. She decided to ask Sally some questions about Zoe's case in supervision. Sally described how she was making great progress on the case plan and that Zoe was meeting all of her goals so far.

When Sally's supervisor asked her about the skills that Zoe was developing and what she was doing to help Zoe transition out of the service, she realised that she had been going about things the wrong way. Instead of Zoe gaining confidence in her own abilities and developing the skills to manage her own life, she continued to struggle and relied on her caseworker for these tasks. Zoe was not gaining the skills and self-esteem needed to get her out of homelessness.

Sally's supervisor helped her to develop some strategies to engage Zoe in doing the tasks in the case plan rather than doing them for her. Sally would now try getting Zoe to do these tasks and in the process help her to learn these skills and gain confidence to do them for herself.

Practice tips:

- Effective casework support does not equal doing everything for the client.
- Supervision is a key aspect of reflective practice and improving practice.
- The goal of the client/caseworker relationship is to transition the client out of homelessness. Everything you do with a client should work towards this goal.
- Casework support provides many opportunities to educate and empower the client.

3.7 Review

Reviewing is a component of case management that is integrated throughout the process. It is about monitoring and checking that everything is on track with the case plan and that the current support is still relevant. It also ensures the client understands the process and is developing their capacity to help themselves. Further still, reviewing is about the caseworker reflecting on their practice.

Reviewing involves ensuring that there are formal processes in place to check and celebrate progress in the case plan. It evaluates if the organisation is operating effectively and efficiently to meet the needs of the target group. Reviewing or monitoring therefore involves a combination of formal and informal processes to ensure the ongoing provision of high quality and relevant services to clients.



Reviewing can be a threatening concept for some staff as they may feel that by inviting feedback or checking their practice, they are being judged on their work.

Staff need to be supported and encouraged to develop a culture of continuous quality improvement that sees feedback as a means to continuous improvement rather than judgement.

It requires staff to acknowledge that there is always room for improvement and this often needs to be led by the service manager.

When to review

Reviewing should occur at regular points throughout the support period. It should happen between caseworker and client; caseworker to caseworker; manager to caseworker; and organisation to funding provider (for service review). Each will have a different purpose and consider different factors.

Reviews need to happen informally and formally. They are completed using individual feedback and data analysis. For example, a caseworker and client will need to review the progress against a case plan but a funding provider will want to review service outputs and how funds were spent to achieve agreed outcomes.

Formal case management reviews should ideally occur at least every three months and annually for all clients, in terms of service outputs in relation to effectiveness. This may include reviewing the number of clients:

- who got what they needed from the service
- successfully transitioned into long-term housing
- satisfied with the level of case management support.

A review will also be needed when a client's circumstances change and or when new issues emerge.

Strengths-based rather than deficit-based

A strengths-based approach to reviewing requires caseworkers to keep a focus on achievement and skills development rather than failure. Even if a client makes little progress, there may be evidence of increased insight and new lessons learnt about life, that they can now use in the next phase of support.

Reviews are an opportunity to point out success and identify the skills that were used or developed. Most clients will be used to being told about their problems and failures. This contributes to a lack of motivation and feeling overwhelmed by these issues. A strengths-based approach, in contrast, helps motivate clients by reinforcing their abilities and developing their self-belief. It also sends clear messages of hope.

The strengths-based assessment tool in Appendix 12 may help when reviewing a client's progress and identifying new goals.



A strengths-based review has the following characteristics:

- focus on achievements rather than failures
- motivate the client to continue working towards their goals
- increase client's confidence to meet their goals
- focus on potential rather than inability
- try to include the client and give them information
- facilitate client's access to resources
- be client-centered and solution-oriented
- give the client a voice.

Case review/case conference meetings

A case review is a meeting to check the client's progress towards their case plan goals. The recommended guideline for case reviews is that they occur within the first six months of the support period and then ideally at least every three months to ensure everything is on track. In some cases, a review will occur more regularly due to the service type and client needs.

A case review meeting will generally involve all of the key stakeholders. These include:

- support workers
- significant family members
- other professionals such as a school principal or psychiatrist.

Who comes will depend on who is involved in the case plan and can make a valuable contribution to it.

Before inviting anyone to a case review the caseworker must first discuss it with the client. The review is about them and they should have a direct say over who takes part. Those who do not attend the review may provide a comment in writing or over the phone, which can then be raised at the meeting. If there are too many people at the meeting it can be overwhelming for the client and make the process difficult. Therefore try to keep the number of people to a minimum.

It is important to prepare the client for the case review meeting by helping them understand what to expect and how they can contribute. The review is about the client and enables them to get feedback and stay in the loop about who is doing what. It is therefore important to ensure there is a focus on the client's strengths and that any achievements in the case plan are acknowledged and emphasised rather than the failures.

The caseworker may like to use a self-review tool to help the client consider their progress and any changes that may be needed. A sample client self-reflection form is included as a guide in Appendix 13. The caseworker should use this tool to explore the thoughts and feelings of the client. This process helps the caseworker to start reassessing the client's needs, so they can update the case plan.



Planning a case review

Sufficient notice must be given to other workers so that they can attend. The meeting should therefore be planned and advertised to the relevant people about a month in advance.

If an invited person is unable to come it is useful to ask them for a brief written statement about the client's progress towards their goals.

It is useful for the caseworker to prepare an agenda for the case review in partnership with the client. This can be an empowering process for them.

A case review agenda can include the following:

- introductions
- update and feedback from caseworker
- comment from the client about their progress
- comments from family or other personal supports
- update and feedback from professionals
- discuss changes to the case plan
- agree on focus for next period of the case plan
- arrange next meeting date.

Keep in mind that being involved in preparing for and running a case review meeting can be a useful educational process for a client as it:

- teaches skills about running and preparing for a meeting
- helps them to be empowered to reflect on and monitor their needs
- develops self-advocacy skills
- helps develop effective problem-solving skills
- teaches reflective and planning skills they can use in future
- helps build insight and self-awareness of strengths and limitations.

Therefore case reviews, if used correctly, can be an effective part in the process of helping a client to break the cycle of homelessness and become more independent.

During the case review

The lead caseworker will generally chair the meeting and guide those present through the agenda items. It is important that the caseworker ensures the client understands each step of the meeting. The caseworker should also spend time with the client after the meeting to ensure they understood everything and see if they have any questions or comments about the meeting and the discussions.

Caseworkers must also take a role of challenging negative concepts about the client and reinforcing their strengths rather than deficits. In some cases, a caseworker will need to be the voice for their client.

Someone should be nominated to write notes during the meeting. These minutes should be typed up as soon as possible after the meeting and given to each person present, including the client.

Information from the case review meeting should then be used to adjust the case plan. Once it is updated the caseworker should discuss it again with the client and make any changes as needed. Once finalised, a copy must be given to each person who is part of the case plan.

Client feedback

Client feedback gives important information about what works and what doesn't work in the casework support and other services your organisation provides. Client feedback, if done well, also empowers clients to have a say in how the organisation delivers support. Client feedback should therefore be used to guide service development and measure effectiveness.

Good client feedback processes show that the organisation is willing to receive feedback and improve services as a result. If not done well, client feedback will be seen as tokenistic and not taken seriously; therefore practice changes cannot occur.



- Client feedback should be collected at regular intervals throughout the support period.
- Processes should be in place to encourage informal feedback as well as formal feedback.
- Informal feedback can be collected by asking clients for their views and opinions about the supports provided.
- If suggestions are made for improvement then caseworkers should aim to make these changes if appropriate or at least give reasons why they cannot be made.

A service can get formal feedback as part of the case review process and at the end of the support period. This can be done using client feedback or client-self reflection forms during the case review process.

Samples of these forms are included in this resource kit. See Appendix 13 for the client self-reflection form and Appendix 14 for the client feedback form.

It is also useful to consider collecting a mix of personal and anonymous feedback. Anonymous feedback can be done at the end of a support period by asking the client to fill out a form without their name and place it in a box that will be collected by the service manager. This helps to get more genuine and honest feedback on service delivery.

Client feedback should be collated and used in quarterly and annual service reports to management and funding providers. This data should also be used in annual planning days to see if a change in service delivery or a new type of service is needed as part of continual quality improvement.

For example, client feedback data may highlight the need for a new partnership to fill a service gap or it may suggest the need to change referral and intake procedures.

Client complaints

Client complaints may arise during casework and clients may need support when making a complaint. This is an important part of client empowerment. The caseworker should ensure they stay impartial and maintain strict confidentiality. Complaints can also come from external community members or other workers.



When supporting a client with a complaint or speaking to a complainant, it is useful to know a few details such as:

- when the incident happened
- what the details are
- where the incident happened
- who was involved
- were there any witnesses?

Caseworkers must follow their service's client complaints procedures. They often include the need to record complaints and the actions taken to investigate them. All complaints should be investigated no matter how insignificant they seem to be. Information about complaints involving staff should be kept in a separate confidential file and not placed on the client's file.

Clients also have a right to get feedback about their complaint. The caseworker or manager should give them a summary of the investigation's findings without breaching the confidentiality of other informants. A person who is subject to a complaint also has a right to get similar feedback. More information about complaints can be found at:

NSW Ombudsman Office

Phone: Telephone 02 9286 1093

If you are outside the Sydney metropolitan area you can call 1800 451 524.

Website: <http://www.ombo.nsw.gov.au/>.

NSW Commission for Children and Young People

The Commission for Children and Young People reports directly to the NSW Parliament.

Address: Level 2, 407 Elizabeth Street, Surry Hills NSW 2010

Phone: 02 9286 7276

Fax: 02 9286 7267

Email: kids@kids.nsw.gov.au

Website: www.kids.nsw.gov.au.

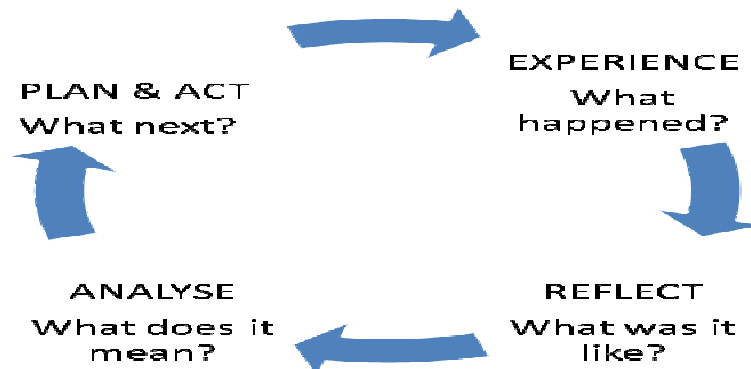
Reflective practice

Reflective practice is a key part of case management and essentially what reviewing is all about. It involves taking the time to think critically about and analyse your practice and then adapt and improve casework practice. Without reflective practice caseworkers will become ineffective over time.



Reflective practice can happen at any time and anywhere. Supervision and discussions with colleagues are the most common ways to formally look at practice.

Kolb (1984) has developed a Reflective Learning Cycle that provides a visual way of understanding the reflective process. It shows an ongoing process of reflecting, thinking about the meaning, choosing to act and then reflecting again. It helps caseworkers improve practice by learning from what happened.



Therefore reflective practice is about providing support, reflecting on what was done, what it meant and if it can be done differently or better next time. Sometimes improvements will be identified and sometimes they will not.

A more comprehensive set of reflective factors is shown in the following diagram. It offers some prompts to help caseworkers reflect on their practice and find alternate issues and practice options. This diagram is adapted from the following document at http://www.pearsonschoolsandfecolleges.co.uk/FEAndVocational/Childcare/NVQSVQ/NVQSVQ_CCLD/Samples/SamplematerialfromtheSNVQAssessorHandbookforCCLD/NVQAssHB_Chpt5.pdf.

Diagram 7: Reflective practice



The following is a brief summary of each element in the above diagram:

- **View things from a different perspective:** Consider things from other people's points of view (especially the client's) as a way of trying to identify things you may have missed or different explanations for issues. For example, what appears as oppositional behaviour may actually be a cultural way of responding to authority.
- **Think about consequences:** Think about how changing practice might affect your work with the client or that of other support workers or colleagues. Will any changes to your practice impact on anyone else?
- **Keep an open mind:** Avoid assuming that a different way of working will not work and be ready to have a go at changing. Remain open minded and teachable in your work.
- **Test ideas:** Try out new practices or visit other caseworkers who may do things in different ways. For example, select one client and try doing things a bit differently.
- **Ask 'what if?':** Be confident enough to try out new ideas and think about things in different ways. Encourage innovation in your team. Research current literature on best practice with your client group and try to implement something from it and review the results.
- **Synthesise ideas:** Be ready to investigate new ideas and then try to adapt them to practices in your workplace. Use team meetings to review new ideas that have been tested or training that someone has attended.
- **Identify and resolve problems:** Be proactive in making things work and taking a problem-solving approach to any difficulties. Deal with problems directly and creatively rather than avoiding them.
- **Question the way that you do things:** Are some things done in a certain way simply because that is how they have always been done? Question the way things are done and encourage others to do that also.

- **Seek alternatives:** Explore and research different ways of working. Attending training is a good way of exploring alternate ways of working. There is no single best way to support SHS clients and always something new to learn. Make time for training.

A self-reflection tool for caseworkers is included in Appendix 15. It is adapted from a reflective-practice guide developed by Human Systems and Outcomes Inc (2001). This tool has a series of questions caseworkers can use to reflect on their casework practice in more detail.

Monitoring casework service delivery

Monitoring involves an ongoing process of checking that things are happening the way they should be. Monitoring is normally the responsibility of a supervisor/manager and involves:

- checking that records are up to date
- reviewing client data
- checking service outputs
- reviewing client complaints and client feedback
- checking that policy and procedures are being implemented.

A caseworker must also be involved in monitoring as part of reflective practice and continuous improvement.



Caseworkers should take opportunities to formally review their practice at least annually.

This may involve a combination of:

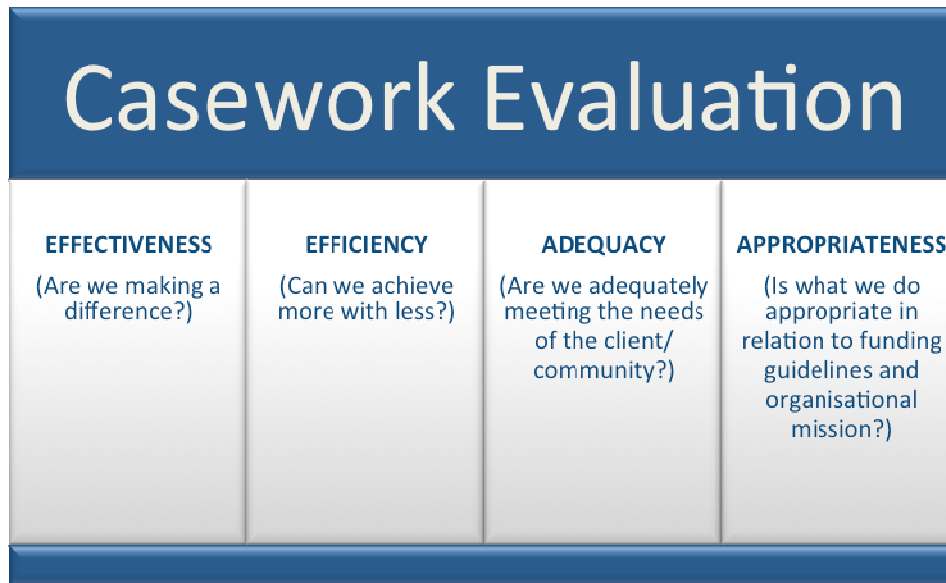
- gathering client and stakeholder feedback
- considering client-outcome data
- checking if casework practice is consistent with policy and procedures.

Service evaluations and continuous quality improvement

Evaluation is about asking the question ‘Given the nature of the change processes we are evaluating, have we sufficient evaluation strategies in place to convince a reasonable person about the worth of what we are doing?’

Evaluation helps organisations to know whether they are achieving what they set out to do and to work out improvements that can improve the quality of service provided. It involves looking at the four elements in the following diagram:

Diagram 8: Evaluation questions



Effective caseworkers are plan driven rather than event driven (i.e. proactive). Caseworkers benefit from decisions and actions that are based on facts and data (evidence-based practice). Continual improvement relies on continuous learning and investing in the ongoing improvement of casework service to clients.



When conducting an evaluation caseworkers need to ask the following questions:

- What do you want to evaluate?
- What are the objectives of the program you want to evaluate?
- What measures can you use to establish effectiveness?
- What information do you need to collect to measure effectiveness?
- What tools will you use to collect information? E.g. surveys, focus groups, interviews, client evaluations, complaints and statistical analysis?
- Who will you include in the evaluation process?

Evaluation requires taking time out to reflect on practice and identify personal and professional development goals that can be followed up in supervision.

Samples of some self-evaluation questions for caseworkers are included as a guide in Appendix 12 and Appendix 15. Caseworkers should use these questions to self-evaluate and then discuss them in supervision.



Review summary

- Check your progress with the client and review the quality of your work.
- Reviewing involves reflective practice which aims to consider alternate ways of working and improving practice.
- Client reviews should take place every three months to ensure that the appropriate level and type of support is being provided and that case plan goals are being met.
- Complaints are an important source of client and stakeholder feedback and should be treated as an important part of service development.
- Client feedback helps to empower clients and inform practice development.
- Caseworkers must work hard at ensuring that reviewing is strengths-based rather than deficit-based.
- Formally evaluating service delivery each year is an important part of maintaining quality services to clients.

3.8 Working with other services

The *Good practice guidelines* (2006) for Community Services funded programs suggests that SHS organisations have:

- a process to seek and develop partnerships with other organisations, including businesses, private providers and government, to meet identified needs
- partnerships in line with the organisation's values, objectives and plans.

Collaborative working relationships with other services can enhance the ability of caseworkers and organisations to effectively meet the needs of clients. Partnerships give services access to a greater range of services without the need for significant increases in funding. They also reduce duplication and give clients access to other sources of professional expertise and support.

Essentially, working with other services can enhance case management as clients and caseworkers can more effectively access the required support and information when needed.

Partnerships can be defined as collaborative agreements with other services to meet a mutually-identified need. They can be anything from a service guarantee to use of a facility. They can include partnerships with other services, businesses, private service providers and/or government organisations.

Partnerships are therefore about relationships and enable an organisation to do more with less. They enhance their capacity to better help their clients with the same resources. Without this sense of mutual benefit they are unlikely to work out in the long run.

Partnerships enable sharing of some responsibilities or help in meeting funding requirements. Increasingly, there are partnerships developing between organisations so they can access new funding opportunities or establish services to respond to emerging community needs. Partnerships can essentially be developed around any aspect of service delivery or organisational business.



Community organisations need to operate in a collaborative way to meet the needs of their targeted population and this often requires regular consideration of gaps in service delivery.

Start with identifying the service gaps in your organisation and then look for partners in your community who may be able to meet them.

The best match will be found with organisations or businesses that can also benefit from your service's skills and resources.

Examples of collaboration for SHS may be with:

- a community health centre for on-site assessments
- another organisation for outreach support for clients.
- a private real estate agency for access to private rentals for clients
- schools for preventative activities
- GPs and nurses for on-site health services.

Partnerships enhance case management by:

- providing timely access to support and information services for clients
- creating more seamless service delivery for clients
- simplifying referral processes
- minimising information sharing for clients
- meeting service gaps in the local community
- strengthening advocacy for clients
- maximising outcomes for clients.

Setting up an effective partnership arrangement

A successful community partnership should be grounded in:

- **Solid planning** – How will the partnership work? Who will do what? How and when will it be implemented?
- **Mutual respect** – Is there common respect for what each partner can provide and their role in the partnership? It is important that one does not feel used by the other.
- **Shared values** – Is there alignment in the mission and values of both organisations? Are both organisations trying to achieve similar results in the community?
- **Clear expectations** – Is there a written agreement to ensure clear expectations of the roles and tasks of both partners? Do not assume; put it in writing.
- **A willingness to listen to each other and change if need be** – Is there an agreed process for reviewing the partnership and measuring its success? Is there room to develop and adjust the partnership if necessary? How will this be done?
- **A common understanding of the desired outcomes of the partnership** – Is each party clear of what each is trying to achieve through the partnership? Is it in writing? Has it been a negotiated agreement? Has it been signed off?
- **A strategy to identify and manage problems in the relationship** – What will happen if something goes wrong or the partnership becomes ineffective?

The Our Community website has a fact sheet with a checklist of things to consider when forming a partnership. It can be found at http://www.ourcommunity.com.au/funding/funding_article.jsp?articleId=820.

Writing up an agreement

Once agreement is reached about the purpose of the partnership and how it will work, it is critical that the agreement is put in writing. This helps make expectations about the partnership clear and provides a framework for dealing with any conflict. A written agreement is often called a memorandum of understanding (MOU).



A written agreement or MOU does not need to be complicated but should outline the following:

- who the main contacts are for each organisation
- what each organisation will deliver, including any resources
- expected outcomes of the partnership, including measures of success
- process for reviewing and adjusting the partnership
- process for managing conflict or dissatisfaction in the partnership
- expected duration of the partnership
- decision-making processes; who decides what
- communication strategies
- roles and responsibilities of each partner
- management of client information between the two organisations.

The Our Community website also has a useful guide to writing a partnership agreement at http://www.ourcommunity.com.au/funding/funding_article.jsp?articleId=845.

A sample MOU is included as a suggested template in Appendix 17.

Principles of successful partnerships

The following points are crucial to effective and sustainable partnerships:

- good partnerships are based on a foundation of honesty and trust; which is built up over time
- there should be a commitment to mutual benefit
- although groups in a partnership may not be equal in size, it is important that they treat one another as equals
- partners should have open communication, be able to speak freely and raise any concerns without anxiety about the consequences
- good partnerships maintain realistic expectations about what can be achieved through the partnership
- partners acknowledge that problems and issues will arise from time to time in the relationship and have a commitment to resolve them.

Managing conflict in a partnership

The key to managing conflict in a partnership is to maintain open and honest communication between each partner. It also helps to have a designated person/position in each

organisation that is responsible for maintaining the partnership and dealing with any conflict that may arise.



Conflict may occur for many reasons but most commonly will be the result of:

- negative feedback
- a partner not fulfilling their responsibility in the agreement
- one partner being dissatisfied with the quality or level of service provided in the partnership.

These matters can often be resolved through open and honest communication about the issues and negotiating an agreed resolution. It is important though that discussion occurs as soon as the problem is identified and done with the mutual respect and dignity of both partners.

If disputes cannot be resolved through a professional conversation then it may be necessary to undertake mediation, arbitration or other form of alternate dispute resolution, involving an independent third party.

Having regular meetings and formalised review processes will help to ensure effective communication and conflict resolution processes in a partnership. Partnerships should remain client-centred at all times.

If the conflict cannot be resolved then it may be necessary to end the partnership. If this is the case it is important that each organisation is able to leave the partnership with dignity and without negative public attention.

You should state your intention to withdraw from the partnership in writing. It should outline your reasons for leaving the partnership and what you have done to try and resolve the problems. Try to retain a positive relationship with the partner organisation.

Interagency communication and collaborative practice

Interagency collaboration and communication does not happen without deliberate effort on the part of all workers in the sector. It is the responsibility of every caseworker to ensure that they stay up to date about different organisations in their area and the services they provide. It is also their responsibility to ensure that a client, who gets support from multiple workers, is aware of their different roles and responsibilities. The caseworker also must make sure that each worker communicates with each other to facilitate seamless service delivery through coordination.

Workers and agencies must ensure that each worker is clear about their responsibilities in relation to a client via a case plan and that regular meetings are held with relevant stakeholders. If workers and agencies stay focused on the client and respect differences of opinion, with a willingness to negotiate agreed outcomes, then things tend to work better. Workers need to trust each other and respect each other's opinion to work effectively.

It is important that caseworkers are committed to client confidentiality and privacy when working with other agencies. They should ensure clients have given informed consent to exchange information between workers involved with them. This should not happen once at the start of the support period but regularly reviewed with the client.

Collaborative practice can be described as an interactive process by which individuals with diverse training and from diverse service types meet together to plan, generate and action solutions to identified problems related to the wellbeing of people (Knapp et al, 1993).



Some specific characteristics of collaborative practice include:

- active participation of the client
- sharing or transferring of information and skills across traditional boundaries
- participants see themselves as part of a team and contribute to a common goal
- relationship between participants is non-hierarchical and power is shared
- leadership is shared and participants are interdependent
- participants work together in planning and decision-making
- participants offer their expertise, share responsibility and acknowledge other group members for their contribution to the goal
- clear definition and understanding by team members of participants' roles/responsibilities
- respect for autonomous professional judgement and autonomous choice and decision-making of the client/family
- effective communication skills and group dynamics supported by organisational structures and vision.

AHURI (2009) found that improving coordination between mainstream agencies, specialist homelessness services and other specialist services is critical to improving outcomes for people who are homeless or at risk of homelessness. It further found that multidisciplinary teams providing a case management relationship with the required qualities is proven to deliver reduced homelessness and more client satisfaction.

Similarly, Morse ((2006) in AHURI, 2009) reported that demanding/challenging clients, those with serious mental illness and co-occurring substance use disorders achieved better outcomes from a multidisciplinary team approach.

When working together with other organisations it is also useful to be mindful of legislation and policy on information exchange between organisations about a child at risk of harm. For more information on this refer to Section 2.5.

Community Services in NSW has developed a fact sheet on the benefits of interagency collaboration as outlined in academic literature. It can be found at http://www.community.nsw.gov.au/docswr/assets/main/documents/researchnotes_interagency_collaboration.pdf.

Setting up effective referral pathways

It is necessary to have effective referral pathways available in your community to help clients access the support they need. Unfortunately demand for services is often greater than the available services. Therefore, a key task of the caseworker is to match their client's needs with appropriate local service providers, in a way that gets them noticed.

Many services require a written referral form and some ask for an interview or both. If a caseworker knows the person who does assessments for service entry, it can be much easier to get across the client's specific needs and how the other agency can best address them.

Therefore it is important for caseworkers to actively network with local services to develop respectful professional relationships and get a sound knowledge of what each service can provide clients. This can be done by arranging service visits and attending local interagency meetings that are relevant to your client group.

Furthermore, don't simply submit a referral form for a client to another service. Start by giving the service a call to find out what capacity they have to meet the client's needs and clarify their service's priorities and referral criteria. This will help caseworkers to fill out the referral form effectively and get to know staff in other organisations.



When filling out a referral form, ensure the client's situation and background circumstances are clearly summarised, whilst not telling the whole story in too much detail. Only share what you need to.

Ensure you clearly state what you would like the referral agency to do for your client and how it will complement the support you are giving them.

You will also need to ensure the client has consented to the exchange of this information.

Once you submit the referral form, call the agency again to tell them that you have sent it and ask for a time frame for a response. Suggest the agency contact you if they wish to discuss any details in the referral.

Finally, the caseworker will need to make follow-up phone calls to check on progress if there is no response within the time frame given by the agency.

If the referral is rejected then ask for feedback about the reasons why and try to advocate for your client if necessary. If still not accepted then consider alternate sources of support.

Effective referral pathways rely on SHS organisations working with their local planning teams and other similar organisations to identify strengths and gaps. Strengths can be maximised through effective interagency partnerships that improve access pathways for clients into relevant supports.

Negotiating to redirect available resources, if possible and appropriate, can sometimes fill gaps in service delivery. These discussions may also include mainstream services and joint tendering as a consortium.

Integrated service delivery

Integrated service delivery (DoCS, 2005) is where initiatives cross traditional organisational boundaries to provide 'one-stop shop' access or 'one-door entry' to clients. Integrated services enable multiple organisations to pool resources to provide integrated support more efficiently and seamlessly.

Integrated service delivery can also refer to when multiple organisations synchronise their services to provide an integrated case management service to a client. Organisations need to consider what other agencies in their area can integrate well with their own support services. For example, an SHS accommodation service may develop an agreement where all unemployed clients get support from a local employment agency.



Benefits of service integration:

- helps individuals and families negotiate their way through the maze of agencies, reduce delays in assessment and service provision, increase efficiency, assist resource exchange, and reduce service duplication
- problems facing homeless clients are often multifaceted and resolving them requires special expertise. Integration enables agencies to seek partnerships with specialists to support the work of SHS caseworkers
- integrated service delivery focuses on clients and outcomes.

Multidisciplinary casework is one example of integrated service delivery. For more information on multidisciplinary casework see Section 3.6.

Co-case management

Co-case management is when more than one support worker provides casework support to the same client. This works best where the two organisations or colleagues have complimentary skills and resources. Collaborative casework is best achieved if there is good communication and a clear case plan that each stakeholder has agreed to.

Co-case management enables the client to get additional supports and access a wider variety of skills and resources in their community. For example, a caseworker and a children's caseworker work collaboratively in one service to support a family. Another example is a SHS caseworker who works with an alcohol and drugs (AOD) worker to help a client reduce their drug use, so they can get themselves back into independent housing.

Whatever the mix, co-case management should involve additional client support through complimentary skills and enhanced access to skills, resources and knowledge.



Some tips for making co-case management work are:

- ensure you are clear about your role and that of other support workers
- ensure the client has given informed consent to discuss their situation with other caseworkers
- ensure you communicate regularly with other caseworker/s about your work with the client and anything that may affect their work with them
- ensure the case plan clearly states who will do what, by when and for what purpose
- avoid duplication of support by being clear on who will do what and checking with each other before acting

create a seamless support system for the client, i.e. each caseworker can respond to the client's presenting needs and ensure the right person follows the issue through, rather than initially deflecting the issue to the relevant person.

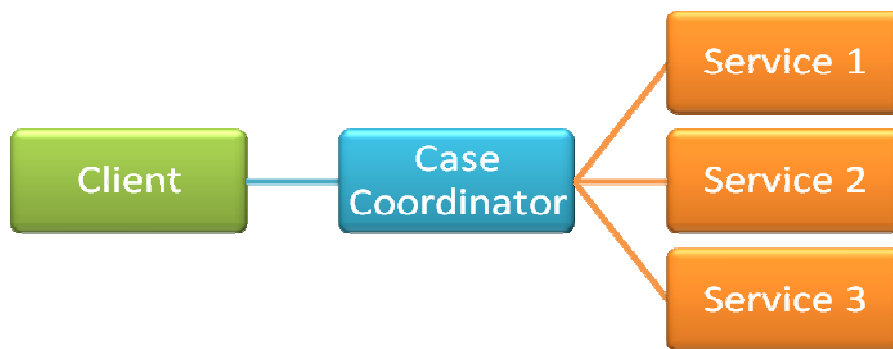
For more ideas about working with other services see the *Child wellbeing and child protection – NSW interagency guidelines* at http://www.community.nsw.gov.au/kts/guidelines/info_exchange/introduction.htm.

Case coordination

When working with other services there will need to be a case coordinator who coordinates the case plan and assists communication between the support workers. The lead caseworker will also ensure that the process stays client focused and that the client understands the role of each support worker.

As shown in the diagram below, the case coordinator's role is to coordinate the work of the various supports and is a conduit of information between the client and support workers. Whilst the case coordinator is not the only one communicating with and supporting the client, they will coordinate the process, develop the case plan and ensure that the client understands who is responsible for what.

Diagram 9: Case coordination



The case coordinator can be any of the support workers. It may be the SHS caseworker or another caseworker already working with the client. During assessment the caseworker should ask the client if anyone else is supporting them and what support they provide. The caseworker should then, with the client's consent, try to contact these supports, which may include volunteers, friends or family members. When it comes to planning the support that the caseworker will provide, it is useful to ask the client what they would like the caseworker and others to support them with.

In this process, it will become clear if another support worker is providing a case coordination role or not. If case coordination is not in place, it is likely that there will be limited contact between support workers and some duplication of support services.

If another support worker already provides case coordination, the SHS caseworker should, with the client's consent, discuss a suitable way for them to support the client. For example, a refugee client may have a social worker, an immigration officer and a GP supporting them. These professionals each have a specialist role in supporting the refugee but may also help with other related matters.

It may be suitable for the SHS caseworker to help the client develop social networks, independent living skills and financial management skills, whilst the other professionals focus on mental wellbeing, healthy lifestyle habits and specific education.



If there is no case coordinator already, the SHS caseworker should take on the role. A case coordinator is responsible for:

- developing a common case plan
- negotiating the focus/role of each support worker
- ensuring the range of client support needs are covered in the case plan
- ensuring the client knows what each support worker is providing in the case plan
- being a central contact point for the case plan
- convening regular communication and review meetings with key support workers and the client.

A case plan that clearly states who is responsible for what supports and by when, is the best way to ensure each support worker and the client knows what everyone is doing. This must be done in consultation with each support worker, who is part of the case plan, and the client. Each party must also agree to and understand the actions allocated to them in the case plan.

If a support worker does not follow the case plan, the case coordinator is responsible for reviewing why this is the case and updating the case plan accordingly.

If the SHS caseworker is a client's first and/or only formal support worker, they will be the case coordinator for their own work with the client. As the caseworker makes referrals, other support workers will come on board. They should provide their support within the framework of the main case plan that the SHS caseworker has already developed with the client.



Working with other services summary

- Identify gaps in your current services and seek out like-minded organisations that can help fill that gap through a partnership.
- All partnerships, no matter how minor should have a written agreement so that expectations are clear and there is a framework for managing conflict.
- Partnerships enable services to pool resources and enhance their service delivery to clients.
- Partnerships work well for the client if they are with specialist services.
- Integrated service delivery models involve multiple organisations working in the same location to provide services to clients.
- Conflict in a partnership can erode and eventually destroy it. Conflict must be discussed immediately and a joint solution negotiated.
- Case coordination is needed if there are multiple support workers.
- Collaborative practice can help to build referral pathways for clients as it helps caseworkers get to know individual staff and entry criteria in local services.
- Good communication, active participation and flexibility are crucial to successful partnerships.



Case scenario: Ruby

Ruby, a 17-year-old woman, is referred to your SHS by her school, as her parents have kicked her out of home. Ruby tells you that there was violence at home for some time, it is overcrowded and she believes her mother has a mental health issue.

Ruby also says that her stepfather drinks a lot and she is alluding to having been sexually assaulted but will not confirm if she has been. Ruby would like to continue at school but has no money, can't sleep and has no idea what to do next. She appears very anxious and fearful.

As a caseworker you engage with Ruby to help her recognise her strengths and what she wants to achieve and how this can occur. You see that Ruby may also be affected by sexual assault and depression and specialist and other services will need to be brought in with her permission. You advise Ruby what her rights and entitlements are and that you will support her for as long as she needs it.

After getting Ruby's permission, you ask the school counsellor to give her ongoing support and assist with any additional resources she needs, to help her continue with her schooling.

You have an agreement with the local brokerage service which helps clients with emergency needs, so you go and buy some basic toiletries and other supplies for her to get by.

You also have an MOU with a semi-independent service nearby. You assess that Ruby has the skills to live semi-independently so you contact the caseworker at this service and make an appointment for an interview. The arrangement you have with this service is that you will provide support to the client in the first six weeks of placement and after this the client will get minimal support from that service. Without this agreement Ruby may not have been offered a placement, as demand is high for this type of accommodation.

You also know the local Police domestic violence liaison officer (DVLO) from attending local interagency meetings. You contact her to arrange an appointment for some help with potential legal issues in relation to violence at home and possible sexual abuse.

Ruby is able to quickly access the supports she needs as a result of you having effective local networks and partnerships.

Practice tips:

- Attending interagency meetings helps caseworkers get to know other local workers that can be called upon when needed.
- Formal agreements with other organisations help to improve access to their services.

Sharing the support load with other services enables the client to access a wider variety of skills and resources.

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Acronyms

ACT	Assertive Community Treatment
ACWA	Association of Children’s Welfare Agencies
AHURI	Australian Housing and Urban Research Institute
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other Drugs
APTCH	A Place to Call Home
COAG	Council of Australian Governments
CSHA	Commonwealth–State Housing Agreement
CMSA	Case Management Society of Australia
CWU	Child Wellbeing Unit
CS	Community Services (a division of FACS)
DVLO	Domestic Violence Liaison Officer
EBP	Evidence-Based Practice
EIP	Early Intervention Program
FACS	NSW Department of Family and Community Services
FaHCSIA	Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs
FHOA	First Home Owners Account
GP	General Practitioner
HAF	Housing Affordability Fund
HAP	NSW Homelessness Action Plan
HASI	Housing and Accommodation Support Initiative
HNSW	Housing NSW (a division of FaCS)
IP	NSW Implementation Plan
KTS	Keep Them Safe
MOU	Memorandum of Understanding
MRG	Mandatory Reporter Guide
NAHA	National Affordable Housing Agreement
NCBD&DD	National Centre on Birth Defects and Developmental Disabilities
NGO	Non-Government Organisation
NPAH	National Partnership Agreement on Homelessness
NQF	National Quality Framework
NRAS	National Rental Affordability Scheme
NSW	New South Wales
OOHC	Out-of-Home Care
PAG	Practitioner Advisory Group
RCMG	Regional Coordination Management Group
ROSH	Risk of Significant Harm
SAAP	Supported Accommodation Assistance Program (now known as SHS)
SMART	Specific, Measurable, Achievable, Realistic and Timely
SHS	Specialist Homeless Service
TIS	Translating and Interpreting Service

Glossary of terms

This glossary was adapted from the following sources: Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (2008), *The Road Home: A National Approach to Reducing Homelessness*, Homelessness White Paper; NSW Department of Premier and Cabinet, the 1997 Case Management Resource Kit for SAAP Services: 9. References, Resources, Acknowledgements and Glossary; and the Queensland Council of Social Services (2008), *A Matter of Interpretation*.

Advocacy: Advocacy is the process of promoting, supporting and representing the rights and interests of people. It also involves the protection of an individual's rights and interests to get justice. Advocacy can involve acting, speaking or responding on behalf of the person, to ensure they have access to and receive services that meet their individual needs, and respect their right to choose.

Advocate: A person who supports or represents a client on a particular issue, ensuring that their interests and rights are given proper consideration.

Affordable housing: Housing that is affordable for low to moderate income households; when housing costs are low enough to enable the household to meet other basic, long-term living costs. For example, housing costs should be less than 30% of household income for occupants in the bottom 40% of household incomes.

Assessment: This is an ongoing process to inform ongoing planning, is comprehensive and applies a client-focused, strengths-based approach. It occurs with the client and over a period of time.

Brokerage funds: Flexible funds that are available to buy and deliver services that are specific to the needs of clients.

Case plan: A case plan ensures that support is purposeful and outlines the agreed goals and how these will be achieved.

Caseworkers: Staff responsible for engaging with the client and supporting them throughout the case management process.

Child wellbeing units: There are four child wellbeing units; in NSW Police, Family and Community Services, Education and Communities and NSW Health: a unit for NGOs is within the FACS CWU. These units provide expert advice to staff from their agency/sector about children and young people who could be at risk, as part of Keep Them Safe.

Client-centred practice: This means keeping the focus on the client's wishes/needs and aspirations. It gives a caseworker flexibility to work with the client in a partnership that results consistently in responses that address their specific needs in a way they accept.

Client file: A client file is the documented information the service records about the client. This includes case notes, plans and client history, whether the information is kept on paper or electronically.

Code of conduct: This is a set of rules to inform consistently high standards of ethics and behaviour in all work with clients, the organisation and community partners.

Collaboration: Working together with other service providers and specialist services to fulfil the range of actions in the client's case plan.

Common ground: The Common Ground model was developed in New York. It provides a comprehensive support system designed to help people regain their stability and independence. Housing that is safe and attractive is provided at affordable rents (approximately 30% of tenants' income). The housing complexes operate as communities and are provided with libraries, clinics and computer centres. Activities promoting interaction between tenants are offered to foster a sense of community. The first Australian Common Ground model is now operating in Adelaide.

Complaint: This is a formal documented process in line with the organisation's policies and procedures, i.e. identified by a mechanism in the service, for clients to express any dissatisfaction about the service and receive a response respecting their confidentiality.

Consent: Permission from the client must be given before any information about them or their children is given to another agency. Wherever possible this permission should be in writing. If not possible and contact is by telephone, the caseworker should make a note in the case file recording the details outlined in the consent form. There are exceptions when it is not possible or appropriate to get consent from a client before involving another agency. Consent is within the limits of the law.

Coordination: This involves understanding the role of other services and developing cooperative working relationships with them, including specialist services. It also means knowing when you have a shared client and who is doing what (with the client's consent).

Council of Australian Governments (COAG): The peak intergovernmental forum in Australia, which includes the Prime Minister, state premiers, territory chief ministers and the president of the Australian Local Government Association. The council's role is to initiate, develop and monitor the implementation of policy reforms that are of national significance and require cooperative action by all levels of government.

Crisis accommodation: Accommodation for people who are experiencing or are at risk of homelessness. It provides short-term accommodation including refuges, shelters, motels, flats, boarding houses or caravan parks.

Critical incident: This is a significant event that threatens the safety of one or more people and/or risks/causes them psychological disturbance.

Cumulative harm: This refers to a series of acts or omissions that, when viewed separately, may not indicate significant risk, but together suggest a pattern of significant harm. Mandatory reporters should keep good records of concerns they have about a child as these may continue and the pattern may require a report to the Child Protection Helpline. The [Mandatory reporter guide](#) includes questions which help determine cumulative harm. The Child Protection Helpline gives feedback to mandatory reporters about what action to take.

Cultural competence: This 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 and remember that the individual and their situation are always unique.

Debriefing: This is support given to an individual or group and discussion after a critical incident. Debriefing aims to help people identify their feelings about the event and reach some resolution about it, so they are able to resume their usual roles and responsibilities.

Domestic and family violence: Domestic violence occurs when one partner in an intimate relationship attempts by physical or psychological means to dominate and control the other. It is generally understood as 'gendered violence' and is an abuse of power within a relationship or after separation. In most cases, the offender is male and the victim female.

'Family violence' is the term preferred by many Indigenous communities. 'Family' covers a diverse range of ties of mutual obligation and support. Perpetrators and victims of family violence can include aunts, uncles, cousins and children of previous relationships.

A wide range of behaviours may be involved in domestic or family violence, including physical, sexual, spiritual, verbal, emotional, social and economic abuse.

Duty of care: Is the legal and ethical obligation to take reasonable care to avoid injury to a person, who it can reasonably be foreseen, might be injured by an act or omission. It is the basis for the civil (court) action of negligence.

Early intervention: Strategies that aim to reduce risk factors through timely identification and tailored advice and support for those at risk of homelessness.

Emergency accommodation: Short-term accommodation provided for people who have recently lost their housing (in crisis accommodation) or are homeless (in shelters, motels, flats or caravan parks). See also crisis accommodation.

Foyer models: Foyer models provide housing for young people who are homeless. The housing is conditional on them being in education, training or employment. Several foyer models currently operate in Australia.

Goals: Statements the client agrees to about what they expect to achieve. Goals may be crisis, short-term, medium-term and long-term.

Housing and Accommodation Support Initiative (HASI): An innovative program that links stable housing to a range of specialist supports for people with mental illness, to enable full participation in the community and improved quality of life. The NSW Government funds the program.

Homelessness: People who are homeless fall into three broad groups. Those who are: sleeping rough (living on the streets); living in temporary accommodation, such as crisis accommodation; or staying with friends or relatives, in boarding houses or caravan parks, with no secure lease or private facilities.

Mainstream services: Generalist services provided by either government or non-government agencies that are available to the general population, such as Centrelink, public and community housing (see social housing), aged care and community health centres.

National Affordable Housing Agreement: The National Affordable Housing Agreement (NAHA) replaces the Commonwealth–State Housing Agreement and the Supported Accommodation Assistance Program V Agreement in 2009. The new agreement covers housing and homelessness assistance provided at all levels of government (Commonwealth, state and territory).

Not-for-profit sector: Non-government organisations providing a broad range of social services, such as for homelessness, education, health, conservation and recreation. The sector is an integral part of Australia's economic, social and political systems.

Prevention: Programs and opportunities that enable and encourage individuals to address possible risk factors before they are vulnerable to homelessness.

Significant harm: 'Significant' harm means it is sufficiently serious to warrant a statutory authority to respond, irrespective of a family's consent. It is not minor or trivial, and may reasonably be expected to produce a substantial and demonstrably adverse impact on the child or young person's safety, welfare or wellbeing. The term 'significant harm' can also apply in the case of an unborn child.

Social housing: Rental housing provided and/or managed by government or non-government organisations. This housing is mainly targeted at people on low incomes who are in greatest need. This includes those who are homeless, living in inappropriate housing, or who have very high rental costs. In public housing, most tenants pay less than the market rent (25% or less of their income). In community housing, rent payments range from less than 25% to more than 30% of income. Tenants also receive a range of support services (such as personal and employment support) and are encouraged to be involved in managing community dwellings.

Social inclusion: To be socially included, all Australians need to be able to play a full role in Australian life. This includes in economic, social, psychological and political terms; with the opportunity to secure a job, access services, connect with others in life, through family, friends, work, personal interests and local community; help to deal with personal crises such as ill health, bereavement or the loss of a job and to have their voice heard.

Specialist homelessness services: Services that work to help people who are homeless or at risk of homelessness. (See also Supported Accommodation Assistance Program.)

Specialist support services: Services that address specific needs, such as domestic violence or mental health services.

Supervision: This is a process that allows for the evaluation and enhancement of a staff member's performance in their role and responsibilities.

Support period: The time during which a person is supported by a SHS. It starts when a client begins to receive support and/or supported accommodation from a SHS agency. It ends when the client ends the relationship with the agency or vice versa.

Supported Accommodation Assistance Program (SAAP): A joint Commonwealth, state and territory government-funded support program, which assists people who are homeless or at risk of homelessness through a range of support and supported accommodation services.

Note: This document refers to SAAP when discussing the program, as it exists up to 31 December 2008. Due to the changes that were implemented 1 January 2009, under the National Affordable Housing Agreement (NAHA), the term 'specialist homelessness services' is used to describe SAAP services and other services that help people who are homeless.

Sustainable housing: Housing that is affordable, offers secure tenure, and is appropriate for the client given their needs and history, such as support for sustaining housing.

Appendices

1. Rights and responsibilities for clients
2. Sample supervision record
3. Sample supervision contract
4. Sample code of conduct
5. SHS client risk assessment tool
6. SHS client risk assessment guidelines
7. Client consent form
8. Case assessment report
9. Case planning tools
10. SMART goals
11. Sample case plan
12. Strengths-based sample questions for caseworkers to use with clients
13. Client self-reflection
14. Sample client feedback form
15. Caseworker's guide for reflective practice
16. Example case plan
17. Sample memorandum of understanding (MOU)

Appendix 1: Rights and responsibilities for clients

You have the right to raise any problems you have in a safe and protective environment whilst at the service.

You are encouraged to be responsible in exercising your individual right to follow through with complaints that are important to you. You will be protected from any reprisal and victimisation that may occur as a result of making a complaint.

You have the right to confidentiality and privacy.

You have the right to secure, safe, comfortable and affordable accommodation.

You are responsible for respecting the safety, security and comfort of others.

You have the right to be treated with respect.

You are responsible for treating others with respect.

You have the right to be heard and understood.

You are responsible for hearing and understanding others.

You have the right to make mistakes.

You are responsible for the mistakes that you make.

You have the right to make your own decisions and choices.

You are responsible for the decisions and choices that you make.

You have the right not to be abused (physically, emotionally, verbally or sexually).

You are responsible for not abusing others (physically, emotionally, verbally or sexually).

You have the right to be accepted no matter what your circumstances are.

You are responsible for accepting others regardless of their circumstances.

You have the right to be yourself.

You are responsible to yourself.

You have the right (if you choose) to appropriate, timely and practical assistance that is planned with you and offered in response to your needs and goals.

You have the right to receive the benefits of well-planned, efficient and accountable service management.

I acknowledge that I have read and understood my rights and responsibilities for this service.

Client name and signature: _____

Appendix 2: Sample supervision record

Staff name: **Date:**

Strengths

Prompting questions:

What do you feel you are doing well at in your work?

What are some ways that you could better use your strengths in your work?

As a supervisor, provide feedback about your observations of the worker's strengths.

Support needs

Prompting questions:

What aspects of your work are you finding difficult to manage?

Have you noticed any negative changes in your health and wellbeing in the last month?

How do you feel you are managing your work/life balance? How would your partner/family/friends answer that question?

What client issues are challenging you the most?

Educational needs

Prompting questions:

What additional skills do you feel you need in order to best meet the needs of the clients you are working with?

What additional skills would help you to be more confident in your work tasks?

What skills do you have an interest in developing in the next 5–10 years?

Accountability items

Prompting questions:

Review accountability items such as punctuality, conduct, professionalism, leave and other entitlements that haven't already been discussed.

Other issues

Discussion about other issues raised by the worker being supervised.

Name of supervisor: Date:

Signature:

Signature of supervisee:

Appendix 3: Sample supervision contract

The following contract summarises arrangements made by you.....and your supervisor.....as part of a professional supervision relationship.

Confidentiality

Information a staff person shares during supervision sessions will remain confidential. However, limits to confidentiality apply to misconduct and risk of harm to self and others. Staff will need to be aware that the information they share in a supervision session may be discussed within the framework of line management.

Structure

A typical supervision session may cover the following items. However, supervision should remain flexible and responsive to individual needs.

- review of client work
- training and professional development needs
- administration issues
- performance issues
- constructive feedback.

Frequency

Supervision will be arranged every.....on.....for approximatelyhr(s).

Records

Supervision records will be kept in individual staff files. Access to these files is limited to your supervisor and the manager. Staff are encouraged to keep their own supervision records in a personal file for their own reference.

I have read (insert service name) Supervision Policy. I understand and agree to comply with the policy and procedures set out in the policy.

Staff signature: Date:

Supervisor signature: Date:

Review date:

Appendix 4: Sample code of conduct

This sample code of conduct was sourced from Marist Youth Care and is included with permission. The document was adapted to make it generic for use in a range of different SHS organisations.

Introduction

The aim of this code of conduct is to set out the ethical commitment, legal obligations, conduct and behaviours required of all (INSERT SERVICE NAME) staff members, volunteers and contractors.

As an employee, volunteer or contractor with (INSERT SERVICE NAME), you are expected to work in accordance with the agency's mission, values and code of conduct.

1. Partner with and respect (INSERT SERVICE NAME)'s values, mission, policies and practices

- a) You must have a commitment to working in the interests of disadvantaged clients, beyond just a willingness to perform a certain job. This requires a genuine interest in the wellbeing, dignity and potential of all clients, and the ability to empathise with them in their various life situations.
- b) We respect your personal values system. However, you are required to abide by the values of (INSERT SERVICE NAME). You are to avoid bringing the agency, in whose name you act, into disrepute. You have a responsibility to meet the high standards of professional and ethical behaviour required by the agency, the public, the community, parents and the social welfare profession.
- c) You will familiarise yourself and comply with the values, mission, policies and guidelines of (INSERT SERVICE NAME) and your position description. In the absence of policy, for clarification, or if faced with a policy which is at variance with your own view, you should discuss the matter with your supervisor who may refer you to an appropriate (INSERT SERVICE NAME) manager to resolve the issue.

2. Legal compliance

- a) You are required to comply with this code of conduct and maintain professional and ethical behaviour at all times. You must respect the dignity, rights and views of others by acknowledging that (INSERT SERVICE NAME) owes a duty of care to clients and staff. You will exercise, with due diligence, the duty of care that you owe to the clients of (INSERT SERVICE NAME). In addition to this, you are expected to take all reasonable steps to protect clients from any risk of harm. This may require making formal notifications to appropriate government agencies, as well as referring matters of concern to relevant personnel within (INSERT SERVICE NAME).
- b) You will respect the law and comply with legislation, regulations and standards relevant to your position, and you will always act in accordance with your legal duty of care to clients. This includes, but is not limited to, legislation relating to industrial relations, resident's protection, privacy, discrimination and occupational health and safety.
- c) You are required to comply with all other (INSERT SERVICE NAME) policies and procedures, including occupational health and safety in the workplace.

3. Maintaining professional standards

- a) You will have a commitment to your ongoing professional development, supervision and performance appraisal. Your prime responsibility is to the clients with whom you work. In order to safeguard yourself and the organisation, you are expected to familiarise yourself with legal and regulatory requirements relevant to your position.
- b) You will maintain appropriate boundaries between your personal and professional life, and where uncertain about any related issues, you will seek your supervisor's advice or direction.
- c) You are not able to bring members of your family to work whilst you are involved in your duties with clients in (INSERT SERVICE NAME) care.
- d) You must be sensitive to the potential for abuse of clients by systems, procedures and individuals. You are to be familiar with current professional knowledge concerning different forms of abuse, and aware of the legal requirements and (INSERT SERVICE NAME) policy and practices to be observed in situations of allegations of abuse.
- e) Clients in (INSERT SERVICE NAME) care are never to be referred to by staff in derogatory, demeaning or sarcastic terms.
- f) You have a significant role in maintaining a workplace environment that is safe, positive and supportive and must apply the principles of natural justice in all your interactions with others. You are required to report any matters contravening these principles to your supervisor.
- g) You are required to exercise all your role accountabilities and responsibilities conscientiously, prudently and reliably.
- h) You will accept responsibility for your ongoing professional and career development.
- i) You are required to conduct yourself in a manner that is reasonable and sensitive in all matters related to the discipline, management or care of the clients, having due regard for their age, maturity level, health and other characteristics.
- j) You will contribute to the safety, welfare and wellbeing of clients by adopting work practices, which respect an individual's right to safety, and model responsible and respectful behaviour.
- k) You are required to develop effective, consistent and appropriate management strategies in your day-to-day interactions with clients. These strategies should be developed in accordance with other (INSERT SERVICE NAME) policies.

4. Out-of-work activities

- a) You are not to engage in social interactions with clients outside of work or work-related activities, without the express knowledge and approval of your supervisor.
- b) You must always treat clients in a consistent manner without inappropriate familiarity. Unacceptable behaviour includes inviting clients to your home or engaging with them socially in any non-work-related activity or outside your working hours without management approval. Other unacceptable behaviour includes communicating inappropriately with them verbally, in writing, via phone, email, or SMS (text messaging). For clarification on any matters about appropriate behaviour with clients you are advised to seek your supervisor's advice or direction.
- c) You are required to follow agency policy and procedures for transporting clients and to use agency vehicles for this purpose. You require permission from your supervisor to use your own private vehicle for agency business, unless this is stipulated in your employment contract.

- d) Should a client engage, or attempt to engage, you in inappropriate behaviour of a sexual or physical nature, you must immediately discourage this behaviour and report the matter immediately to your supervisor.
- e) You must notify your supervisor or manager immediately if you suspect any form of reportable conduct or concern of risk of harm to a client, in accordance with (INSERT SERVICE NAME)'s Child Protection Policy and Procedures. You must also be aware of individual mandatory reporting requirements under the *Children and Young Persons (Care and Protection) Act 1998*.

5. Relationship with clients

- a) You will maintain a genuine and professional relationship with clients at all times. You will maintain appropriate boundaries between your personal and professional life and set appropriate boundaries in your relationships with clients. You will not enter into close personal or financial relationships with clients or other people who are significant in their lives.
- b) Personal contact with clients after they have left our services is only sanctioned if such contact is part of a case plan and is approved by a staff member's supervisor.
- c) You will respect client self-determination and the growth potential of every individual. You need to be aware of the power differential that exists between you and clients, and avoid an attitude, which creates any remoteness or unnatural distance between you and the clients.
- d) You are prohibited from inflicting any physical, sexual, emotional or verbal abuse on clients. You must ensure that they are not exposed to situations in which they may be exploited, neglected or abused.
- e) Your relationships with clients should be based on a deep respect for them, regardless of their situation in life, reflecting your personal acceptance of them and a willingness to walk with them rather than talk down at them. You should be aware that your interactions with clients must be based on trust and your relationship with them is always open to scrutiny.
- f) You will be sensitive to the religious and cultural origins of each individual client.
- g) You must be aware of the adult role model you provide for clients and in your dealings with them you must be sensitive, courteous and appropriate.
- h) You are required to develop and exercise careful judgement and sensitivity regarding all interactions with clients. You need to be aware of the potential for any alleged inappropriate behaviour to be reported under child protection legislation, and of your obligation to cooperate fully with any investigation process that follows a complaint or allegation against you.

6. Appropriate physical contact

- a) You must exercise caution to ensure that when physical contact with a client in your care is a necessary part of the role, it is appropriate and acceptable for the action to be taken. You will be held responsible and accountable for the manner in which you exercise physical intervention with clients.
- b) As a general guide you should avoid physical contact with clients unless:
 - the contact is non-invasive and not sexual and is initiated or consented to by the client
 - there is a legitimate reason for such contact for the client's own safety, welfare and wellbeing (e.g. administering first aid, removing them from impending danger, comforting a highly-distressed child in an emergency situation, etc).

Physical contact for the client's safety and welfare should only be to the extent required and no more

- the physical contact is part of an approved personal care plan for a client who needs physical assistance with personal care tasks due to disability or short-term injury.
- c) Avoid being alone with a client in any closed room or isolated location unless:
- another adult is in the vicinity and has been informed when you commence and finish being alone with the client in a closed room
 - there is a legitimate reason for doing so for the client's or another client's own safety and welfare.
- d) Never enter a room when a client is dressing, undressing, bathing/showering or toileting, unless there is a legitimate reason for doing so for the client's or another client's own immediate safety, or help with these tasks is part of an approved personal care assistance plan. You should never allow another client to enter when you are completing these personal care activities.

7. Relationships with colleagues

- a) You will be a role model and encourage and promote behaviour consistent with this code, including:
- adopting a consultative approach about how work is to be performed
 - being receptive to and considerate of divergent thinking, ideas and modes of operation
 - participating in risk-reduction programs where mistakes and adverse events are identified, reported without blame, discussed and corrected
 - encouraging a climate which is open, supportive, caring and sensitive to the needs of all
 - contributing positively to the development of teams
 - working cooperatively and recognising the skills, abilities and relevant life experience of other team members, and providing mutual support
 - cooperating actively with other organisations with which you network.
- b) You are required to disclose to your manager any family or personal relationship, with another (INSERT SERVICE NAME) staff member (or client in our care). The agency must ensure that you are not placed in a position where any such relationship could give rise to a potential or actual conflict of interest (see conflict of interest).

8. Competency and performance

- a) You are expected to maintain and improve the skills, knowledge and competencies required for your position, by keeping abreast of advances and changes in the body of knowledge and the professional and ethical standards relevant to your duties. Where you are aware of gaps in your knowledge or the skills required for your position, you are expected to bring this to the attention of your supervisor without delay.
- b) You will exercise care, responsibility and sound judgement when carrying out your duties and conform to the principles of natural justice. You will maintain adequate documentation to support any decisions made and ensure procedural fairness is followed in all processes.

- c) You must undertake to be mentally and physically fit to carry out your employment responsibilities at all times.
- d) You must not consume alcohol or illegal substances, or any drugs which may impede your performance, while on duty, including during excursions and other activities where you are in the presence of, or responsible for, clients.
- e) You must refrain from reporting for duty, or carrying out your duties, if under the influence of alcohol, any illegal substance, or any drug that may impair your performance and judgement.
- f) You will observe safe work practices to minimise the risk of workplace injury to clients, yourself and others. This requires compliance with OHS and other (INSERT SERVICE NAME) policies and procedures (see legal compliance).
- g) You will not take or seek to take improper advantage of any official information gained in the course of employment, nor take improper advantage of your position to benefit yourself or others. You will not allow personal political views/affiliations or other personal interests to influence the performance of your duties or exercise of responsibilities. You will not accept gifts or benefits in the course of your duties (see conflict of interest).
- h) You will recognise legitimate authority within (INSERT SERVICE NAME) and ensure due consultation in your decision-making. You will carry out the reasonable directions of management within your position accountabilities. Failure to do so may result in disciplinary action, including the termination of employment.

9. Requirements of confidentiality

- a) You will maintain appropriate confidentiality as a mark of respect for the individual as well as being a requirement of ethical standards and legislation. Where confidentiality is not appropriate, for example, where clients disclose incidents having implications for their or others care and protection, you will advise them of your responsibility to act on their information and to inform the relevant personnel.
- b) You will act in accordance with (INSERT SERVICE NAME)'s privacy policy and maintain confidentiality of files and data systems in accordance with (INSERT SERVICE NAME) policy, legislation and reporting requirements.
- c) You will ensure that due clearances are obtained in the collection and communication of information on clients.
- d) You acknowledge that access to confidential information is restricted to authorised personnel and that disclosure to third parties, including media, other agencies or clients, will require the prior approval of the manager.
- e) You will inform clients of the policy and procedures relating to confidentiality.

10. Fitness for duty

- a) You are required to be physically and mentally fit to carry out your responsibilities whenever you are on duty. Where you are not able to carry out your duties, for whatever reason, you will inform your supervisor as soon as practicable.
- b) You are required to inform your supervisor of shifts undertaken at other (INSERT SERVICE NAME) units during your time off, to enable your supervisor to manage OHS obligations.
- c) You are required to inform your supervisor of any employment commitments external to (INSERT SERVICE NAME) and to ensure that they do not adversely affect your ability to perform your (INSERT SERVICE NAME) duties.

11. Management of resources

- a) You are fully accountable for the use of agency work time and resources. Your paid work time is to be committed solely to the work of (INSERT SERVICE NAME) and allocated in such a way as to achieve maximum benefit for the clients.
- b) You have a duty to ensure that agency resources are used only for their intended purpose, are well maintained, and secured against theft or misuse. Agency resources include finances, facilities, equipment, vehicles and any other property that is the responsibility of (INSERT SERVICE NAME).

12. Reporting and recording

- a) You will cooperate with and observe (INSERT SERVICE NAME)'s policies and procedures for reporting and recording all necessary information. This includes appropriate maintenance of documentation on: client records, operational matters, disciplinary procedures and child protection notification processes, investigations under the NSW Ombudsman Act in relation to child protection, workplace incidents (work injuries, work-caused illnesses and dangerous events) arising from work-related activities, and others per (INSERT SERVICE NAME) policy.
- b) You will document and accurately maintain any decisions, rationale or explanations relating to a client in your care ensuring that any required written reports are objective, accurate in content and temperate in language.

13. Conflicts of interest

- a) You will not participate in any activities that could lead to an apparent or actual conflict of interest. A conflict of interest occurs where an employee has, or appears to have, a personal or professional interest influencing the objective performance of his or her duties.
- b) Conflicts of interest should be assessed in terms of the likelihood that a particular interest could influence you or may appear to influence you in the performance of your duties on a particular matter. A conflict of interest that leads to biased decision-making may constitute corrupt conduct.
- c) Examples of where a potential for conflict of interest may occur include:
 - personal or family relationships between you and other (INSERT SERVICE NAME) staff or you and clients
 - use of position for financial or other gain
 - personal or political beliefs or attitudes that influence the impartiality of advice given
 - secondary or outside employment
 - accepting or offering money, gifts or other inducements.
- d) You are required to notify the manager, in writing, of the existence of an actual or potential conflict of interest, as soon as you become aware of it. Any employee who fails to declare such an interest may face disciplinary action. For advice or clarification on what constitutes a conflict of interest, refer to management to resolve the issue.

14. Breaches of the code of conduct

Breaches of this code can result in (but are not limited to) any one or more of the following:

- disciplinary action
- dismissal
- notification to an external agency
- criminal charges in the case of an alleged criminal offence by a staff member.

15. File copy of the signed acknowledgement form

A copy of the staff member's acknowledgement that they have read the code of conduct will be stored in individual personnel files. The acknowledgement assumes that the staff member has read the code of conduct and agrees to abide by it as part of their employment contract.

16. Acknowledgement

I acknowledge that I have read, understood and will abide by the (INSERT SERVICE NAME) code of conduct, as a condition of my employment.

I fully understand that, should I have a problem with any of the clauses in this code of conduct, I am obliged to discuss the issue and resolve it with my supervisor.

Name:

Signature:

Date:

Appendix 5: SHS client risk assessment tool

Area of client information	STEP ONE Trigger questions	STEP TWO Potential follow-up questions you could ask
RISK TO SELF General health Mental health	Can you tell us about any health condition for which you are, or should be, taking medication or treatment? Prompts – mention mental health conditions, physical health problems, recent visits to the doctor.	Consider asking questions about medications taken; reminders needed to take medications; health support services received; past admissions to psychiatric units; past community treatment orders; children’s care during periods of illness.
RISK TO SELF Alcohol and other drugs	This is a drug- and alcohol-free environment. What difficulties or challenges could this mean for you? Prompts – you cannot drink while here, you cannot come back stoned or drunk, no alcohol or drugs allowed on the premises.	Consider asking questions about current drugs or alcohol use; patterns of usage; drug and alcohol support received and needed; past experience with withdrawal symptoms, overdoses, seizures, blackouts, substance-induced aggression and self-harm.
RISK TO SELF Suicide and self-harm	What do you do if you are down and depressed and feel that it’s hard to go on? Prompts – staying in bed, crying, self-harm, suicide thoughts or attempts. Consider culture here.	Consider asking questions about the effect of those rough times; if this is happening now; how the person is dealing with those feelings Look for talk of wanting to die; indications of no reason for living; reckless acts; giving away valued possessions; noticeable changes in daily activities like eating, sleeping or socialising; a plan or method.
RISK TO OTHERS Aggression from self Risk to property	What do you do when you get frustrated or angry? Prompts – shout at others, hit someone or something, go quiet, meditate, throw things, get wasted, go for a walk.	Consider asking questions about any incidents of violence/assault; what makes the person angry; anger problems at other services; whether past incidents were in response to provocation, under the influence of alcohol or drugs, when ill or in crisis, immediately or a day after a stressful incident, impulsive or planned towards a person or object, towards men, women or children, towards a larger or smaller person.

<p>RISK TO OTHERS Shared household issues</p>	<p>What's been your experience in living in shared accommodation with people you don't know?</p> <p>Prompts – follow house rules and agreements, do rostered chores, sharing rooms, respect others, leave other's property alone.</p>	<p>Consider asking questions about what worked well and didn't in the past in shared households; what is important for people to keep in mind when living in shared households?</p>
<p>RISK TO OTHERS Legal issues</p>	<p>What's been your experience with the Police and legal systems?</p> <p>Prompts – verbals, warrants, charges, scheduled court appearances, AVOs, bonds, probation.</p>	<p>Consider asking questions about Juvenile Justice or probation officers, bond or probation conditions, criminal convictions; support needed for outstanding legal matters.</p>
<p>RISK FROM OTHERS Aggression from others Risk to property</p>	<p>Is there anyone wanting to cause you harm who may know where you are?</p> <p>Prompts – current or ex-partners, their family members, gang members, others who may be threatening, aggressive or violent.</p>	<p>Consider asking questions about gang involvement; how dangerous this person is; their access to weapons; understanding of AVOs and need for one.</p>
<p>RISK FROM OTHERS Accompanying children</p>	<p>In what situations can your kids get difficult to manage?</p> <p>Prompts – past involvement with Community Services, difficulties in controlling kids, challenging behaviours.</p>	<p>Consider asking questions about how the kids have been coping with the situation; custody and access arrangements; details of challenging behaviours; support needed to manage the children.</p>

SHS client risk management tasks

STEP THREE Determine severity of risk	STEP FOUR Consider risk management strategies	STEP FIVE Make decision
<p>What is the frequency of exposure to the risk situation? How often does it occur?</p> <ul style="list-style-type: none"> • Low (infrequent) • Medium (occasional) • High (frequent) • Extreme (at least weekly) • Chronic (ongoing & present) <p style="text-align: right;">↓</p> <p>What is the likelihood of the risk situation occurring?</p> <ul style="list-style-type: none"> • Very likely to occur • Likely to occur • Unlikely to occur • Very unlikely to occur <p style="text-align: right;">↓</p> <p>What are the potential consequences of or harm from the risk situation to the client, other clients, staff, etc?</p> <ul style="list-style-type: none"> • Insignificant • Minor • Moderate • Major <p style="text-align: right;">↓</p> <p>Combine frequency, likelihood and severity to determine the overall severity of risk.</p> <ul style="list-style-type: none"> • Low • Medium • High <p style="text-align: right;">↓</p> <p style="text-align: center;">Then go to Step 4 – Consider risk management strategies</p>	<p>What things can the client do to manage the identified risk factors?</p> <ul style="list-style-type: none"> • Work within case plan • Manage own medications • Attend counselling, training, support groups • Arrange support services, AVOs <p style="text-align: right;">↓</p> <p>What things can your SHS service do to assist in the management of the risk factors?</p> <ul style="list-style-type: none"> • Rearrange your resources • Include risk management strategies in case plan • Provide staff information and training • Revise rosters • Arrange specialised support services • Arrange case conference • Negotiate joint case management <p style="text-align: right;">↓</p> <p>What can other support services do to assist in managing the risk factors?</p> <ul style="list-style-type: none"> • Provide direct access to support services and staff • Provide or upgrade support • Provide financial or staffing resources • Provide joint case management • Participate in case conferences • Provide back-up support and training <p style="text-align: right;">↓</p> <p style="text-align: center;">Then go to Step 5 – Make decision</p>	<p>Consider and balance:</p> <ul style="list-style-type: none"> • Collected risk assessment information • Your assessment of severity of risk • All risk management options <p style="text-align: right;">↓</p> <p>Decide whether:</p> <ul style="list-style-type: none"> • Level of risk is acceptable without changes to existing OH&S policies and procedures • Level of risk is acceptable with adjustments to resources and a risk management plan • Level of risk is too high and cannot be mitigated by risk management strategies <p style="text-align: right;">↓</p> <p>If accepting the client, follow entry procedures and put in place</p> <ul style="list-style-type: none"> • Case plan • Risk management strategy, if needed • Monitoring and review strategy <p style="text-align: right;">↓</p> <p>If not accepting the client:</p> <ul style="list-style-type: none"> • Explain and document reasons • Outline appeals processes • Identify referral options with client • Refer with client consent

Appendix 6: SHS client risk assessment guidelines

Guidelines for client risk assessment and management in SHS services

Originally prepared by Age Communications in April 2006 and modified by Crystal Phoenix in July 2011 as part of the Specialist Homelessness Services Case Management Resource Kit Project.

Introduction

Background to the SHS client risk assessment project

In 2004, the NSW Ombudsman's report, *Assisting homeless people – the need to improve their access to accommodation and support services* identified issues which the office believed were hindering access by homeless people to services funded under the Supported Accommodation Assistance Program (now known as SHS). The report concluded that some client exclusion policies and practices may contravene anti-discrimination legislation. It was recognised that some exclusions may be influenced by inadequate risk assessment processes.

The community services field is moving towards better practice in occupational health and safety without compromising the quality of service and support to clients. Part of this practice is focused on more effective screening of clients to better determine the level of occupational health and safety risk a client presents to the SHS agency.

In response, the Department of Community Services provided funds to Homelessness NSW on behalf of the three SHS peaks to develop and trial a client risk assessment process and tool that could be adapted to the broad range of SHS service settings.

During 2005, the successful tenderers for the project, Age Communications and Tribe Research developed and successfully trialled the risk assessment tool and process. They used a representative sample of 26 SHS services and almost 700 clients across NSW.

The SHS agencies and 83 workers who took part in the trial reported increases in awareness and skills in client risk assessment through external and internal training and use of the tool and process with all clients who were seeking entry to the SHS service. All were able to integrate or adapt the process into their existing intake, assessment and case management systems.

This version of the guidelines was adapted for use by agencies that did not participate in the SHS Client Risk Assessment Project. It is complemented by:

- the SHS Client Risk Assessment Tool which is available in two versions – a standard process that can be used as a guide to the overall client risk assessment process and a tick box version that can be attached to an individual client file
- a set of PowerPoint slides that can be used for internal training and refreshers.

About risk assessment

What is risk assessment and management?

A risk is a workplace hazard to which people are or may be exposed. A risk must be foreseen before controls can be put in place. Responding appropriately to workplace risk involves two basic processes; identifying and assessing the level of foreseeable risks and developing strategies to manage the risk effectively.

Basically the risk assessment part of the process answers the following questions:

- what can go wrong?
- what is the probability it could go wrong?
- what could be the consequences if the risk becomes a reality?

In the risk management part of the process the controls to minimise or manage a risk are:

- identified
- developed
- implemented
- monitored
- reviewed.

About risk assessment in SHS

Risk assessment and the SHS standards

Risk assessment and risk management should be at the core of a SHS service's occupational health and safety system. Section 9 of the NSW *SHS standards* (1998) outlines many indicators of good practice around safety, security and the physical environment including:

- providing well-maintained, comfortable and home-like residential accommodation
- providing appropriate and well-maintained equipment
- providing a safe work environment for staff with written occupational health and safety policies and procedures
- ensuring that clients are as safe and secure as possible
- promoting good hygiene within the service.

SHS has many risks in common with other Australian workplaces. Due to the nature of its business, part of a SHS's response to its occupational health and safety challenges must be about the potential risks posed by clients entering and using the service. These risks may be to the client themselves, staff or other clients and visitors to the service.

Client risk assessment and SHS

All clients entering and using SHS services will present or be exposed to some level of risk. Risk assessment and management is, therefore, an ongoing and ever present task for workers in SHS services. The essence of client risk assessment in SHS is to first realistically

identify foreseeable risks and then analyse the extent of these risks and their likely impact. The next part of the process is to decide what needs to be done.

There are three options when a risk and its severity is identified by a SHS worker who provides intake, assessment or case management services. The risk can be:

- **controlled** by existing occupational health and safety practices
- **mitigated** or lessened by using specific risk management strategies
- **not accepted** by referring the client to another agency.

SHS workers do accept certain levels of risk whenever they admit clients into the service. Even the most thorough intake and assessment procedures are unable with total certainty to ensure that information the client and referral agents give is honest, accurate and complete.

Generally, an agency's occupational health and safety, home visiting and managing aggression policies and procedures are enough to protect staff and clients from harm and there is no need to adapt or adjust them to individual circumstances. These policies and procedures should be in line with the risk assessment and management principles outlined in the next section.

Many areas of client risk can be mitigated, or minimised, by developing a special response to management of that risk. It is important to remember here that what works in one situation for one client may not necessarily work for another client.

The response to risk, therefore, is tailored to the specific needs of the individual client. This is the ideal outcome in situations in SHS where client risk is identified. It is totally in line with, and can be included in the SHS case management process; an individualised and planned response to resolving a client's homelessness issues.

SHS services have varying opportunities to refer a client with an unacceptably high level of risk to another agency. So much depends on availability of needed services, their capacity to accept the client and ability to manage the risk.

While making a referral to another agency is often the outcome, this should only be done after the SHS service has carefully and fully considered its risk management options. Maybe the client can help manage the risk. Maybe the SHS service can help through a negotiated case management plan. Sometimes, external agencies can provide the needed support.

SHS workers also need to consider whether they are actually increasing the risk of harm to the client or others, if they reject the client or refer them to another agency due to perceived risks.

Risk assessment and management starts at the first point of contact with the client and continues through the eligibility, intake and assessment stages of entry into the service. It does not stop there. Risk assessment and management is an integral part of case management, as identified areas of risk are monitored and reviewed as part of the process.

SHS risk assessment and management policy principles

The processes and tools of SHS client risk assessment are based on the following set of principles.

1. Client risk assessment and risk management is an essential part of a SHS service's commitment to occupational health and safety in the workplace.
2. Client risk assessment is an ongoing process that starts at the point of first contact with the client, continues through the assessment process, is included in case management practice and evaluated when the client leaves the service.
3. Client risk assessment practice is in line with:
 - SHS service's duty of care responsibilities
 - occupational health and safety legislation
 - anti-discrimination legislation.
4. All SHS staff who have contact with individual clients have a role in managing client risk. All staff manage client risk according to their responsibilities and accountabilities
5. Safety for all in SHS services depends on effective staff induction and training in recognising areas of client risk and minimising the likelihood and impact of incidents arising from risk areas.
6. A large proportion of risks arise from client needs and behaviours and, therefore, require a risk management response tailored to the individual and their situation.
7. Including risk management strategies in case planning, monitoring and evaluating are the preferred ways of responding to client risk.
8. The SHS client risk assessment process focuses on identifying and assessing the level of client risk and developing workable risk management strategies to minimise that risk, wherever appropriate.
9. Eligible clients are only excluded on the basis of risk when a vacancy exists if:
 - the area of identified risk has been thoroughly assessed
 - there are no realistic options for risk management within the resources available to the client, the SHS service and other support providers
 - the SHS agency has carefully and consciously decided that it cannot accept the client without unduly risking the wellbeing of the client, other clients and/or staff
 - the SHS agency is satisfied that it is not discriminating against the person by not accepting them as a client.
10. SHS staff follow good occupational health and safety practices whenever responding to client risk situations.

SHS risk assessment and management procedures

Overview of the process

The SHS risk assessment process is based on five steps that start when the SHS service considers accepting a new client to fill a supported accommodation or program vacancy.

The five steps which are outlined in detail below are:

- Step one: Asking open-ended trigger questions in identified areas of client risk at point of contact or intake.
- Step two: Asking follow-up questions to gain further information to learn more about the person's experience with the issue, if needed.
- Step three: If an issue of client risk is identified, considering how severe the risk is and its potential for harm.
- Step four: Considering management strategy options that could lessen the risk.
- Step five: Balancing severity of risk with the potential to manage the risk in the decision whether to accept the client. Then, if accepting the client, developing a risk management strategy as part of the case plan or, if not, working with them to make an effective referral.

Step one – Ask trigger questions

Rationale

The trigger questions are designed to seek information about areas of client risk common to SHS services. The risk may be to the client themselves, staff or other people including other clients. They basically fall into three subgroups:

- potential risks to self in the areas of general health, mental health, alcohol and other drugs, suicide and self-harm
- potential risks the client poses to others in the areas of violence and aggression towards other people and property, sharing accommodation with others and criminal activity
- potential risks other people pose to the person, such as aggression from others, and risks to accompanying children entering SHS services.

They are open questions that should encourage conversation rather than closed 'yes or no' answer questions. They are in a logical order moving from general to more specific questions to encourage the building of trust and rapport. They move from talking about the impact of these life challenges on the person; to talking about the person's impact on others; and then to discuss the effects other people might have on the situation.

SHS workers ask these questions at or near the point of first contact with the client. Workers doing intake will need to have the communication skills to know, either through observation or the client's answers, whether more information is needed about a potential area of risk. If concern is triggered by one or more of the client's answers then go on to step two.

The trigger questions

The worker should have already determined if the client fits into the agency target group and is eligible to enter the service.

Risk to self

1. *Can you tell us about any health condition for which you are, or should be, taking medication or treatment?*

Prompt, if needed, by mentioning mental health conditions, physical health problems, recent visits to the doctor, etc.

2. *This is a drug- and alcohol-free environment. What difficulties or challenges could this mean for you?*

Prompt, if needed, by saying things like 'you cannot drink while here', 'you can't come back stoned or drunk' or 'you can't have alcohol or drugs on the premises'.

3. *What do you do if you are down and depressed and feel that it's hard to go on?*

This can be a very sensitive question, particularly to people with strong cultural taboos about suicide or discussing deeply personal issues with strangers. Please read the later section on policy and procedural issues for more detailed information. Questions like 'do you ever feel (have you ever felt) so sad/bad about your life that it seems too hard (you don't want) to go on?', 'do you have a name for this feeling?' or 'what do you do when you feel like this?' may be more culturally appropriate.

Risk to others

4. *What do you do when you get frustrated or angry?*

Prompt if needed, by suggesting common strategies like shouting at others, hitting someone, punching walls, going quiet, meditating, throwing things, getting wasted or going for a walk.

5. *What's been your experience in living in shared accommodation with people you don't know?*

Prompt, if needed, by mentioning things like following centre/house rules, doing rostered chores, sharing rooms, respecting others and their property.

6. *What's been your experience with the Police and legal system?*

Prompt, if needed, by mentioning verbals, warrants, charges, scheduled court appearances, AVOs, bonds and probation conditions.

7. *Is there anyone wanting to cause you harm who may know where you are?*

This could include current or ex-partners, their family members and others who have been, or are likely to be aggressive or violent towards them. The later section on 'other policy and procedure considerations' has more information on asking culturally-appropriate questions in this area of risk assessment.

8. *In what situations can your kids get difficult to manage?*

Prompt by asking about past involvement with FACS (formerly DoCS), past difficulties with looking after their children or their challenging behaviours. Note that you may need to explain the role of FACS. The later section on 'other policy and procedure considerations' has more information on asking culturally-appropriate questions in this area of risk assessment.

Important considerations

- Select the question according to the situation. Not every SHS agency will need to ask every trigger question on every occasion.
- Do not overwhelm the client at this contact point. Be as friendly as possible and build what rapport you can.
- Assure the client that these questions are asked of every new client and their answers will help you to work out what type and level of support they may need from your agency.
- Be aware of your own prejudices and how they could affect your assumptions and judgement about risk.
- Do talk about aspects of the service that may challenge the client.
- Recognise that the client is seeking some kind of support from your agency and may give answers they think you want to hear. Learn different ways to ask the same question. You might get different answers when you do.
- Recognise that it is hard to get an accurate picture of the client at first sight. It is even harder when the first contact is by phone. Remember that all you are doing at this stage is identifying any potential area of risk that needs further investigation.
- Remember that this process is designed primarily to assess risk and develop a planned response to mitigate it. The primary focus is finding a suitable way to support the client not to find a reason for excluding them.

Step two – Ask follow-up questions where required

Rationale

Follow-up questions are asked when concern about potential client risk is identified either through the answers to the trigger questions or through the SHS worker's observations of the client. If concerns about risk are not raised, there is generally no need to ask follow-up questions.

Follow-up questions aim to uncover more information about the issue raising risk concerns. What needs to be asked will vary from situation to situation and, in some cases, will be similar to questions asked in assessment processes. The areas for further questioning in the Risk Assessment Tool and the more specific questions later in this section of the guidelines, are suggestions only.

The critical thing here is to build trust so that the client feels as comfortable as possible in talking freely about their issues. Closed questions requiring yes/no or short answers will restrict the conversation. Open questions starting with words like 'can you tell me about...', 'what happens to you when...' and 'how do you feel about...?' are much better at helping a client to talk.

This stage of the risk assessment and management process is still an information gathering and exchange exercise. It is not about deciding whether you have the resources available to adequately support the client.

Follow-up questions

Some follow-up questions seek general information about the issue and its effect on the client's situation. Others can try to get quite specific information.

The following questions are examples only of the type of information that may be relevant to the risk assessment and management process.

General and mental health

- What medications do you take and for what conditions or health problems?
- Do you take them on your own or do you need to be reminded?
- What medical or health support services do you receive?
- Have you ever been admitted to a psychiatric unit? Can you tell me more about what was happening to you at the time?
- Have you ever been placed on a community treatment order?
- How do you manage your children when you are ill?

Alcohol and other drugs

- Do you currently use drugs or alcohol on a regular basis?
- At what times or in what situations do you get drunk or stoned?
- What do you take and how often?
- What have been some of the consequences of your drinking or drug taking in the past?
- Have you ever received or sought help, treatment or rehab for your drug or alcohol use?
- Do you need support from a drug and alcohol worker?
- How have you managed without alcohol or drugs in the past?
- Have you ever had withdrawal symptoms when you stopped drinking or taking drugs?
- When using drugs or alcohol, have you ever had an overdose, a seizure, blackouts, been aggressive, harmed yourself or someone else?
- Do you understand the consequences of drinking or drug taking while you are a client at this service?

Suicide and self-harm

- In your culture, what does it mean for someone to be feeling like this?
- How do people in your culture who feel like this generally cope with their feelings?
- Is there anyone they would talk to?
- Can you tell me a little about how those rough times affected you?
- Is this happening or are you feeling this way now? If yes, is there anything you are doing to support yourself through this? If no, when was the last time you felt this way and what was happening for you at the time?
- What help have you had to deal with these feelings? How did it help?
- When you are feeling this way, what sort of things do you find yourself doing?

- Ask yourself:
 - Is the person talking or hinting about wanting to die?
 - Is the person indicating that they have no reason for living?
 - Is the person acting recklessly or giving away valued possessions?
 - Are there noticeable changes in daily activities like eating, sleeping or socialising?
 - Is there a plan?
 - How serious is it?
 - Is a method available?

Aggression and violence

- How do you respond if you are in a situation and not getting your own way (e.g. you are told you are not allowed to do something)?
- Have you ever been involved in a fight?
- If you get really angry with someone, what do you usually do?
- Have you had problems managing your anger?
- What happened the last time you lost your temper?
- Have you ever been violent and assaulted someone? What happened?
- What tends to make you angry and/or violent?
- Have you had any anger problems at other services?
- Did the violent incident occur:
 - in response to provocation
 - under the influence of alcohol or drugs
 - when you were ill or in crisis
 - immediately or a day or more after a stressful incident
 - impulsively or was it planned
 - towards a person or object
 - towards men, women or children
 - towards someone bigger or smaller?

Living in shared households

- Have you ever lived in shared accommodation before with people from different cultural and other backgrounds? What was your experience in the situation?
- What worked well for you in the past in shared households?
- What didn't?
- What do you think is important for people to keep in mind when living in shared households?
- What things are you good at around the house (e.g. cooking, cleaning, household chores)?

- What do you have trouble doing around the house?
- How do you manage conflict with housemates?
- What level of supervision do you need to live in shared accommodation?
- Are you willing to attend house meetings?

Legal and criminal matters

- Do you have any criminal convictions?
- Have you had any recent contact with the Police?
- Do you have a Juvenile Justice or probation officer?
- If on a bond or probation, what conditions have been set?
- What help or support do you need to help with any outstanding or upcoming legal matters?

Violence from others

- How dangerous do you think this person is?
- Does this person have access to weapons?
- Do you know what an AVO is?
- Do you have an active AVO?
- Do you need to take out an AVO?

Accompanying children

- Tell me about your children (e.g. school, likes, dislikes, hobbies)?
- How have your children been coping with what's been happening at home?
- Have you noticed any changes or differences with their behaviour (bed wetting, clinging, challenging behaviour)?
- (After explaining that they will be sharing living space with other families) How do you think your kids will cope with this type of environment?
- Are there custody and access arrangements in place for the children?
- What types of things do you do if your children are being difficult?
- What kind of support will help you to manage your children if they are being difficult?

A note on seeking advice from other agencies

Strictly speaking, background checks only need to be done when the SHS service identifies an area of risk and is uncertain about whether a workable risk management strategy can be designed and implemented. Therefore the questions and guidelines in this tool can be adapted to help collect information from other agencies about potential risks.

If this is the case, the SHS service should first get the client's consent to contact the other agency to exchange relevant information. Exchanging information without the client's consent will breach privacy legislation and your own service's privacy policy.

Information exchange without client consent can only occur in situations where duty-of-care considerations override confidentiality. This means when:

- there are serious concerns about the client's safety (e.g. the person may be suicidal)
- other people may be in danger if key client information is not exchanged.

Even in these situations, it is best practice to still seek consent from the client and, if not given, to advise them that confidentiality cannot be kept in this situation.

Information exchange needs to be confined to relevant information about the identified area of client risk.

In some situations, the SHS service may not feel it has the expertise to assess the area of risk. When this occurs, the SHS service can ask for a specialised assessment from an agency with this expertise. Again this is done with the client's consent. Relevant information from this specialised assessment can then be built into the risk assessment information already gathered.

Considerations

- It can be helpful to immediately follow a specific closed question like 'have you ever been admitted to a psychiatric institution?' with an open question like 'can you tell me a little about what was happening for you at the time?'
- Be aware of your natural tendency to increase the number of closed questions when people aren't giving you much information. These make it even more difficult. You should be asking open questions.
- If doing the initial trigger questions over the phone, follow-up questions can wait until you have a face-to-face meeting with the person, allowing for a more thorough assessment. If this is the case, it is good practice to tell the client that you may be able to provide accommodation and/or support based on further assessment.
- Consider using a staff meeting to generate a number of follow-up questions appropriate to your agency. These can be added to suggested intake and assessment procedures.

Step three – Determine the issue's severity

Rationale

The third step in the risk assessment and management process is to assess how severe the risk really is. This step should prevent SHS workers from jumping to hasty conclusions and excluding the person because they have simply disclosed a problem in one of the identified potential risk areas. The tasks in this step are to assess the:

- frequency in which the risk situation occurs
- likelihood that the risk situation is going to occur
- potential consequences should the risk occur.

This information builds on that already collected in the first and second steps of the process. It gives the SHS worker an objective and realistic picture of the risk situation and its potential impact on the client and the agency. This gives the worker enough information to take the next step; options to effectively manage and reduce the risk situation.

Key questions

Frequency of exposure

The first assessment task is to determine the frequency of exposure to the risk situation. The key question here is 'how often does the risk situation occur?'

Does the risk situation occur?:

- infrequently; less than monthly (low)
- occasionally; monthly (medium)
- frequently; few times a month but less than weekly (high)
- at least weekly (extreme)
- ongoing or more than once a week (chronic).

Likelihood of exposure

The next assessment task is to determine the likelihood of the risk situation occurring while the person is a client of your service.

Is the risk situation?:

- very likely to occur; the risk situation occurs routinely and can be expected to happen given the client's circumstances while they are with your service
- likely to occur; the risk situation occurs often and there is a good chance it will while they are a client of your service
- unlikely to occur; the risk situation could possibly occur at some time based on the client's past or current circumstances
- very unlikely to occur; the risk situation could possibly occur but it would be an exceptional circumstance if it did while the client is with your service.

Consequence

The third assessment task in this step is to consider the potential consequence or harm that could result if the risk situation occurred while your service is supporting the client. Possible consequences are:

Insignificant

- no likely injury to self or others
- no likely damage to property
- no financial loss
- no effect on the public reputation of the service
- no disruption to the service

Minor

- first aid treatment only is likely to be needed for the person
- minor damage to property

- incident likely to affect those directly involved
- minor financial loss
- minor impact on the public reputation of the service
- minor disruption to the service

Moderate

- medical treatment may be needed for the person or injured others
- significant damage to property likely
- some intervention by an outside agency needed
- high financial loss
- serious loss of public reputation
- moderate disruption to the service

Major

- extensive physical injuries, permanent impairment or death likely to the person or affected others
- major damage to property
- significant intervention needed from an outside agency
- major financial loss
- serious loss of public reputation over a period of time
- major disruption to or ceasing of service.

Overall severity of risk

The SHS worker then combines all the risk assessment information to determine the overall severity the risk poses. This can be categorised as low, medium or high. The following table is a guide.

	Insignificant or minor consequence	Moderate consequence	Major consequence
Very unlikely to occur	LOW	LOW	MEDIUM
Unlikely to occur	LOW	LOW	MEDIUM
Likely to occur	LOW	MEDIUM	HIGH
Very likely to occur	MEDIUM	MEDIUM	HIGH

Generally:

- A low rating implies that the risk management strategies the service commonly uses are likely to be sufficient to manage the risk.
- A medium rating implies that some specific risk management strategies will need to be included in the case plan. The service may need to adapt usual risk management strategies to the situation.
- A high rating implies that considerable attention will be needed in developing new risk management options to manage the unique needs of the risk situation.

Considerations

- It is important here that the SHS worker does not jump from this step to the decision about accepting the client. The issue at hand is to judge the issue's severity. That is all.
- This step will involve asking the client about their previous experiences with these risk situations and what happened as a result on those occasions.
- Remember that what happened in the past may not necessarily happen again. Things may be different if you use a case management approach with risk management strategies included in the case plan. Risk could be reduced if your agency and other support agencies provide the right type and level of support.

Step four – Consider risk management strategies

Rationale

The process now moves from a focus on risk assessment to risk management. The emphasis is now on identifying realistic options for the effective management of the risk situation.

This task is done with the client using a strengths-based, empowerment approach. For this reason, the first consideration should be on the client and what they can do to manage the risk themselves? They may be able to take total control in some situations with support, encouragement and monitoring from the service.

Often, the client and the service work in partnership to implement and monitor risk management strategies. The service may initially provide higher levels of support and monitoring, gradually reducing active involvement as the client learns to take control of the situation. The idea is that the client learns risk management strategies that they will be able to use after exiting the service.

The second consideration is what the service can do to manage the situation. All SHS services have the flexibility to respond appropriately to the needs of individual clients. This is an extension of that flexibility. At this time, the service needs to ask itself how its resources can be used or adapted to help manage the risk. This may mean changing the way some things are done to meet the needs of the situation. It may be a temporary measure until the immediate situation eases or needed until the client exits the service.

Finally, the SHS worker needs to consider what extra resources could be drawn in to help manage the risk situation. The SHS service and the client do not exist in a support vacuum and it is not reasonable for the service to be their only real support. Building a range of risk management supports can help the client to manage their situation in the longer term.

As with the SHS service, other supports may include the type and level of specialist support the other agency usually provides or may require services to be adapted to meet the unique needs of the situation. Risk management support from another agency can easily be built into the case plan and then monitored by the case manager or jointly with the other agency.

Tasks and considerations

Client contribution to risk management

The SHS worker does this task with the client. The idea is to find out what the client can contribute to the risk management strategy. The aim is for them to take some responsibility in the risk management plan. This could include, for example:

- agreeing to work with a case plan and meeting with the caseworker
- managing their own medications
- attending counselling or seeking support from a specialised service like a mental health team, drug and alcohol counsellor or family support worker
- arranging support services
- attending courses or support groups like anger management, Alcoholics Anonymous or Narcotics Anonymous meetings
- taking out an AVO
- doing rostered chores.

SHS service contribution to risk management

Consider what your service and staff can contribute to the overall risk management strategy. Your aim here is to think beyond what is provided under current resources to what could be done with the same resources to manage this unique situation.

Options could include:

- developing and monitoring a case plan which includes risk management strategies
- putting a special support agreement or contract in place
- giving training and information to staff on specific skills and strategies to manage the situation
- providing extra staff support through revising rosters; such as more staff at key times
- implementing internal risk management programs with the client and providing information and risk management strategies for other affected clients
- arranging specialist support services
- arranging a case conference with the client and the full range of support agencies and personnel involved in managing the risk situation
- negotiating joint case management with clearly defined responsibilities with other services.

Other agencies' contribution to risk management

Consider what other agencies can contribute to the risk management strategy. This is not decided in isolation as it depends on the current resources available to the other service.

This part of the risk management strategy needs to be developed in negotiation and collaboration with the other agency.

Options could include:

- direct access for the client to support programs and specialised services
- providing or upgrading support
- financial or staffing resources to enable extra on-site support, if needed
- joint case management services with the SHS service
- participating in case conferences
- back-up information, training and support to SHS staff working directly with the client.

Step five – Make the decision

Preliminary considerations

Your SHS service should now have:

- as complete a picture as possible about the area of client risk and its severity
- a realistic idea of potential risk management strategies that could reduce the risk to the client, staff and others.

Before deciding whether your service can accept the client, there may be a need to get an internal second opinion. In complex situations, the SHS worker who does the risk assessment may seek the advice of a co-worker, the team or a more senior staff member. In some SHS services this procedure is used for all clients

You should now have enough information to decide whether to accept the client.

Procedure

1. When deciding whether to accept a client, consider and balance:
 - all risk assessment information from the client
 - all risk assessment information from other services
 - the service's assessment of the severity of risk
 - the risk management options the client, your service and other specialised support agencies have given.
2. Decide whether the level of risk is:
 - acceptable and can be managed by existing occupational health and safety procedures and your services' policies
 - acceptable and will require adjustments to resources and the negotiation of a risk management strategy to be included in the case plan
 - too high and cannot be reduced through risk management strategies or rearrangement of available resources.

3. If accepting the client, follow your service's entry procedures and put in place:
 - an individual case plan
 - a risk management strategy, if needed
 - a monitoring and review system.
4. If not able to accept the client:
 - explain the reasons to them in a supportive environment and manner
 - outline your service's appeals procedure and how to access it
 - identify referral options together with the client
 - with their consent, refer them appropriately
 - document the reasons.

A note on appeals

The person rejected on the grounds of client risk does have the right to appeal the decision. When this happens, advise the person of:

- the service's complaints and appeals procedure
- their right to access the appeals procedure and how to do it
- their right to an advocate or support person to help with the appeal.

The person should also be told about their right to complain to the NSW Ombudsman and given the toll-free number 1800 451 524.

Other policy and procedure considerations

Exclusions based on pregnancy or disability

When the client is pregnant

The Ombudsman's report, *Assisting homeless people – the need to improve their access to accommodation and support services* (2004:8) found that 'refusal to accommodate a pregnant woman in a service that she would otherwise be eligible for is unreasonable and may be unlawful, unless it is based on an individual assessment of the actual risk to the pregnant woman, unborn child or any other residents'.

As most pregnant women either do not have significant health problems or can still be accommodated with support from a specialist health service, it should pose a negligible risk to the client. The issue is not included as a risk assessment trigger for this reason.

If your service asks the question 'are you or could you be pregnant?' with the intention of excluding the woman if she is, seriously consider if you are being discriminatory and breaching the Anti-Discrimination Act. It would be okay, however, to ask the question as part of the assessment process if you are simply finding out their health status.

When the client has a physical disability

The Ombudsman's report (2004:44) also discussed concerns about exclusion of clients with a physical disability. The report suggests that SHS agencies should review policies and procedures on this issue.

The report states that 'exclusions should not be based on assumptions of dependence or inability to negotiate physical access'. It points out that, although services may not be wheelchair accessible, other people with physical or sensory disabilities may still be able to move safely around the premises.

If included as a risk assessment question, it may be discrimination if you reject a client on the basis of a disability. If challenged, a SHS service would need to show that it would cause unreasonable hardship to make the building accessible or other necessary arrangements to accommodate the person.

Culturally-appropriate questioning on sensitive issues

Assessing mental health and/or suicidality

The way a person expresses mental illness or suicidal behaviour can be affected by culture, religion and gender. When these all intersect, assessing risk can be especially challenging. For example, if a person's religion forbids suicide, disclosing suicidal thoughts or feelings can be almost impossible, so signs like acting recklessly, giving away valued possessions or making a plan may not be present.

Cultural taboos in talking about mental illness and suicidal behaviour can make it particularly difficult to assess people from some cultural backgrounds. Sometimes, even finding mutually understood words to describe feelings is hard. For example, depression and anxiety are often viewed as physical symptoms with no obvious organic cause and suicidal thoughts may not be spoken about.

For these reasons, the Multicultural Mental Health Association (MMHA) suggests asking questions that enable people to talk about their belief systems on these issues. Understanding these beliefs may help the worker to better understand a client's behaviour and attitudes.

Some possible ways to ask about suicide are:

Step 1: Trigger questions

- Do you ever feel (have you ever felt) so sad/bad about your life that it seems too hard (you don't want) to go on?
- Do you have a name for this feeling?
- What do you do when you feel like this?
- Have you ever deliberately hurt yourself, or thought about this?

Step 2: Follow-up questions

- In your culture, what does it mean for someone to be feeling like this?
- How do people in your culture who feel like this generally cope with their feelings?
- Is there anyone they would talk to?

Assessing risk from others

Sometimes domestic/family violence situations can involve members of extended families. For example, a woman living with her in-laws may sometimes be abused not only by her husband but also other members of his family. If she is on a spouse visa, she may also have been threatened with deportation if she tries to leave.

Possible questions, not already in the tool, are:

Step 1: Alternative trigger questions

- Has your ex/husband or anyone else in his family (or connected to him) been aggressive, violent or threatening towards you?
- What have they said or done?

Step 2: Follow-up questions

- What is your immigration status?
- What would it mean for you to take legal action?

Risk to or from accompanying children

Some migrants and refugees come from countries where there is no government child protection system and so the role of FACS may need to be carefully explained. Risk assessment questions need to reflect this possibility.

Step 2: Alternative follow-up questions

- Is there a government agency responsible for child protection in the country you came from/used to live in?

Duty of care, privacy and confidentiality

Privacy and related legislation

The privacy and confidentiality policies of SHS services and their risk assessment and management practices must meet the requirements of four major pieces of legislation. These are the:

- A. Commonwealth Privacy Act 1988
- B. Commonwealth Privacy Amendment (Private Sector) Act 2000
- C. NSW Privacy and Personal Protection Information Act 1998
- D. NSW Health Records and Information Privacy Act 2004.

Other legislation is also relevant to risk assessment and management, particularly in situations when legal requirements override those of privacy. They include:

- NSW Occupational Health and Safety Act 2000
- NSW Children and Young Persons (Care and Protection) Act 1998
- Commonwealth Crimes Act 1914
- NSW Crimes Act 1900
- Commonwealth Freedom of Information Act 1982

- NSW Freedom of Information Act 1989
- NSW Mental Health Act 1990
- Commonwealth Disability Services Act 1986
- NSW Disability Services Act 1993

SHS agencies should ensure that their workers are familiar with information exchange provisions under these pieces of legislation.

Privacy principles

These pieces of legislation each have a set of privacy principles. Following is a list of those principles and their legislative sources.

1. The agency will only collect personal information that is relevant to the function of the agency and the provision of the agency's services (legislative source A, B, C).
2. Clients of the agency are informed about why personal information is collected and to whom or what agency it is usually disclosed (A, B, C).
3. The agency takes all steps to ensure that client information is accurate, up-to-date and complete (A, B, C).
4. The agency has security safeguards that protect client records from loss, unauthorised access, misuse, modification and disclosure; and procedures that ensure appropriate disposal of client information (A, B, C).
5. Clients of the agency are told how they can get access to their records containing personal information (A, B, C).
6. The agency has a policy covering:
 - the nature and purpose of client record-keeping
 - how long client records are kept
 - who has access to client records
 - how clients can get access to their own records (A).
7. Clients of the agency are entitled to have access to their records (A, B, C).
8. Clients of the agency are able to correct any information held by the agency that is incorrect, incomplete or misleading (A, B, C).
9. Client information is not used by the agency for any other purpose except with client consent unless necessary to prevent harm to life or health (A, B, C).
10. Client information is not disclosed by the agency to another person or agency without consent unless necessary to prevent harm to life or health (A, B, C).
11. The agency does not use the same client identifying numbers or codes that are used by other agencies (A).
12. The agency only uses client identifying numbers or codes if necessary for the efficient functioning of the agency (C).
13. Clients of the agency have the option of not identifying themselves (A, C).
14. Sensitive information, such as health information, is collected by the agency with client consent unless necessary to prevent harm to life or health (A).
15. The agency takes reasonable steps to de-identify health information before it is disclosed for data collection or research purposes (A).

16. Information is collected directly from the client by the agency unless the client is a minor, under guardianship or has given consent for someone else to provide the information (A, B, C).
17. Health information collected by the agency can only be included in a system to link health records with consent (C).

Therefore as a rule, client information is only exchanged with other agencies with the client's full knowledge and informed consent. It is good practice to ask the client to sign a consent form showing that they have given written or verbal consent for the exchange of information between nominated agencies.

Informed consent

Consent, or withholding consent, is central to privacy. Consent is considered genuine if the person from whom it is sought has the capacity to give or withhold consent. This means that they have the ability to understand the nature and effect of their decision and can communicate their consent. Consent is considered valid when it is voluntary, informed, specific and current.

Consent may be written or verbal. Written consent is preferable if possible. It is important when discussing consent that the client understands that they are agreeing to the sharing of their information with nominated agencies.

There are four possible pathways for consent.

1. The client, the advocate appointed by the client or their legally-appointed guardian, in your opinion, understands and agrees to the exchange of information. This means the agency believes that informed consent has been given.
2. In the opinion of the worker collecting the information, the client does not have the capacity to give informed consent. This can apply when the client has dementia, a brain injury, a mental illness or an intellectual disability. When this happens, there are two main decision-making options
 - substitute decision-making if the decision is made by the client's representative
 - procedural decision-making if the agency uses clear and consistent criteria to assess whether the exchange of client information is in their best interests
3. The client refuses to give consent to certain or all agencies. This means the client is unwilling to give consent. This also needs to be balanced by duty of care considerations.
4. There is no need to exchange client information with other agencies and, therefore, consent is not needed.

More information about consent and how it applies to handling personal information of people with decision-making disabilities is available in the Privacy NSW *Best practice guide*. This document is available from the website at www.lawlink.nsw.gov.au/lawlink/privacynsw.

Duty of care

'Duty of care' is a legal term used to describe the duty or responsibility agencies and their workers have to consider the effects of their actions on other people's welfare. In community services this includes clients, unknown members of the community, paid and unpaid staff members and other service providers.

Agencies and their workers have a legal duty to take reasonable care to prevent another person being harmed. This duty of care refers not only to the actions of a worker but also their inaction or advice which they may give or fail to give.

This means that agencies should pass on information about significant areas of client risk of harm posed to self and others in referrals and background checks, even if the client has not given consent to the exchange of this specific information.

As described above, in certain situations, duty of care may override confidentiality provisions when:

- disclosure is required in the client's interest, such as when they are suicidal or could suffer harm
- there may be danger to a third party, such as a carer or another service provider.

Sources and resources

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Buhrich, N, Hodder, T & Teesson, M 2003, 'Caring for homeless people who have a mental disorder', *Down and Out in Sydney*, vol. 2.

Burwood Council 2003, Risk Indicator Chart, developed for implementation of the National Framework for Comprehensive Assessment, Inner West HACC Development Project.

Dawson, D 1999, *Risk of violence assessment: Aboriginal offenders and the assumption of homogeneity*, paper presented at the Best Practice Interventions in Corrections for Indigenous People Conference, Adelaide, September 1999.

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Kulkunna Cottage Women's Refuge Ltd (undated), Eligibility Criteria and Assessment Form, agency policy and assessment tool.

Marian Centre (undated), Intake Procedure.

Mission Australia (undated), Risk Assessment Checklist.

NSW Advisory Committee on Abuse of Older People 1995, *Legal issues manual*, NSW Ageing and Disability Department.

NSW Department of Ageing, Disability and Home Care 2004, Managing Client Risks, departmental policy statement.

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NSW Department of Community Services 1998, *SHS standards*.

NSW Ombudsman 2004, *Assisting homeless people – the need to improve their access to accommodation and support services*, a special report to Parliament under section 31 of the *Ombudsman Act 1974*.

Rosa Refuge (undated), Entry Screening Form and Risk Assessment on Intake Form.
Salvation Army (undated), Suicide Risk Assessment and Risk Assessment for Intake, forms and policies.
Shire Wide Youth (undated), Assessment of Risk.
Stepping Out (undated), Referral Form and Occupational Health and Safety Procedure.
Thomson Goodsall Associates Pty Ltd 2003, People who are Assisted by SHS Services and Require a High Level and Complexity of Service Provision, discussion paper.
West Sussex Addictions Services (undated), Behavioural Risk Assessment.
Wollongong Women's Housing (undated), Home Visitation Policy.
WorkCover NSW 2004, The Community Services Safety Pack.
WorkCover NSW and Central Sydney Area Health Service 2001, *Prevention and management of workplace aggression: guidelines and case studies from the NSW Health industry.*

Appendix 7: Client consent form

Whilst receiving support from (insert service name) there may be the need to request or provide information to or from another person who is involved with you in some way. Due to privacy laws in Australia, we are unable to request or provide information to others without your informed consent. This means that we need to inform you about what information we would like, how it will be used and who we would like to ask for it. We must also seek your consent before we can give information to other individuals who may ask.

There are some situations, however, where we must, usually by law, provide information to others when requested. This would include a request for information from the Police, Community Services or in an emergency medical situation. We must also by law provide information to Community Services if we feel that a child may be at significant risk of harm.

We will however aim to inform you first when we are planning to request or share information with/from another person and we will respect your right to privacy in all circumstances. You may also withdraw your consent at any point.

The kinds of information that we may ask for from another person may include, information that will help us to understand your situation better, information about the kind of support being provided by other professionals and to advocate on your behalf.

The kinds of information that we may need to give to others includes giving details about your stay to other professionals working with you or your family, talking to your child's school about progress and school issues, talking to other services about you when referring your family on to other services or providing information about the type of support that our service is providing for you.

As part of our funding agreement we must also collect information about you for the purposes of national data collection. This information will remain confidential and some non-identifying data will be sent to a data collection agency in Canberra. This will assist with making decisions about ongoing funding and research into homelessness and its causes. By signing this form you also consent to this data collection.

If you are unsure of any of the things in this document, please discuss it with your support worker.

Thanks,

(insert name and organisation)

Permission to release and obtain client information

Your name: _____

Date of birth: _____

I, _____

give permission for the staff of the following services, agencies or people to **release information** relevant to my case plan to the staff of (insert service name):

-
-
-
-

Other (provide details) _____

This information may be shared verbally or in writing, whichever is most appropriate in the situation.

Signature

_____/_____/_____
Date

Witness

_____/_____/_____
Date

I, _____

give permission for the staff of (insert service name) to **provide information** relevant to my case plan to the following services, agencies or people:

-
-
-
-

Other (provide details) _____

This information may be shared verbally or in writing, whichever is most appropriate in the situation.

Signature

_____/_____/_____
Date

Witness

_____/_____/_____
Date

Appendix 8: Case assessment report

Case report for (insert client name)

By (insert your name)

Introduction

(Provide a summary of the client's case history and set the context for why she/he has now come to you for support. Include key points about past experiences and relationships with others.)

Current needs

(Provide an overview of the client's needs, remembering to be holistic. Make sure you identify which needs you consider to be more critical and why.)

Analysis of current situation

(Provide an analysis/discussion of the client's current situation. You should identify any links between issues and try to answer the question of why the client is in the situation she/he is now. Try to identify the root causes of her/his problems and start to argue for what you consider to be effective intervention strategies. Ensure that you justify your opinions with factual observations.)

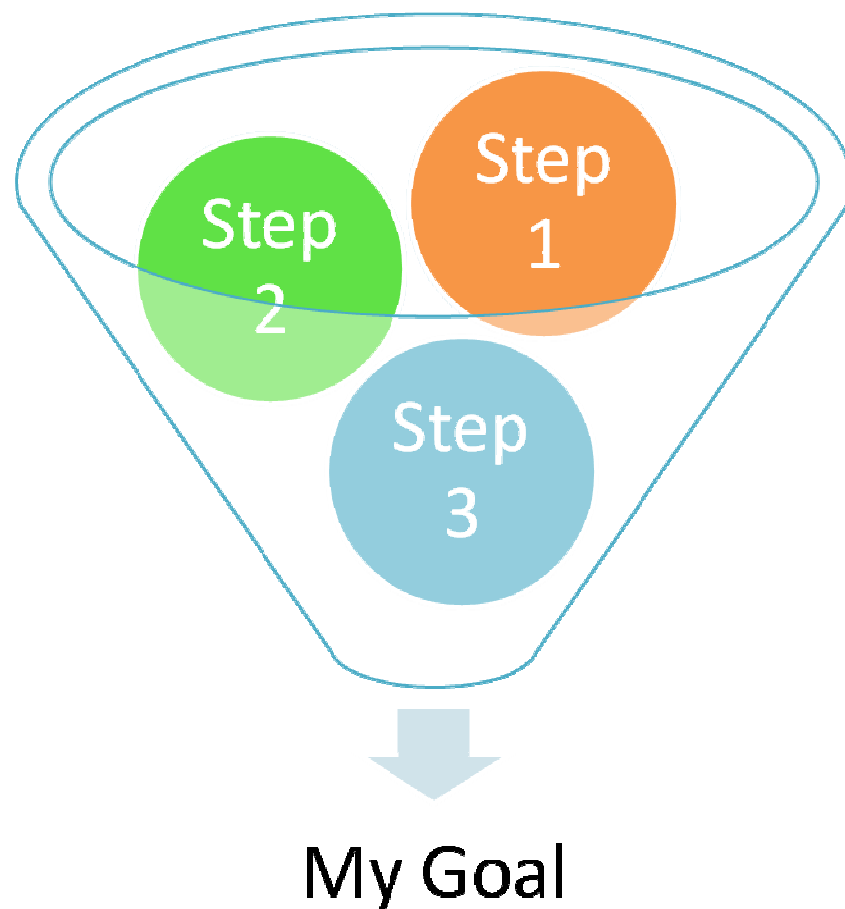
Recommendations for support

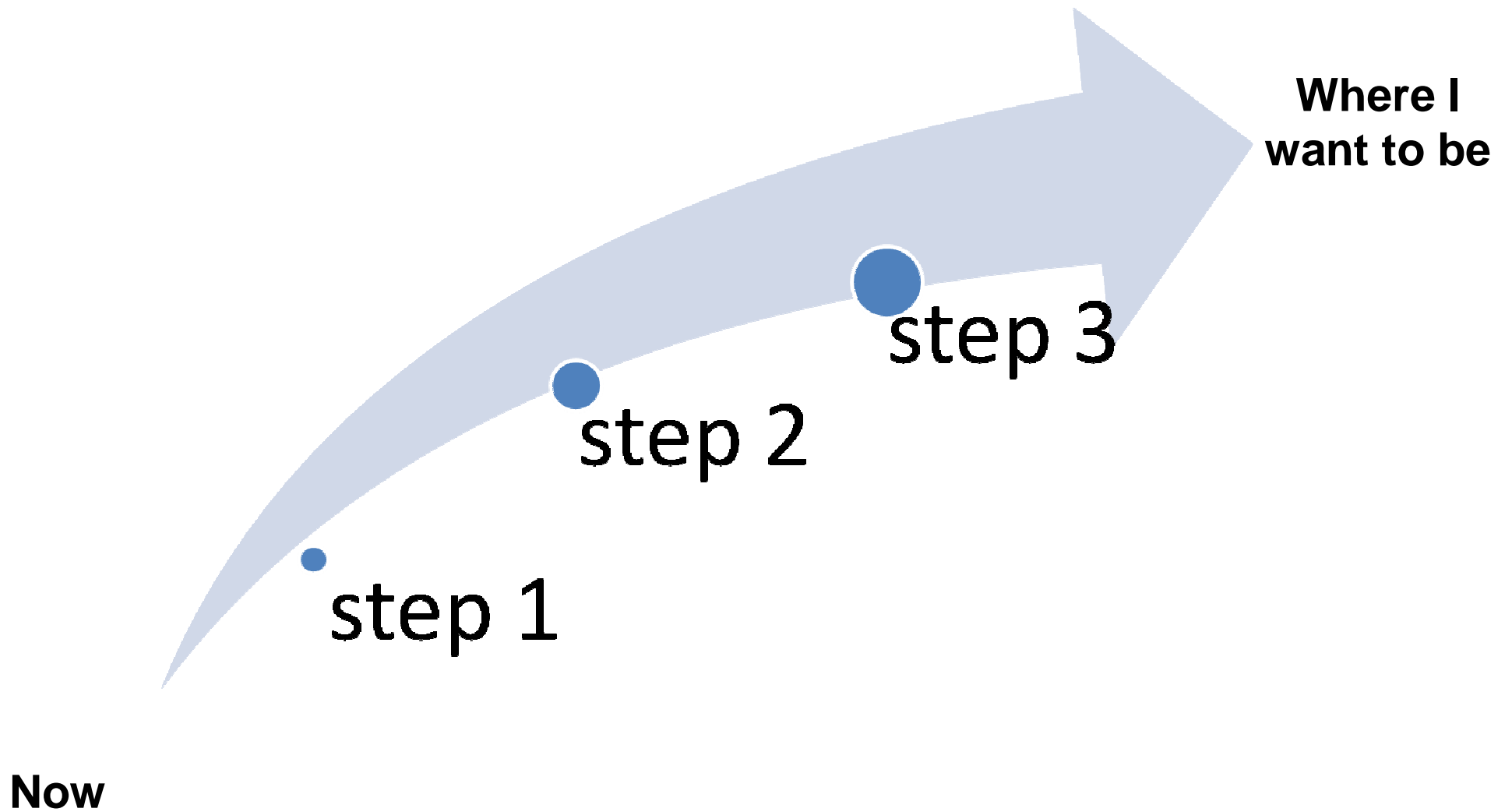
(Provide a summary of the supports and recommended services that you think the client requires. These points should feed directly into your case plan.)

Appendix 9: Case planning tools

The following are some visual tools that caseworkers can use to help clients to work out goals and the steps to achieve them.

For each tool the caseworker will need to ask the client to identify a goal and then ask the client what the steps might be so that they can reach their goal.





Where I
want to be

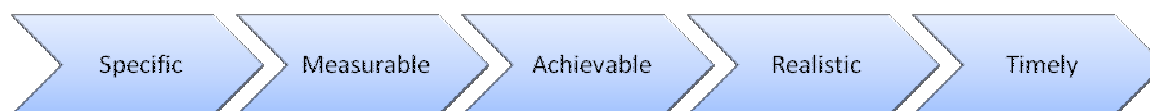
Now



Appendix 10: SMART goals

It is useful to ensure that when goals are developed they are specific, measurable, achievable, realistic and timely (S.M.A.R.T.). The following is a simple explanation of SMART goals adapted from the Top Achievement website at <http://www.topachievement.com/smart.html>.

Diagram 10: SMART goals



Specific – a specific goal has a much greater chance of being accomplished than a general goal. To set a specific goal the client must be assisted to answer the six 'W' questions:

Who: Who is involved?

What: What do I want to accomplish?

Where: Where is the location it can be achieved?

When: When can it be achieved (time frame)?

Which: Which requirements and constraints are needed?

Why: Why accomplish the goal (specific reasons, purpose or benefits)?

Example: a general goal would be 'get in shape.' But a specific goal would be 'join a health club and work out three days a week.'

Measurable – In partnership with the client work out concrete criteria for measuring progress towards reaching each goal the client sets. When you measure the client's progress, they are able to stay on track, reach their target dates, and experience the exhilaration of achievement that spurs them on to continued effort required to reach their goal.

To determine if a goal is measurable, ask questions such as 'how much?', 'how many?' or 'how will I know when it is accomplished?'

Achievable (or sometimes attainable) – When you identify goals that are most important to you, you begin to figure out ways you can make them come true. You develop the attitudes, abilities, skills, and financial capacity to reach them. You begin seeing previously overlooked opportunities to bring yourself closer to achieving your goals.

A client can achieve almost any goal they set when they plan their steps wisely and establish a time frame that allows them to carry out those steps. Goals that may have seemed far away and out of reach eventually move closer and become achievable, not because their goals shrink, but because they grow and expand to match them.

When a client lists their goals they build their self-image. They see themselves as worthy of these goals, and develop the traits and personality that allow them to possess them.

Realistic – To be realistic, a goal must represent an objective toward which a client is both **willing** and **able** to work towards. A goal can be both high and realistic; the client is the only one who can decide just how high their goal should be. But be sure that every goal represents substantial progress.

A high goal is often easier to reach than a low one because a low goal exerts low motivational force. Some of the hardest jobs you ever accomplished actually seem easy simply because they were a labour of love.

A client goal is probably realistic if they truly **believe** that it can be accomplished. Additional ways to know if your goal is realistic is to determine if the client has accomplished anything similar in the past. You could also ask the client what conditions would have to exist to accomplish this goal.

Timely – A goal should be grounded within a time frame. With no time frame tied to it there's no sense of urgency. If a client wants to get independent housing, when do they want it by? 'Someday' won't work. But if they anchor it within a time frame, 'by May 1st', then they've set their unconscious mind into motion to begin working on the goal.

T can also stand for **tangible** – A goal is tangible when you can experience it with one of the senses, that is, taste, touch, smell, sight or hearing. When the client's goal is tangible they have a better chance of making it specific and measurable and thus attainable.

Appendix 11: Sample case plan

Client name:

Date of birth:

Program:

Referral date:

Caseworker:

Case coordinator:

Client file number:

1. Housing

Goal	Detailed strategies	Who	Time frame	Evaluation

2. Health

Goal	Detailed strategies	Who	Time frame	Evaluation

3. Education/employment skills

Goal	Detailed strategies	Who	Time frame	Evaluation

4. Income

Goal	Detailed strategies	Who	Time frame	Evaluation

5. Emotional and behavioural functioning (including counselling needs, mental health, etc)

Goal	Detailed strategies	Who	Time frame	Evaluation

6. Social living skills and peer relationships (including life skills, recreation, interpersonal skills, etc)

Goal	Detailed strategies	Who	Time frame	Evaluation

7. Family/interpersonal relationships and identity (including time frame for support, family issues and relationship repair)

Goal	Detailed strategies	Who	Time frame	Evaluation

8. Legal and justice issues

Goal	Detailed strategies	Who	Time frame	Evaluation

9. Transition planning

Goal	Detailed strategies	Who	Time frame	Evaluation

10. Any other issues/actions

(Including recreation, religious or cultural needs and any immediate needs)

Goal	Detailed strategies	Who	Time frame	Evaluation

Next planned review meeting

Date:	Time:	Place:
--------------	--------------	---------------

Signature of client:

Signature of caseworker:

Appendix 12: Strengths-based sample questions for caseworkers to use with clients

Area of information gathering	Responses	Action required
Self-concept		
	What are you good at? (may need some prodding as many people don't feel comfortable talking about this)	
	What else would you like to be good at?	
	What do you enjoy doing?	
	When are the best times for you?	
	What makes you proud about yourself?	
	What positive things do people say about you?	
	What have you learned about yourself and your world during those struggles?	
Relationships		
	How do you get on with your friends or family members?	
	What makes those relationships work?	

Caring for others

How do you care for others?

How do you feel when something unfair is happening to you?

How do you feel when something unfair is happening to another person?

How do you manage this?

What would you like to do better?

Caring for yourself

Do you do special things for yourself?
What are these?

How do you make yourself feel better when you are upset?

Protective behaviours

How do you avoid risky situations?

What do you need to do this better?

Links with the community

Do you attend/participate in community events, e.g. street fairs?

What do you enjoy the most when you go out? Why?

Self-control and coping strategies

What makes you angry?

What do you do when you are angry?

What seems to help, even if doesn't solve the problem?

How do you manage tricky situations when you still have to do what is expected of you?

How do you feel when you have managed a tricky situation?

What do you need to do this better?

Health

How do you maintain a healthy lifestyle?

What do you need to do this better?

Is there anything else that you feel you need support with?

Date: _____

Appendix 14: Sample client feedback form

Everyone who has been supported by our service is asked to fill out a feedback form to help us evaluate and improve the support we provide. You will be asked to complete this as part of an exit interview and then place it in an envelope for the manager to read. You may keep your answers anonymous if you like.

Please circle what you think. You can complete this form more than once if you wish.

1. How did you find your time with our service?

Not good Okay Good Very good Difficult

Comment:

2. What did you think about the support you were given?

Not good Okay Good Very good

Comment:

3. Were any of the rules that you had to follow?

Unnecessary Okay Necessary Not enough

Comment:

4. Did you get the information that you needed to help you?

Not really Sometimes Mostly Always

Comment:

5. Did you feel that your opinion was valued?

Not really Sometimes Mostly Always

Comment:

6. Generally, how did you find our staff?

Helpful Not helpful enough Very understanding Not understanding Bossy

Comment:

7. If you did any workshops or group sessions were they?

Interesting Useful Not useful Okay Unnecessary

Comment:

8. How do you think the service could generally be improved?

9. Is there anything that you did not like about the support you received?

10. What do you think you got out of your time with this service?

Appendix 15: Caseworker's guide for reflective practice

Reflective questions in practice areas

ENGAGING:

Has a trust-based working relationship been established with the client and other service partners involved in this case?

1. Have you met with the client face-to-face and identified their strengths and needs?
2. What has the client identified as their strengths and needs?
3. What has the client shared with you about how they believe their needs can be met?
4. In what ways has the client engaged as an active participant in the casework process?
5. Which of the important people in the client's life are included in the support team? [Education, medical, legal, juvenile court, mental health, other agencies and service providers, church, mentors, friends, etc.]
6. Is every member of the support team committed to helping the client and to achieving positive results? How is this demonstrated?
7. What engagement, support, and intervention techniques are working with the client so far? What makes these techniques successful?

UNDERSTANDING:

Does the service team understand the client situation well enough to provide supports and services that will produce the desired results?

1. What are the presenting problems and underlying issues? Are they clearly identified and agreed upon by the service team?
2. Is the client's functional ability in daily settings accurately assessed and understood in context?
3. Are issues related to education, substance misuse, mental health, developmental or physical disabilities diagnosed and understood by the support team?
4. Which known risks of harm (e.g. abuse, neglect, domestic violence, health crisis, suicide) have been identified? Is a safety plan required? How is it used and understood?
5. Are the special needs, risks of harm, transition requirements or need for additional assessments understood by the support team?
6. Are you confident in recognising and working with the client's cultural identity? Does the client need a language/sign interpreter? Are you able to access multicultural/Aboriginal/disability services and resources?
7. Are you confident in recognising the client's sexual identity? Do you know about services specific to their needs? Do you need any additional support/resources?
8. How are the basic needs of the client being met?
9. Is there a recognisable pattern of concern present that should be addressed?
10. How does the team recognise/respect the capacities, resources and preferences of the client?
11. Are other interveners in the client's life participating in developing a 'big picture' understanding of the case situation?

PLANNING:

Is service planning an ongoing process that reflects current understanding and drives the service process toward desired short-term results and long-term outcomes?

1. How is the client engaged as an active participant in the service planning process?
2. What makes the strategies and supports in the case plan consistent with the strengths, needs, goals, and choices of the client?
3. How are focal problems, functional challenges, risks and underlying conditions reflected in the choice of goals and strategies?
4. How are family and team decision-making included in the case plan?
5. What is the long-term plan for this client? Does it focus on ending homelessness for the client now and in the future?
6. What is the transition plan? What has been put in place to support a successful transition out of the homelessness support system?
7. What sustainable supports (formal and informal) are being planned? How will these supports enable the client to function safely and successfully after the service process is completed?
8. How do support team members support the case plan? Are treatment and intervention efforts unified?
9. In what ways are the strategies, interventions and supports for this client individualised to fit their situation?

IMPLEMENTING SERVICES:

What services are called for in the client's case plan? Are services provided competently, on time, and consistent with the intervention path to achieve safety, independence, and wellbeing?

1. How is the client engaged as an active, ongoing participant in the service implementation process?
2. How are supports, services and interventions being implemented? Are they consistent with case plan goals, strategies and requirements?
3. What supports, services and interventions are being implemented? Are they are timely, competent and culturally respectful?
4. Does the support team have timely feedback about the services being provided to the client? How are services being adjusted as a result of this feedback?
5. Is the case plan modified promptly as goals are met and circumstances change?
6. How do support team members fulfil their roles and responsibilities to insure that services are of sufficient intensity, duration and continuity to achieve desired results?
7. Where necessary, are safety/health procedures implemented correctly and effectively?
8. Where necessary, is concurrent planning being implemented in a timely and appropriate manner?
9. Is an adequate and sustainable support network, including informal resources, being established for the client? How will these supports stay with this client after case closure?
10. How are support efforts integrated and coordinated across providers? How does this help to maximise benefits and reduce duplication?

GETTING AND USING RESULTS:

Are intervention efforts leading to positive results? How is the knowledge gained through experience used to refine service planning and provision of supports and services for the client and their family?

1. Is the client engaged as an active, ongoing participant in the evaluation of services and results?
2. What positive changes are being observed in the client's self-management skills?
3. How is the client demonstrating functional improvement in routine daily activities?
4. How are any known risks of harm being reduced or properly managed? How can you tell that wellbeing (e.g. health, safety, emotional) is currently adequate or substantially improving?
5. If a transition is imminent or in progress, what makes the process run smoothly and successfully for the client?
6. What has been done to establish an adequate and sustainable support network for the client?
7. How are results being used to shape strategy, solve problems and determine case closure conditions and readiness?
8. Is the knowledge gained through intervention experiences being used to advance assessment and service planning?
9. How satisfied are the client and other stakeholders with the services provided and results achieved?

General reflections

- **Successes achieved in this case:** What successes are advancing this client toward exiting homelessness within a reasonable amount of time?
- **Barriers encountered in this case:** What barriers are limiting progress toward safety, independence and wellbeing for this client?
- **Assistance needed or requested:** Which of the following sources of assistance would help address any problems or barriers experienced in this case?:
 - mentoring assistance
 - modelling of or coaching on a practice technique
 - specialty consultation
 - multiagency problem-solving assistance
 - training on a specific practice or technique
 - other assistance.
- **Actual assistance offered:** What specific assistance is being/has been offered to the worker or support team in this case?
- **Follow-up needed:** What follow-up actions are indicated in this case? What follow-up is planned?

Practice discussions

Practice discussions offer the following benefits:

- identify successes and opportunities in a case selected for a reflective practice discussion
- affirm good practice when observed in the case
- brainstorm suggested options for any barriers encountered
- provide assistance to the caseworker, as needed
- discover patterns across cases and plan actions accordingly
- professional development for other support staff
- normalisation of casework experiences
- protection against secondary trauma.

Appendix 16: Example case plan

Client name:

Tiffany Blogs

Date of birth:

19.03.1995

Unit of residence:

Best Accommodation

Parent/guardian:

Bev Blogs (mother)

Referral date:

31.07.2010

Caseworker:

Monika Smith
Jasmine Brown

Other caseworker/s:

Kate Silver, FACS
Brendon Winter, Legal Aid
Sophia Gold, Community
Health Centre
George Stuart, Housing NSW

Client file number:

TB310707

1. Health

Goal	Detailed strategies	Who	Time frame	Evaluation
Get independent Medicare card	<p>Support and resource (this may include taking) Tiffany to Medicare office to complete and register forms for Medicare card. Ensure Tiffany has sufficient identification with her.</p> <ul style="list-style-type: none"> email Medicare forms to unit complete Medicare forms take Tiffany to Medicare office to hand in forms. 	Monika & Tiffany	2.08.10 3.08.10 4.08.10	
To have good physical health	<p>Book appointment for a medical check-up with an Aboriginal-specific service. Work out a health plan, e.g. develop healthy eating habits, get more exercise, do a quit smoking program</p>	Monika Tiffany & Monika	6.08.10 9.08.10	

2. Housing

Goal	Detailed strategies	Who	Time frame	Evaluation
Return to live with family once I develop some independent skills	Work on other aspects of my case plan aimed at helping me to return home, e.g. ask my mum to attend a family therapy session with me.	Tiffany with Monika	11.08.10	
	Investigate semi-independent options in case this does not work out.	Tiffany with Monika	17.08.10	

3. Emotional and behavioural functioning (including safety plan, counselling needs, incident management, etc)

Goal	Detailed strategies	Who	Time frame	Evaluation
Stop smoking marijuana	Give Tiffany information about services for rehab and counseling.	Sophia	18.08.10	
	Encourage and support Tiffany to make appointment and attend program.	Monika & Sophia	21.08.10	

4. Legal issues

Goal	Detailed strategies	Who	Time frame	Evaluation
Get help from Legal Aid for possession of drugs charge	Give Tiffany information about Legal Aid and support her through this process.	Monika	24.08.10	

5. Financial

Receive regular Centrelink payments	Call Centrelink to make an appointment.	Tiffany & Monika	24.08.10	
	Attend appointment.	Tiffany & Monika	TBA	
Learn to budget money	Complete budgeting form with Tiffany fortnightly on every second Wednesday night.	Tiffany & Monika	Fortnightly	

6 Social living skills and peer relationships (including life skills, Life Story, recreation)

Goal	Detailed strategies	Who	Time frame	Evaluation
Develop independent living skills	Complete living skills assessment with Brendan.	Tiffany, Monika &	26.08.10	
	Learn to cook FIVE unassisted complete meals:	Jasmine Tiffany	Weekly	
	<ul style="list-style-type: none"> learn to cook one new meal each week 	Tiffany & Jasmine	Tuesdays	
	<ul style="list-style-type: none"> gather budget and time-appropriate recipes on Tuesday evenings 	Tiffany & Jasmine	Tuesdays	
	<ul style="list-style-type: none"> plan for ingredients to be bought in the weekly shopping and presented at team meetings every Tuesday evening 	Tiffany	Tuesdays	
	<ul style="list-style-type: none"> cook the chosen meal for the week on the same day each week and use minimal support from unit staff if asked. 	Tiffany	Tiffany's rostered cooking day	

Complete GLOW program	Attend GLOW program every Wednesday from 9 am – 2.30 pm. <ul style="list-style-type: none"> Sophia to take and bring back Tiffany every week from the program. 	Tiffany Sophia	Refer to Tiffany's daily planner	
Start Life Story work	Tiffany to explore her Aboriginal cultural roots through her Life Story work, including artwork, photos, stories, music and dance every Monday night.	Tiffany & Monika	Refer to Tiffany's daily planner	

7 Family/interpersonal relationships and identity (including time frame for placement, family issues and relationship repair)

Goal	Detailed strategies	Who	Time frame	Evaluation
Increase family contact	Tiffany to spend every Friday with Bev and younger siblings.	Tiffany & Bev	Refer to Tiffany's daily planner	
	Have a weekly dinner at Hay's place alternating with Egan's every Friday night.	Tiffany, Bev, & younger siblings	Refer to Tiffany's daily planner	
	Extra staff support alternating between weeks to attend the dinner.	Monika & Sophia	Fortnightly	
	Tiffany to call Bev every Tuesday evening to maintain phone contact.	Tiffany	Refer to Tiffany's daily planner	

8. Transition planning (including estimated time frame and plan/approach for returning to home or other)

Goal	Detailed strategies	Who	Time frame	Evaluation
Have stable housing that is affordable	George to assist Tiffany with Housing NSW accommodation.	George & Tiffany	By 19.10.11	
	Identify household needs and source essential items.	Monika & Tiffany		
Family to return home in a safe environment	Monika to provide Tiffany with aftercare and service options/information for family work.	Monika	13.10.12	

9. Education/skills training (including tutoring, learning difficulties, school issues, etc)

Goal	Detailed strategies	Who	Time frame	Evaluation
Complete Year 12	Attend PCYC Monday, Tuesday, & Thursday each week from 9 am – 2.30 pm.	Tiffany & Monika	Refer to Tiffany's daily planner	
	<ul style="list-style-type: none"> Monika to pick up Tiffany at 8.30 am and drop Tiffany off at school. Unit staff to pick up Tiffany from school at 2.30 pm and take her back to the unit before their shift. 	Sophia		
	Do homework for one hour each evening at 4.30 pm.	Tiffany		

10. Any other issues/actions (including recreation, religious or cultural needs and immediate needs)

Goal	Detailed strategies	Who	Time frame	Evaluation
Get a birth certificate	Make GITS referral for payment of birth certificate.	Monika	24.09.07	
	Complete form and send off.	Tiffany & unit staff	28.09.07	
To have more clothes	Access GITS money for additional clothing.	Monika	24.09.07	
	Take Tiffany shopping for more clothing.	Mary & Tiffany		

Next planned quarterly review meeting

Date: 3.10.11	Time: 3.00 pm	Place: Head Office
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I have helped develop this case plan and agree to participate. Each part of the plan has been discussed and explained in detail.

Signature of young person: **Date** **Signature of caseworker** **Date** **Signature of casework coordinator** **Date**

Appendix 17: Sample memorandum of understanding (MOU)

Made on this day of 20

Between (insert service one) and (insert service two) in the state of NSW.

This Memorandum of Understanding recognises and formalises the mutually beneficial relationship between (insert service one) and (insert service two) for the purposes of delivering (complete this sentence with a brief statement of purpose for the MOU).

1. Foundational values and framework

(In this section there should be a summary of the aligning values and principles of each organisation involved in the MOU. It should state the common values that underpin the agreement and if necessary describe the framework within which it will operate.)

2. Scope of the program

(In this section there should be a description of what the partnership will involve and its scope. In other words, it should identify the terms and limitations of the agreement and what it will involve and who will do what.)

3. Outcomes

(List all of the anticipated or desired outcomes from the partnership, as well as some of the measures for how you will know that you have achieved these outcomes. These statements will end up being the focus of the partnership and the elements by which you evaluate the partnership, so ensure you spend adequate time working these out so that each party is happy with them.)

4. Administration

(In this section a detailed description needs to be provided outlining who will be responsible for what and how communication will be facilitated between each party.)

5. Principles of partnership

(This section is like a group agreement that you may have in a project group. You should articulate the agreed principals which will guide how you work with each other and the expectations of each other in the partnership.)

6. Conflict management

(In this section you should outline what process will be used to manage any potential conflicts, concerns or misunderstandings that arise in the partnership. This will be similar to how you may deal with a conflict with a colleague.)

7. Term of this memorandum

This Memorandum of Understanding will commence on the date of signing and continue for a period of xx months. At this time the memorandum will be reviewed and consideration given to its renewal.

This memorandum is not legally binding on the parties but expresses the goodwill and intentions of the parties towards one another.

.....
Name/role

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Name/role

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Signed

.....
Signed

Date:

Date: