CHCCSM012

Coordinate complex case requirements

Aspire
Learning Resources

CHCCSM012
Coordinate complex case requirements

Release 1

Learner Guide

Aspire Version 1.1

Aspire
Learning Resources

CHCCSM012 Coordinate complex case requirements, Release 1

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First published March 2023

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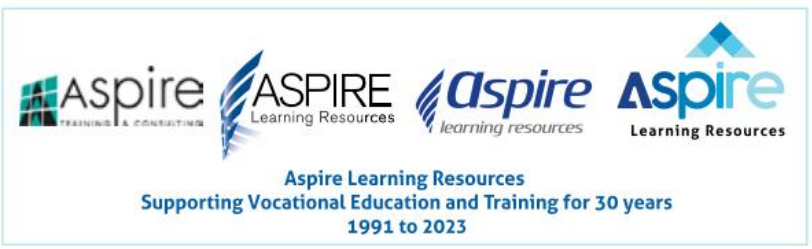
Printer Doculink Australia Pty Ltd, 1d/28 Rogers Street, Port Melbourne VIC 3207

e-ISBN 978-1-76123-165-0 (PDF version)
ISBN 978-1-76123-164-3



Contents

Aspire acknowledges the homelands of all Aboriginal and Torres Strait Islander peoples and pays our respect to Country

Before you begin

This Learner Guide is based on the unit of competency *CHCCSM012 Coordinate complex case requirements*, Release 1.

Your trainer or training organisation must give you information about this unit of competency as part of your training program.

How to work through this Learner Guide

This Learner Guide contains a number of features that will assist you in your learning. Your trainer will advise which parts of the Learner Guide you need to read, and which Practice Tasks and Learning Checkpoints you need to complete.

Feature of the Learner Guide	How you can use each feature
Learning content	Read each topic in this Learner Guide. If you come across content that is confusing, make a note and discuss it with your trainer. Your trainer is in the best position to offer assistance. It is very important that you take on some of the responsibility for the learning you will undertake.
Examples	These highlight learning points and provide realistic examples of workplace situations.
Practice Tasks	Practice Tasks give you the opportunity to put your skills and knowledge into action. Your trainer will tell you which Practice Tasks to complete.
Callouts	Callouts reiterate key learning points to help students revise for their assessments.
Weblinks	Weblinks provide learners with additional content to contextualise their learning and develop their understanding.
Videos	Videos provide a visual reference of key concepts to aid comprehension and guide learner exploration. Each video is accessed by a QR code in the Learner Guide (or a button in the eBook version) for ease of access.  
Glossary/margin definitions	Key terms are defined where they first appear to help consolidate understanding. A glossary of terms is provided at the end of the Learner Guide to assist learner revision of key concepts.
Summaries	Key learning points are provided at the end of each topic.
Learning Checkpoints	There are Learning Checkpoints at the end of each topic. Your trainer will tell you which activities to complete. These activities give you an opportunity to check your progress and apply the skills and knowledge you have learnt.
Case studies	Case studies are interspersed throughout the learning content to provide a workplace setting that contextualises key concepts.

Foundation skills

As you complete learning using this guide, you will be developing the foundation skills relevant for this unit. Foundation skills are the language, literacy and numeracy (LLN) skills and the employability skills required for participation in modern workplaces and contemporary life.

These skills are listed below:

Foundation skill area	Foundation skill description
Reading	• Understanding how documents are presented and being able to navigate through documents • Understanding industry- and job-specific terminology • Interpreting key information in relevant documents • Understanding routine workplace checklists and documentation
Writing	• Planning, drafting and writing reports and documents • Communicating through written letters, email and online • Recording progress; reporting incidents
Oral communication	• Clarifying instructions • Providing information • Supporting others through encouragement, negotiation and conflict resolution • Using body language to model desired behaviour and responding to others' body language
Numeracy	• Calculating costs, weights, measurements of height and distance • Interpreting measurements
Learning	• Understanding your job role, organisational procedures and legal responsibilities • Managing your work and seeing how well you are going • Making goals for yourself at work • Seeking professional development opportunities for continuous improvement
Problem-solving	• Identifying problems • Working out how to fix a problem using problem-solving processes • Reviewing the outcome
Initiative and enterprise	• Recognising opportunities to develop and apply new ideas • Generating ideas by thinking of new ways to do something • Making suggestions to improve work
Teamwork	• Working well with other people by cooperating, collaborating, encouraging and building rapport
Planning and organising	• Planning your workload and commitments • Implementing tasks • Completing work on time • Knowing how to deal with hazards and risks

Foundation skill area	Foundation skill description
Self-management	• Understanding and applying decision-making processes • Reviewing your behaviour and the impact of your decisions
Technology	• Efficiently using digitally based technologies and systems correctly and safely • Accessing, organising and presenting information • Using equipment correctly and safely

Note: Not every unit of competency will contain all foundation skills.

What do you already know?

Use the following table to identify what you may already know. This may assist you to work out what to focus on in your learning.

Topic	Key outcome	Rate your confidence in each section
Topic 1 Establish coordination function	1A Determine and agree on requirements of service provision	❑ Confident ❑ Basic understanding ❑ Not confident
	1B Develop a client plan	❑ Confident ❑ Basic understanding ❑ Not confident
	1C Obtain consent and agree on services to be provided	❑ Confident ❑ Basic understanding ❑ Not confident
Topic 2 Support the person to access multiple services	2A Identify, implement and maintain duty of care responsibilities	❑ Confident ❑ Basic understanding ❑ Not confident
	2B Provide information to suit communication requirements and preferences	❑ Confident ❑ Basic understanding ❑ Not confident
	2C Work with the person and other services to access services	❑ Confident ❑ Basic understanding ❑ Not confident
Topic 3 Monitor the person's progress	3A Facilitate communication between services and manage duplication	❑ Confident ❑ Basic understanding ❑ Not confident
	3B Monitor progress towards goals and obtain feedback about services	❑ Confident ❑ Basic understanding ❑ Not confident
	3C Complete documentation according to policies and procedures	❑ Confident ❑ Basic understanding ❑ Not confident

Topic 1: Establish coordination function

1A Determine and agree on requirements of service provision

1B Develop a client plan

1C Obtain consent and agree on services to be provided

1A Determine and agree on requirements of service provision

Case management involves playing a central role to liaise with other professionals, networks and services to meet a person's needs and goals.

Case manager
A worker or professional who has the central role of liaising with other professionals, networks and services to help make sure the person can meet their needs and goals.

Case management is a process in which a case coordinator or **case manager** assesses a client and assists them to access options and services. A case manager is the 'go-between' – the person who shares information between a client and collaborates with other services or professionals. Case managers investigate different options available to deliver services, and then help to link the person to that service.

The person receiving services needs to be provided with information so they can make informed decisions on what services are available and how they will be delivered.

Many people who use community services are referred by a case manager. The case manager might be a community services case manager, a social worker or other professional who links the person with different services. The role can have different names in different settings such as a specific position or job title, such as:

- consultant
- disability services officer
- human services officer
- program manager
- regional manager
- service manager
- senior practitioner
- rehabilitation officer
- team leader

or a generic or descriptive term, such as:

- care adviser
- care coordinator
- case coordinator
- case worker
- client consultant
- client services manager

- client support officer
- customer relationship manager
- nurse navigator
- service coordinator
- service delivery consultant
- support adviser
- support coordinator.

Source: www.cmsa.org.au/about-us/what-is-a-case-manager

For this work, we will be referring to 'case manager' and 'case coordinator'.

Workers in a range of settings – such as mental health, alcohol and other drugs (AOD), homelessness, child protection and family violence services – also have case management responsibilities and, in this sense, are part of the case management team.

Case management often involves a continuous cycle of identifying, analysing and addressing the person's needs.

The case manager:

- helps the person to identify their needs or problems
- works with the person to develop a plan and goals for support
- helps the person to choose and connect to services to meet their individual needs
- follows up on the person's progress
- reviews and evaluates the outcomes of supports.

As extra issues and concerns are identified, this process may be repeated.

A case management framework

Depending on the context of case management, the terms 'case management framework' and 'service coordination framework' may be used interchangeably.

Service provision in a case management framework is ideal for people with complex needs because multiple services can be accessed to address multiple needs. The coordination of services is important to reduce the likelihood that co-existing needs snowball into greater issues, and to minimise the adverse effects of these co-existing needs.

A framework usually includes access to multiple publicly funded services. This requires coordinating and communicating with people accessing services, their families and significant others, formal networks of government and non-government service providers, and the community. They must identify the available options and support the person to identify those services that will benefit them and are cost-effective; that is, fit within the funding the client has access to. They will then introduce and make arrangements with various service providers to provide supports.

Models of case management

There is a wide range of case management models and service/care models used in different organisations and sectors.

Models of case management differ in the way they are implemented, but there are significant similarities across the models. For example, they are all outcome-focused, person-centred and evidence-based. Also, service providers must operate under laws and regulations specific for their sector. The differences in case management are largely due to organisational practices, sector-specific requirements and funding issues.

A range of models are outlined below.

Brokerage model
In the brokerage model, the case manager does not provide any direct services to the client. Instead, they act as a conduit, facilitating and arranging access to services to meet needs that can range from personal care through to social and psychological support.

Clinical model
The clinical case management model is an extension of the brokerage model, in that the case manager facilitates and arranges access to services and also provides services; for example, early intervention where needs and issues are identified and addressed at the earliest possible point to prevent an escalation or worsening of issues. This model focuses on continuity of care with the case manager relationship as an ongoing relationship. Other services are brought on board for specific purposes; for example, financial support. The case manager must be appropriately qualified to provide services. Examples of personnel qualified to provide clinical case management services include social workers, psychologists and nurses.
Network model
The focus here is on improving the social network of the client to increase capacity for the network to provide social, practical and emotional support.
Rehabilitation model
Rehabilitation case management focuses on outcomes and goals of the person. With this model, there is first high engagement between the client and professional and this decreases over time once knowledge and skills are built up.
Assertive Community Treatment model (ACT)
This model is mostly used with people who have complex or co-existing needs such as mental health and AOD issues or family and domestic violence and an intellectual disability. ACT is an intensive model and includes collaboration with the client, intense support during crisis, integrated health and social needs and community team-based support. The range of services provided by the ACT team can be building daily living skills (cooking, cleaning, shopping), building communication skills, developing financial management skills, exploring work and education opportunities, medical appointment support and exploring life goals.

Approaches of case management practice

Practices that underpin case management are used across the community and health sectors and include the following:

- **person-centred approach**
- **strengths-based approach**
- **evidence-based practice** approach
- early intervention and proactivity approach.

Person-centred approach
Providing tailored support for each person and taking time to learn about their individual preferences, needs and goals.

Strengths-based approach
Recognises that all individuals are resourceful and resilient experts in their lives, and can progress in a way that enhances their quality of life.

Evidence-based practice
Making use of real, current and validated research, data and information collected about the person and the industry to inform your work.

Here are some more details.

Person-centred approach	• Planning is tailored to the person and focuses on their unique needs, goals and preferences. The person accessing services is at the centre of decisions about their life and the support they receive. • This approach respects differences and helps the person to make their own way in the world, whatever that means to them. It respects the contribution the person can make to meet their own needs. • The client is supported to identify and work towards their own goals and aspirations, rather than goals someone else has determined to be appropriate. The priorities of service delivery are driven by the needs of the client, not by the interests of the organisation. • **Self-determination** and choice are the goals of a person-centred approach to supports. • The client's family, friends and significant others become partners in the process of planning and support, and are encouraged to identify services that best align to their goals and aspirations.
Strengths-based approach	• The focus is on the person's existing strengths, rather than providing support that tries to 'fix' their weaknesses. The emphasis is on what clients can do and what motivates them, rather than what they cannot do. A strengths-based approach aligns with a person-centred approach. • The case manager encourages **empowerment** and **capacity building**. This builds on existing skills and interests, and seeks to set people up to experience success.
Evidence-based practice approach	• Evidence-based practice is used to assess needs, and determine, monitor and review services for their effectiveness. This means that decisions about support are informed by relevant and reliable evidence. • The tools, screening methods, client feedback and service provider feedback are all ways to collect reliable and current information about the person receiving services.
Early intervention and proactive approach	• This approach aims to identify issues before they arise by recognising risk factors and taking action to prevent or minimise risk of harm. • When needs or issues are identified early, risks and problems can be identified and addressed before they become more complex. • Early intervention requires that organisations have processes to identify and respond to needs, risks and barriers as early as possible, in preference to a reactive approach to issues (after the event) that could have been prevented or minimised.

Self-determination
A person's right to have control over their own life and make independent choices about decisions that affect them.

Empowerment
The process of gaining strength and confidence to voice one's own opinion.

Capacity building
Helping people to develop and strengthen skills that enable them to maintain independence.

Video: Person-centred care in practice

For more information about person-centred care, go to: aspirelr.link/youtube-person-centred-care

Alzheimer's WA uses a model of person-centred care with its staff through training and ways they can put it into process in the way they work with the people they support.

Here are some examples of how to use evidence-based work practices.

Strategy to maintain evidence-based practice	Example
Keep updated on industry changes	• Subscribe to and read industry journals and websites about new and emerging best practice. • Attend webinars, conferences and training sessions on your area of work. • Maintain email subscription to updates from your industry regulator.
Network with other professionals	• Attend networking events to meet and talk with others in your industry about how they have improved services. • Ask for input from other professionals in your organisation about how to manage a challenging case or problem. • Engage experts where needed, such as talking to a psychologist about your approach to counselling a person who is angry and resistant. • Use the expertise of community leaders and community groups, such as lesbian, gay, bisexual, transgender, intersex, queer (or questioning) plus (LGBTIQ+) advocacy groups or First Nations community leaders.
Harness the lived experience of people from marginalised groups	• Listen to and use feedback from past and current clients about their experience with your service and your practice – and make changes accordingly. • Use surveys, forums, advisory groups and interviews with clients and workers to improve your work practice and when developing new programs. • Listen to the person's own ideas and preferences when developing and reviewing goals. • Listen to and use lessons from the **lived experience** of communities, such as First Nations peoples, when delivering services to people from marginalised or disadvantaged groups.

Lived experience
A person's personal knowledge about their own situation gained through direct, firsthand experience, or through cultural or generational exposure to discrimination, trauma or other experiences.

Example

Brokerage model of case management

Stanley is 62 years old and has been living alone in his own home since his wife passed away nine months ago. His two children come to visit around once or twice a month. Stanley has diabetes and now self-administers his insulin injections and he uses a wheelchair for mobility. He used to love playing golf and squash.

Stanley was married to his wife for 42 years. He has become increasingly isolated since his wife's death. He and his wife used to cook together and Stanley now doesn't want to cook as he lacks motivation and he has no support in the kitchen.

Stanley wants to keep living at home and is referred to My Aged Care (MAC) by his doctor and is assessed as being eligible for a range of funded support services.

Diane is a case coordinator. After a needs assessment, she meets with Stanley to look at service and support options to address his needs. Diane considers the assessment outcomes and Stanley's personal goals, and together they agree that Diane put the following suite of services and supports in place:

- disability support service to support Stanley to attend the golf club and reconnect with his friends
- a physiotherapist to build up strength and support with golf activities
- Rotary club volunteers to accompany Stanley to weekly 'fish and chips' night
- a roster with his children to each cook with Stanley once a month.

Principles and practices of case management

The principles of service coordination and case management are built into organisational policies, procedures and practices.

The principles used in case management link to and stem from the standards, legislation and regulatory requirements that govern the various sectors of the industry. These underpin the delivery of services to clients and define the parameters of a case manager's role.

The following principles are those that most community services organisations adhere to.

Logical and systematic	Case coordination requires a logical, structured, step-by-step approach, starting with intake, undertaking full needs assessment, and involving well-considered planning, monitoring and review.
Sound assessment	A robust assessment process (using evidence-based information) is undertaken to assess the full range of client needs, priorities and preferences.
Collaboration and partnership focus	Case coordinators build partnerships and collaborative relationships with people accessing services, their families and significant others, formal networks of government and non-government service providers, and the community. Collaboration and **inclusion** are central features, and partnerships benefit the client giving them opportunities for service provision.
Outcomes-driven	All services and inputs are focused on supporting clients to achieve agreed outcomes, and undertake the monitoring and reviews needed to ensure outcomes are being met.
Advocacy	Service providers support clients to understand, access and claim their legal rights and entitlements to funding and service options.
Accountable	Service providers hold themselves accountable to provide high-quality services, and take responsibility for implementing processes and policies to facilitate this. Complaints are dealt with fairly.
Holistic	Services are planned and delivered to support the whole person, including physical, social and emotional needs.
Dynamic	Revision of goals, strategies, resources and outcomes is ongoing throughout the process of case management. They need to be responsive to the client's changing circumstances.
Competent	All services and support activities are carried out by appropriately trained and qualified staff. The scope of roles is managed, and staff are supported through supervision, training and mentoring.
Transparent	All processes are open and applied equally to all.
Inclusive	Diversity is respected and valued. People receive services on the basis of eligibility, assessed need and priority. There is no discrimination on the basis of personal characteristics. Services are planned and delivered so that client diversity is supported.

Inclusion
Providing equal access to opportunities and resources for people who might otherwise be excluded or left out.

Example

Approaches and models of case management

Rocky played football at a high level until he was injured at 20 years of age. He was enrolled in a Bachelor of Business but after his injury he became more socially isolated and stopped going to classes.

Rocky is referred by his GP to Didsbury Mental Health Services, where Susan is appointed as his case manager. Rocky explains that he would like to understand his experiences better and be able to connect with his friends again.

Susan works with Rocky and his psychologist to develop a client plan to address some of Rocky's needs. Susan coordinates the services using the clinical model. She:

- arranges weekly sessions with a counsellor to explore the trauma related to the accident. The sessions focus on Rocky's goals to understand his experience and reconnect with his friends
- connects Rocky with a local mental health support service, which has a group where Rocky meets people with similar experiences
- connects Rocky to an adviser at his university so he can stay motivated to complete his work and attend classes, and can also receive academic support when needed.

Rocky's case plan is reviewed at regular intervals to see how he is progressing towards his goals.

Legal and ethical foundations in coordination

Case coordinators have legal and ethical standards, codes of conduct and legislation that apply to their organisation and industry sector.

A legal and ethical framework that underpins work practices and service delivery is based on obligations such as:

- organisational standards, policies and procedures
- regulatory standards
- codes of conduct
- legislation.

To ensure best practice, workers must follow legal guidelines but also ethical guidelines. Some actions may not be noted in legal documents but should not occur because they are unethical. An example of this can be blurring the boundaries of their professional role and using client relationships for personal gain and affection or a professional who lies about their qualifications.

Organisational standards

Organisational standards, policies and procedures outline the way in which an organisation conducts business and the organisation's expectations of how staff will behave.

Organisational standards underpin codes of conduct and ethics. A code of conduct outlines the organisation's expectations and rules for staff professional conduct. An organisation embeds the ethical requirements into workplace policies and procedures so that staff will demonstrate ethical practice when performing their work role. These are used to direct and guide staff behaviour.

In addition, there are ethical codes of conduct that apply to specific sectors of community services. Here are some examples:

Australian Association of Social Workers code of ethics outlines values and ethical responsibilities that must be upheld: aspirelr.link/aasw-coe

National Code of Ethics for Case Management from Case Management Society of Australia & New Zealand & Affiliates outlines case management values, principles, ethical decision-making, and the practice and conduct expected of a person in a case management role: aspirelr.link/cmsa-nsp

Regulatory standards

Various industry standards specify the level and quality that organisational services must meet.

Standards that govern service delivery for specific industry sectors are monitored by the relevant state/territory and/or Commonwealth regulatory bodies.

Regulatory bodies do regular accreditation audits to determine whether an organisation is meeting the standards. If so, the organisation will be granted accreditation and be able to continue providing services, usually for a period of no more than three years.

Standards are legally binding, and if organisations are found to be non-compliant, a range of sanctions can be applied including withholding funding until the organisation makes the required rectifications.

Here are examples of regulatory standards for community service sectors.

The Aged Care Quality Standards apply to services delivering aged care and to all residential aged care facilities. View the standards: aspirelr.link/acq-standards

The National Principles for Child Safe Organisations are standards recommended by the Royal Commission into Institutional Responses to Child Sexual Abuse. View the principles and related resources: aspirelr.link/child-safety-principles

Legislation

Legislation are laws passed by parliament at a state/territory or Commonwealth level.

All organisations in the community services sector must ensure they operate in compliance with the relevant governing legislation.

Video: Australian legal system

Watch this video on the Australian legal system: aspirelr.link/yt-aus-legal-system

Consider these questions when you are watching:

- What is the difference between Commonwealth and state/territory law?
- Is child protection legislation part of Commonwealth or state/territory law?

Video: Legislation

If you want to understand more about how legislation is made in Australia, watch the following video from the Parliamentary Education Office: aspirelr.link/yt-legislation

The Privacy Act

The *Privacy Act 1988* offers protection for clients' personal information including medical records and bank account details. People accessing services and their representatives must be fully informed of the reasons the organisation needs to collect their personal information, and the type of information required. Organisations must only collect information that is needed to facilitate service delivery.

Read about the 13 Australian Privacy Principles and their purpose: aspirelr.link/oaic-privacy-principles-quick-reference

Following is an outline of how case coordinators can meet their privacy obligations.

Storing and securing personal information
• Paper-based information must be stored in locked facilities. • Electronically stored information must be stored with password controls. • Records (paper or electronic) that need to be taken out of the office must be transported safely and securely. Check with your supervisor before relocating files.
Sharing personal information
• Information must not be shared between organisations without written informed consent of people or their representatives. • Information can only be discussed with people who are authorised to know about it.
Respectful handling of sensitive information
• Workers must be respectful of and cautious with sensitive information. • Face-to-face discussions about people and sensitive information needs to happen in spaces that are soundproof and with only relevant workers present • Digital discussions need to happen via approved electronic and protected channels (e.g. work email on a work device, organisational note-keeping software).

Anti-discrimination law

In Australia it is unlawful to discriminate on the grounds of age, disability, race or sex.

Discrimination
The act of excluding or treating a person differently based solely on an attribute such as disability, age, gender, race or sexual orientation.

Anti-discrimination law means that case coordinators must ensure that services are provided based on assessed need and eligibility. There must be no preferential treatment or discriminatory treatment based on a client's personal characteristics. Non-judgmental practice must be applied, and services must be delivered in a respectful manner.

Case managers and service coordinators may need to advocate for a person receiving services in the event of potential or actual discrimination.

Examples of federal anti-discrimination laws are outlined in the following table. When a legislation name has '(Cth)' in its name, it means it is Commonwealth legislation.

***Age Discrimination Act 2004* (Cth)**
This Act makes it illegal to discriminate against someone on the grounds of age and age-specific characteristics.

***Disability Discrimination Act 1992* (Cth)**
This Act makes it illegal to discriminate against someone on the grounds of: • disability (all types) • diseases and disorders, including those that affect thought processes, perception of reality, emotions or judgment, or result in disturbed behaviour • the presence in the body of organisms causing or capable of causing disease or illness (e.g. HIV).
***Racial Discrimination Act 1975* (Cth)**
This Act makes it illegal to discriminate against someone on the grounds of: • race • colour • descent • national or ethnic origin • immigrant status (in some cases). Racial hatred is also made illegal under this Act. Racial hatred is defined as a public act likely to offend, insult, humiliate or intimidate on the basis of race.
***Sex Discrimination Act 1984* (Cth)**
This Act prohibits sexual harassment and makes it illegal to discriminate against someone on the grounds of: • sex • marital or relationship status • pregnancy or potential pregnancy • family responsibilities • breastfeeding • sexual orientation • gender identity and intersex status.
***Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013* (Cth)**
This amendment inserted new grounds into the Sex Discrimination Act, making it illegal to discriminate against a person on the grounds of their: • sexual orientation • gender identity • intersex status. Same-sex couples are also protected from discrimination under the definition of 'marital or relationship status' (previously 'marital status').

***Equal Opportunity Act 2010* (Vic.)**

This Act aims to eliminate discrimination, sexual harassment and victimisation. It also protects people who require an assistance dog. The Act states that there must not be discrimination in the provision of goods and services, including:

- refusing to provide goods and services to the other person
- the terms on which the goods or services are provided
- subjecting the other person to any other detriment in connection with the provision of goods and services.

The Act covers discrimination in employment, education, accommodation, clubs, land sales and local government.

Find a quick guide on Australian discrimination legislation here: aspirelr.link/human-rights-aus-discrimination-laws

Health and safety legislation

The 'model' laws are a single set of work health and safety (WHS) laws that have been implemented in most states and territories across Australia. Here are some ways workers can meet their WHS obligations through policies, procedures and systems to keep clients and staff safe:

- conducting risk assessments to identify and report hazards (physical and psychological) (e.g. assessing risk in the home of the person before support staff provide in-home care)
- devising risk control strategies in response to client-related and other workplace risks
- attending training (e.g. emergency response and personal safety)
- completing incident reports and other documentation
- ensuring the safest strategies and rosters are in place for staff who are delivering direct care support services
- monitoring the safety of direct care staff when they are working with people accessing services
- arranging training for direct care staff
- following policies and procedures that identify hazards and assess and control risks
- reviewing incident and hazard reports to identify trends in risks
- providing feedback on policies, procedures and practices based on incident trends.

Example

Statutory interventions

Here are some examples of when workers may need to consider court orders when working with clients:

- A man with schizophrenia is at serious risk of harm to himself and others, and has an order to be held as an involuntary in-patient in a mental health unit under the *Mental Health Act 2014* (Vic.).
- A female client has been granted an apprehended violence order against her ex-partner, who has made threats to her life.
- A child has been ordered by the courts to be placed in out-of-home care because of ongoing neglect and abuse.
- A father who has been charged with family violence offences has been ordered to undertake a family violence behaviour change program.

Case manager role and responsibilities

The requirements and responsibilities of a case manager's role will be outlined in their position description. This details the scope of the role, and the duties and activities that the staff member is legally able to perform. Case managers must undertake only the activities and duties that are specified by their role and not exceed the authority of their position. Performing duties outside the job description may have legal implications for the organisation and the person involved.

Here are some examples of a case manager's tasks.

Case manager role	Example
To provide the client with options and choices	You are not a decision-maker; instead, you help the person to navigate options.
To give only the help that the client needs	Sometimes the person simply needs to know who they can call to get help with a particular need. In other cases, they might need you to make a phone call or fill in a complaint form online. Always encourage and support the person to make as much of this contact as they can themselves.
To use or recommend external resources if the case manager or service cannot meet the client's needs.	You are not trained to do everything for the person. Health and allied health professionals can also play an important part in the person's wellbeing. Government sources and other authorities, including websites, helplines and local government services, can provide many supports for the person that you and your service might not be able to provide.

Work role boundaries

Firm and clear professional boundaries protect the case manager and the person accessing services. They provide guidelines, rules or limits that identify reasonable, safe ways for people to behave that can be communicated to clients. Boundaries also protect the client from feeling let down by unrealistic expectations of you.

Case managers must remain impartial to act in the best interests of the person and the community. If they are not impartial, the person accessing services can be taken advantage of or decisions can be made that put the case worker at risk of conflicting interests.

There must be a clear definition of boundaries that separate your working role from your personal life. Here are some examples of professional boundaries:

- Do not attempt to be a friend to the person accessing services. An interaction with a client is a professional working relationship. Do not share personal details about yourself, including your personal contact details, or agree to see the person outside of your work role.
- Declare any conflicts of interest to your manager, such as prior relationships with clients or family members.
- Avoid touching the client. This could be misconstrued as friendship or a sexual advance.
- Avoid sexual jokes or innuendo.
- Avoid entering into discussions about politics, religious beliefs or other sensitive topics. It is important to stay neutral in most discussions, unless you are concerned that the person is at risk of harm or abuse because of their beliefs.
- Do not provide medical, legal or financial advice. Your role is only to refer the person to others who can help with these decisions.

A position description, organisational policies and procedures, and codes of conduct provide information on professional boundaries. There will be times when you do not have the expertise or competence to provide the assistance required. You must be able to recognise these situations and seek help when necessary from a supervisor, more experienced work colleague or other healthcare professional.

Your organisation will also have policies and procedures outlining how you escalate different work situations to the correct person.

Example

Professional boundaries

Tony works as a case manager in a small country town where everyone knows each other. He has a case with a family he knows well. The family run a small business in town and Tony regularly hears gossip from the locals about the family.

The family are seeking help with services relating to AOD and family violence. While Tony keeps the family's information confidential, he feels uncomfortable listening to the family's issues being discussed by other professionals.

Eventually, the family's involvement with AOD and family violence services becomes the subject of gossip and whispers, and spreads widely around the town. The family are concerned that Tony is the source of the gossip and refuse to continue to see him or other services. Tony did not breach confidentiality, but he is concerned that the family's chances of overcoming the problems they face are now very low. He decides to discuss the situation with his supervisor and suggest he pass the case management role to another of the staff.

Practice Task 1

Question 1

Match the case management model with its description.

Rehabilitation model	The case manager acts as a coordinator, facilitating and arranging access to services to meet the person's needs such as personal care or social supports.
Assertive Community Treatment model (ACT)	The case manager facilitates and arranges access to services and also provides services if they are qualified to do so.
Brokerage model	The focus is to improve the social network of the client to increase capacity for the network to provide social, practical and emotional support.
Clinical model	The outcomes and goals of the person are the focus and after initial high engagement between the client and professional, this decreases over time once knowledge and skills are built up.
Network model	Used with people with complex or co-existing needs and includes collaboration with the client, intense support during crisis, integrated health and social needs and community team-based support.

Question 2

Which of the following statements relate to evidence-based practice? Tick all that apply.

- ❑ Decisions are informed by relevant and reliable evidence.
- ❑ Practices that were effective with other clients are used with current clients.
- ❑ Information is provided by professionals with qualifications in the specialist area.
- ❑ Research and feedback from clients is used to determine supports.
- ❑ Feedback given by the service provider is valued more than client feedback.

Question 3

Which of the following statements are correct? Select yes or no for each one.

a. In a person-centred approach, planning is tailored to the person and focuses on their unique needs, goals and preferences.	Yes / No
b. A strengths-based approach means focusing on trying to 'fix' a person.	Yes / No
c. Capacity building is working with a person to develop and strengthen skills that enable them to maintain independence.	Yes / No
d. An early intervention approach involves addressing needs to prevent issues escalating.	Yes / No
e. Case coordinators work best on their own.	Yes / No

Question 4

Briefly outline each of the following principles and practices used when planning services for clients:

- Logical and systematic
- Sound assessment
- Collaboration and partnership focus
- Advocacy
- Outcomes-driven

Question 5

Which of the following statements are correct? Select yes or no for each one.

a. Standards are legally binding, and if organisations are found to be non-compliant, a range of sanctions can be applied.	Yes / No
b. The Privacy Act encourages information to be shared so the client benefits from having access to current information about their case.	Yes / No
c. Anti-discrimination laws ensure non-judgmental practice and that clients are not excluded or treated differently based solely on an attribute such as disability, age, gender, race or sexual orientation.	Yes / No
d. Organisational policies and procedures outline the way in which an organisation conducts business and the organisation's expectations of how staff will behave.	Yes / No
e. Workers need to develop their own unique set of ethical standards so they know how they must act and behave with their clients and other staff in their workplace.	Yes / No

Question 6

Give three tips that would guide a case manager in working within their professional boundaries of their work role.

1B Develop a client plan

The client plan is the foundation for setting up useful services to the client.

Planning services and support strategies and interventions should be a collaborative process, involving the person accessing services, others who are significant to them, any advocate, representative or substitute decision-makers who choose or need to be involved, and relevant stakeholders from organisations that will be providing services.

Planning occurs during a formal planning meeting (or series of meetings). Meetings must be person-centred and client-driven. The person receiving services is the primary stakeholder and has the primary responsibility for making decisions about their goals and needs.

This is the point at which the client has approached the service or been referred and has been allocated a case coordinator. It is important to gather information about the person and their situation to establish eligibility for services and supports available.

Client plans

Assessment outcomes and information gathered during the assessment phase are used to develop client plans.

A case plan is a document that includes the person's assessment, needs and goals. It also includes tasks that need to be undertaken by the person, case manager, support workers and other providers and health professionals.

Depending on the organisation and sector of the community services industry, the client plan may be referred to by another name.

Common names used for client plans include:

- care plan
- case plan
- person-centred plan
- support plan
- National Disability Insurance Scheme (NDIS) plan
- individual service plan.

Planning complex service inputs

Initial contact may be made by the client or via a referral from another professional or service. In the first contact, the client needs to be given information on the process to enter the service, any costs involved and any waiting periods that might apply.

Intake
The eligibility requirements and details of the person accessing services are reviewed by an organisation to determine if the service is appropriate for their needs. For example, does the organisation specialise in this area or do they have the capacity to provide service delivery to meet the person's needs? The specific services the client will receive have not yet been determined and the initial intake process will depend upon the sector of the community service industry and the protocols of each organisation.
Initial needs assessment
The case coordinator works with the person accessing services to begin to understand their needs, preferences, priorities and aspirations. They need to understand what the person hopes to accomplish through the services they will receive. This involves a holistic look at the areas of the client's presenting needs and risks, and the level of urgency with which they require services. This phase gives a picture of the client's eligibility and service provision requirements. Where a specialist is required to identify needs, the person is also referred appropriately. The initial needs assessment can be part of the intake process or it can be a separate process that follows after someone has been accepted to a service. This process is ideally in a face-to-face meeting with the client and their significant others or a representative. The initial needs assessment is just the first step and will be reviewed several times to determine their changing needs, priorities and aspirations.
Multidisciplinary assessment
People accessing services may require clinical assessments to help determine how best to manage their complex needs. Clinical assessments are those relating to medical, psychiatric, psychological, allied health or other specialty areas. These must be undertaken by appropriately qualified personnel in an organisation, or by professionals external to an organisation that a person has been referred to. For example: • a physiotherapist to assess mobility needs • a psychiatrist to assess mental health needs • an audiologist to assess a person's hearing.

Example

Alex's story

Alex has not seen his daughter Susan for eight years. Susan broke contact with her father when his alcohol abuse affected their relationship. Alex has recently been referred to a community service organisation to address his complex needs, which include:

- homelessness
- depression
- unemployment and minimal job prospects
- fractured family relationship
- poor physical health.

In discussion with his case coordinator, Alex disclosed that part of his depression stems from not having contact with his daughter. Alex says that restoring his relationship with Susan is more important to him than finding a home.

Example

Madeline's story

Madeline has been accepted to receive services from Southeastern Community Services. She has been staying with a friend since leaving a long-term de facto relationship with an abusive partner. Madeline experiences anxiety and depression, and is scared that her ex-partner will find out where she is living and come to harm her. Madeline only leaves the house to buy alcohol. She has stated that alcohol helps her relax. She has access to a small amount of money and has not been receiving Centrelink benefits.

An initial needs assessment indicates the areas of Madeline's short- and medium-term needs, which include:

- financial help and crisis payment from Centrelink
- emergency accommodation (immediate)
- mental health support
- subsidised housing (medium term)
- assessment for alcohol usage and dependency
- health assessment (GP).

Funding requirements and eligibility

All funding has eligibility requirements, which are the criteria that must be met to obtain the funding.

Funding criteria and eligibility requirements will vary depending on the industry sector and the funding body. Service delivery organisations must ensure that their client intake and assessment processes reflect the relevant funding requirements. Organisations may be required to report to funding bodies to justify that funds have been used within the required parameters.

Funding criteria and requirements may relate to:

- age, such as the pension or employment benefits provided and monitored through Centrelink and My Aged Care (MAC)
- disability – NDIS
- a specific condition or diagnosis – provided and monitored through Centrelink
- family situation such as single parent or carers allowance or domestic or family violence and crisis payments from Centrelink
- financial situation such as low income or unemployment
- migration status such as temporary residence and limits on earnings and access to government benefits
- Aboriginal and/or Torres Strait Islander origin
- living situation such as homelessness due to domestic or family violence or low income or unemployment
- AOD or substance abuse leading to poverty or unemployment, homelessness etc.

Funding arrangements

Here are some examples of funding options that a client may need to access.

Consumer-directed care (CDC) and portable funding

CDC allows the client or consumer of services to have the main say over the services they use. Under CDC, the government funding is directly allocated to the client, not the organisation that delivers services. The CDC model gives the client choice, control, information and knowledge about the service providers they prefer, and greater purchasing power. It allows clients to move to another service provider if they are not happy with a service – the funding is 'portable'.

Examples of CDC are the NDIS and Home Care Package funding.

Grants

Organisations can receive grants from government bodies to deliver services. This means the funding goes to the organisation so it can reduce or eliminate cost to the client.

Read more about CDC for aged care services: aspirelr.link/cota-cdc

Two funding bodies that clients may need to access are the NDIS and My Aged Care (MAC).

NDIS

If a person is assessed as eligible for NDIS funding, a National Disability Insurance Agency representative will contact the client or their nominated representative and start the planning process. The first plan will usually be determined over the phone. The client's first plan will identify the reasonable and necessary supports required to meet their immediate needs and start to identify their goals for the future.

Once completed, the first plan will provide the client with individualised funding that they control and choose how to use. The client will have a support coordinator allocated to support the implementation of the NDIS plan and to coordinate the process of sourcing and accessing services. NDIS plans will be reviewed annually, unless the client's circumstances change significantly before that time, in which case, a review will occur earlier.

MAC

There are variances in the intake and assessment process across Australian states and territories. Initial information is taken by the MAC operator and the person will receive a home support assessment from the Regional Assessment Service (RAS) to look at their needs, level of function, services required, services currently received and natural supports.

The RAS assessor will work with the person and their family to develop a Home Support Plan, to identify their strengths, difficulties and personal goals. The RAS can support the person to identify service providers who can address their complex needs, and prepare a referral. If the client requires a greater level of support, the RAS assessor will organise for the client to receive a comprehensive assessment.

For more information about NDIS and eligibility visit: aspirelr.link/ndis

For more information about MAC visit: aspirelr.link/my-aged-care

Evidence gathering used in an assessment

Evidence is data and information from which conclusions can be drawn and action can be planned.

Data collected in a client's assessment needs to be quantitative and qualitative. Quantitative data is numeric. It tells you how often or how many. Qualitative data is in the form of words. It tells you about experiences, thoughts and feelings.

The type of data you have collected will determine the methods you use to analyse it.

Video: Quantitative and qualitative data
This video explains the differences between quantitative and qualitative data: aspirelr.link/yt-quali-quanti

Evidence is used to identify the full range of services that a client may need. The case coordinator can contribute evidence to the health professional conducting the assessment or for their own assessment.

Here are some examples of types of data and information which must be taken into account when planning for services to address a client's complex needs.

Medical evidence	Evidence includes the outcomes of medical tests, clinical assessments, and records of interventions that have been implemented and their effectiveness.
Client feedback	Evidence includes feedback from the person receiving services and other stakeholders including clients' families or representatives.
Client needs	Evidence includes the client's experiences, perspective, journey, aspirations and needs. This can also include information received from previous services in client notes/case history notes or referrals.

Collaborate to identify goals and outcomes

Goals are the outcomes that the client wishes to achieve.

Goals are different from outcomes in the following ways.

Outcome	Goal
States what is wanted to be achieved; the desired result	States actions or methods that will help to achieve the outcome
For example: I would like to be more independent.	For example: I will be able to live independently in my own home by the end of July.

A case manager should help the person to understand the range of options that might be open to them, and support them to find goals that meet their needs and strengths.

Goals should be set using a 'SMART' format, as explained below.

Specific (be clear about what will be done)
Goals must be well defined and clear to the client and everyone involved in the client plan. For example: • Alan will put aside $1,000 in his savings account by 1/8/2023. • Daniel will reduce his alcohol intake over the next six months to reach a goal of no more than one standard drink per day. • Sophie will stop smoking cigarettes by the end of this pay cycle.

Measurable (have a measure or signpost that allows you to determine whether it has been achieved or not)
There must be clear and specific outcome indicators to track progress towards the goal. For example: • the target dates • how much must be achieved • how to determine when the goal has been achieved.
Attainable (within the person's reach and not setting them up for failure)
Goals must not be set that exceed the person's capabilities.
Realistic (reasonable time and resources are available to help the person to achieve the goal)
Goals must be realistic. For example: • The goal must be within the capacity of the service provider to support. • The resources must be available. • The time must be available. • Costs must be within budget.
Time frame (a specified time frame helps to motivate you and the person to achieve the goal)
Goals must have a time frame. For complex or long-term goals, setting key milestones on the time frame will help you and the client track their progress.

Once goals have been developed, the case manager can work with the client and agree upon actions that can help to meet these goals, along with a time frame and the person or people responsible for these actions.

Once a goal has been completed, the person responsible signs off on the action they are supporting the person to achieve. The person can then move on to a new goal. The aim is for the person to regain as much independence as possible.

Example

Applying SMART goals

Read the following example to learn how SMART goals can be applied in various client plans.

Diabetes

Goal

- To help the client maintain blood glucose levels (BGL) in the following range:
  - 4–6 mmol/L before meals
  - 4–8 mmol/L two hours after starting meals

Strategy

- Take BGL measurement three times a day
- Client to self-administer insulin
- Client to access Meals-on-Wheels diabetic diet for lunches and dinners
- Client to choose from a list of diabetic menu options for breakfasts and snacks provided by dietitian

Responsibilities and time frames

- Client's self-management: ongoing
- Client to access GP and community health centre: once a month
- Client to meet with dietitian from the community health centre: once a month
- Meals-on-Wheels specialised meals service: reviewed once a month

Reduced mobility due to bilateral leg amputation, reduced upper body strength

Goal

- To be able to move around independently

Strategy

- Client to use manual wheelchair for short-term mobilising
- Work together with physiotherapist on how to use wheelchair effectively
- Submission for electric wheelchair

Responsibility and time frame

- Case coordinator to prepare submission to Gov-Equip and submit by 10 October
- Client to attend physiotherapy sessions: once a week
- Appointment with physiotherapist from Get Fit Community Physiotherapy: once a month
- Transport to appointments will be provided by volunteers from the Red Cross: once a month

Social isolation
Goal • To help the client connect with other men for regular social interaction **Strategy** • Client to attend Men's Shed every Wednesday **Responsibility and time frame** • Social support officer from All-In Community Services to transport the client each Wednesday: once a week
Grief and depression following loss of wife
Goal • To work through depression and grief **Strategy** • Client to attend fortnightly sessions with psychologist **Responsibilities and time frames** • Appointment with psychologist from the community health centre: twice a month • Appointment with the client's GP: twice a month • Transport to appointments provided by Red Cross volunteers: once a week

Example

Set goals and actions to meet goals

Henry is 22 and has an acquired brain injury. He lives with his parents but would like to move out on his own. Here are the goals and actions that Henry and his case manager developed together.

Goal: Henry will be able to live independently in his own home by the end of July			
Action to meet goal	Who is responsible for this action?	Time frame	Date and sign when completed
Assess Henry's ability to manage on his own	NDIS assessor GP Henry and his family	By 1 January	

Goal: Henry will be able to live independently in his own home by the end of July			
Action to meet goal	**Who is responsible for this action?**	**Time frame**	**Date and sign when completed**
Build Henry's skills in self-management	Case manager will help Henry to enrol in a living skills course	By 6 February	
Source aids to support Henry at home and train him to use them	Occupational therapist	By 15 March	
Determine requirements and funding for home help	Case manager	By 21 March	
Search for suitable rental accommodation in Henry's preferred location	Henry His family	By 30 May	
Assess need for modifications to be made to bathroom, including shower rail and floor levelling	Occupational therapist	By 1 June	

Goals that are difficult to measure

Some goals are difficult to put into the SMART goal framework.

For example, if you are trying to set a goal relating to a client's depression, it seems difficult to set a SMART goal for improvement. It is hard to know how the client will respond to treatment, or quantify how much better they will feel with the supports you can offer.

It is also difficult to measure improvement in how the client feels overall. However, quantitative indicators can apply. For example, a client who was not eating enough due to depression could experience an increased appetite and reach a healthy weight as they start to feel better.

Goals that are not set in the SMART goal framework are difficult to monitor. 'Getting fit', 'paying off all my debts' or 'being happy' will not help a client. You and the person will need to think laterally about correlated outcomes, or set goals that are actions.

Here are examples of goals that involve an action:

- John will see a psychologist each fortnight for the next six months to work on managing his depression. At the end of this time, he will review this arrangement with his psychologist, case manager and GP.
- John will enrol in a 10-week weight-training class at the community centre with a group of friends. His goal is to attend every session. A friend will pick him up from home to help him stay motivated.
- John will meet with a financial counsellor and contact utility companies to negotiate a manageable payment plan for his debts by 1 June.

A client plan should specify what actions or strategies will be taken in relation to reaching the person's goals.

Strategies to help people work towards their goals include:

- creating a plan that identifies all tasks that need to be done to help reach goals
- determining who is responsible for each task
- defining when the tasks need to be completed by
- facilitating discussion on setting goals and making decisions, using a person-centred approach
- discussing motivation for participating in support activities
- valuing all input and efforts by the person
- breaking down goals and celebrating wins
- encouraging the person to take responsibility for their own progress.

Identify available services to support plan

The network of services and agencies is vast and complex.

A case manager needs the ability to navigate this network and to keep up-to-date with information about new services and changes to existing services. Some services address a range of needs, while others specialise or focus on a particular kind of need or a particular sector of the population.

Services need to suit the preferences and situation (financial and geographical) of the person. The range of services included in the plan can be resources provided by government or not-for-profit organisations such as:

- housing services
- health services and allied health professional services (e.g. GP, physiotherapist, dentist)
- family or individual counselling
- domestic and family violence services
- alcohol and other drugs (AOD) services
- education or vocation support
- peer support services (e.g. AOD groups, grief or trauma support groups)
- financial adviser and support
- meal support or personal care
- legal aid
- volunteering services (e.g. social activities, dog walking)
- community services and interest groups (e.g. yoga classes, pottery classes)
- complementary health services (e.g. naturopath, reiki)
- multicultural or religious support services
- carer support services.

There are many places to research local services. Here is one example of an online directory of services in Western Australia: aspirelr.link/wapha-service-providers

Before referring a client to formal services, explore the 'natural' supports that the person has been using now or in the past. This can only be done with the person's consent and agreement. Natural supports might include the person's family members, friends, neighbours and colleagues.

Here are more examples of services and resources that can help to meet specific needs or complex issues.

Problem or need	Service or resource
People in financial need	• Centrelink can help the person to access financial supports and rental assistance. • Charities such as St Vincent de Paul and the Salvation Army can help provide emergency accommodation, food parcels and short-term financial support. • Utility companies and services in the community provide discounts for people who have a Health Care Card. • Health Care Card can provide access to cheaper medicines, reductions in admission to activities, and free or reduced-cost travel on public transport.
People who need help to communicate	• Organisations that assist in creating and recommending communication technologies include Hearing Australia, Vision Australia and Scope's Communication and Inclusion Resource Centre. • People who speak languages other than English can access translating or interpreting services. These services can help a person to read and understand documents, complete forms and communicate in meetings. • The Translating and Interpreting Service (TIS National) can help people access a free interpreter for health and other services. • The National Auslan Interpreter Booking and Payment Service provides free or paid Auslan interpreters for people who use sign language.
People with mental health needs	• Beyond Blue provides free counselling support through phone and online chat. • QLife is a counselling and referral service for people who identify as LGBTIQ+.
Older people who need advocacy	• The National Aged Care Advocacy Program provides the National Aged Care Advocacy Line, a telephone service that offers advice, assistance and advocacy on behalf of older people who have a cognitive impairment such as dementia. • Seniors Rights Victoria provides legal services and advocacy to any Victorian aged over 60. • Elder Rights Advocacy provides advocacy and information for aged care residents and their families.

Example

Arranging services

Bill lives in a residential aged care facility. He has mild dementia. Bill receives services related to leisure and health run by the facility's lifestyle department. Bill also goes on weekly excursions with a group on a bus.

Bill's daughter applied to a local Commonwealth Home Support Programme (CHSP) provider to see whether Bill could attend the planned activity group (PAG) three days per week. This group offers social and recreational activities for older people living in the community in need of social and recreational support.

Bill's daughter was informed that Bill was not eligible to attend the PAG because he is living in a residential aged care facility, and is therefore not eligible for CHSP-funded services.

Case management plan formats

While different services use different plan formats, the following sections are often included as part of a plan template.

A typical case plan format includes:
1. The person's urgent, short- and long-term needs
2. How the person's urgent or immediate needs will be met
3. The person's short-term goals
4. The person's long-term goals
5. The person's strengths, skills and abilities that can be drawn on to meet the goals
6. Barriers that might be in the way of meeting goals
7. Strategies to overcome barriers
8. Agreed on strategies, supports and resources that will be used to meet goals
9. Time frames, roles and responsibilities of all involved in the plan
10. How the plan will be monitored and reviewed

Example

Develop a case management plan to reflect needs and goals

Here is an example of a case management plan.

Case management plan		
Name: Bernice Rothko		Contact number:
Ethnicity (circle):	Aboriginal	Torres Strait Islander
	Aboriginal and Torres Strait Islander	Other (please specify) Russian
Nominated support person:	Alexander Rothko	Contact number:
Case officer:	Molly Ralph	Contact number:
Presenting issues: Dementia Risk of falls Emergency respite is needed: N/A		
Cultural identity and needs: N/A		
Communication needs: N/A		
Assessment: Bernice has dementia and lives at home with her husband, Alexander, who is her primary carer. Alexander is finding it increasingly difficult to cope, and he has recently been admitted to hospital for a heart condition. Bernice is confused and asking where her husband is. Her daughter Olga joined us from interstate via Zoom call, and she is concerned about her mother's safety at home alone. A report from Bernice's GP states that she has had several falls in the past month.		
Strategies/interventions to be used:		

Immediate Order ACAT assessment urgently so that urgent respite can be arranged. Short term Request home assessment with a view to home care funding once Alexander returns home from hospital. Organise occupational therapy assessment for home modifications to reduce risk of falls. Long term Organise ongoing monitoring and assessment of safety and coping at home once Alexander returns from hospital, and when Bernice's dementia deteriorates.		
Strengths and resources:		
Networks Daughter Olga lives interstate but has agreed to fly down to be with her mother until respite can be sought. Olga will get in touch with Bernice's next-door neighbour to ask her to mind the dog and collect mail while Alexander is in hospital. GP Will initiate an urgent ACAT assessment by completing application paperwork today Will notify me when Alexander is due to be released from hospital		
Individual's desired outcomes of support received:		
Olga stated the following goal on her mother's behalf: 'I would like to stay in my own home and care for myself for as long as possible, with supports to keep me safe.'		
Case management plan developed in consultation with: Olga (daughter) Tilak Peters (GP) Molly Ralph (case manager)		
Who will provide the required support? GP	Olga	
Commencement date: 7 June 2023		
Review date for individual case plan: 7 December 2023		

Case management plan authorised by:	
(Signature of client)	Date:
(Signature of client or nominated support person)	Date:
(Signature of case manager)	Date:

Practice Task 2

Question 1

Which of the following statements relate to planning complex service inputs? Tick all that apply.

- ❑ The client must be provided with information on the process to enter the service, any costs involved, and any waiting periods that might apply.
- ❑ The intake phase is used to assess the eligibility requirements of the client for services.
- ❑ The initial needs assessment is a single diagnostic assessment to determine the areas of client need.
- ❑ A multidisciplinary assessment may include several clinical assessments involving medical or allied health.
- ❑ A needs assessment is a holistic look at the client's presenting needs, risks, and the level of urgency with which they require services.

Question 2

Briefly outline why each of the following are important to clients when planning services:

- range and criteria for different funding requirements
- appropriateness of services
- availability and time frames for the delivery of services
- expected outcomes of services.

Question 3

Give an example of a different type of service and support that can be provided for each of the following client needs:

- mental health
- vision impairment
- financial
- meal support in the home.

1C Obtain consent and agree on services to be provided

Consent must be voluntary: never encourage or insist that the person gives consent.

Clients (or their representatives) must give **informed consent** for a case coordinator to share their personal information with another organisation.

Informed consent
A person's decision to agree to a healthcare treatment, having been informed about the intervention and any alternative options.

This means the client must:

- be fully informed – by the case manager or by the other service – about what information will be shared and how it will be used
- be able to understand this information, including the risks and benefits
- have agreed to allow information to be shared with other services, and have signed a written consent to allow this to occur.

Some people receiving services cannot legally give informed consent. This includes children, people with cognitive impairments such as dementia, and some people with intellectual disabilities. If the person is not able to give consent, their guardian or substitute decision-maker is able to do so on their behalf.

For informed consent to be effective it is important to:

- provide information about options in services
- discuss consequences of options
- give the client resources and time to decide
- not be coercive or threaten with consequences.

Referral requirements

Referral to other services is a significant part of the case manager role.

To access specialist and publicly funded services, a formal referral may be required. A referral is a formal document or process used to introduce a client to an organisation or practitioner to access services. Clients may enter your service on the basis of a referral from another organisation or practitioner.

Information required in a referral may include:

- the client's name, address, phone number, email address, date of birth and next of kin
- details of a representative, advocate or substitute decision-maker (if applicable)
- the reason for the referral
- brief history outlining why the client requires services from the organisation
- medications the client takes (if the referral is for medical or allied health services)
- level of urgency with which the client requires the service
- the referring party's details and relationship to the client
- important cultural, religious or personal requirements
- dietary requirements, allergies etc. (if applicable)
- communication needs, such as an interpreter
- behavioural issues
- details of pending legal matters, such as court orders
- power of attorney arrangements (medical/financial).

Referrals must be prepared by authorised personnel to ensure the appropriateness of the referral. If this does not occur, funding or service opportunities may be compromised and other legal requirements may be breached. The case manager will often be the person to prepare referrals to other services for clients. It may be a requirement for a case manager to confirm with a supervisor the appropriateness and reasoning behind a referral.

Before a person is referred, consider the following requirements.

Requirement 1: Availability
Consider the availability of the service. Are they currently taking clients? Do they have a waitlist and what is the current waiting time? If there is a long waiting time, you may need to consider an interim service.
Requirement 2: Suitability and expertise
Does the service meet the needs of the clients? This means suitability in terms of psychosocial needs, practical needs, cultural needs and level of needs. If the client needs intense emotional support, does the service have the expertise and appropriate staff available to provide this? The client also needs to meet the specific requirements of the service (e.g. a diagnosis, age eligibility, citizenship status).

Requirement 3: Funding
Is the service publicly or privately funded? If public, does the client meet the requirements of the service and funding? If privately funded, does the client have the funds available or a support network to fund access to the service? Always look for economically smart options first.
Requirement 4: Logistics
What is practically possible in the support process? Sending a client to a service on the other side of the city may not be suitable. Transport and practicality always need to be considered.

Example

Sample consent form

The consent form might look like this.

Client consent form	
I, (insert client name), hereby acknowledge that _____ (insert name of organisation) has advised me of the following: • Privacy and Confidentiality Policy • My right to access personal information • My right to withdraw my consent at any time	
I am aware of, and understand that, the organisation may need to collect and disclose personal information to third parties (as required) in order to provide an improved level of care. I nominate that my personal information be disclosed only to the person or agencies listed below: • _____ (insert names of third parties as agreed with client, e.g. Aboriginal health worker, youth worker). I understand that _____ (insert name of organisation) must comply with relevant privacy laws and I will contact the organisation immediately if I feel that these laws have been breached.	
Name of client:	
Signature:	Date
Name of program supervisor/case worker:	
Signature:	Date

Negotiate collaborative working arrangements

The case manager must be clear about the expectations and roles of the people involved in the client's plan. Establishing role requirements should be formalised in planning meetings and be part of the information given to the client. Some negotiations about working arrangements will occur in meetings, via phone or email, or through the referral process. For example:

- roles and expectations of all parties involved
- services to be provided
- time frame of service provision
- financial arrangements.

Here are examples of working arrangements that may need to be negotiated and agreed on when coordinating services for a client.

- Discussion with health professionals to negotiate how many appointments per week the health professional can commit to. If a particular practitioner has an existing caseload they are struggling with, they may not be able to adequately provide service for the client.
- Collaboration and negotiations with family members need to occur if the client depends on them for care or services, such as driving the client to appointments. Discussions may indicate that transport will need to be provided as a formal service.
- Discussions with home care providers may involve negotiating specific services such as assisting a client with showering three times a week or providing a female care worker to shower a client who requires this for cultural/religious reasons.
- If the client requires care from a health service, arrangements may need to be negotiated. For example, if a client needs to be admitted to a drug detoxification or rehabilitation unit, there may be a waiting list, which means other services may need to be put in place until there is a vacancy.
- Discussions may relate to what services or equipment the client's NDIS funding package (or other source) covers, and under what conditions.

When the client is satisfied with the information provided, they can give their consent to the arrangements outlined in the plan.

Practice Task 3

Question 1

List at least three things a case manager must do to ensure they have informed consent from their client to share and exchange information with other service providers.

Question 2

Suggest something that needs to be considered as part of the referral process.

Question 3

Identify three topics that may need to be negotiated and agreed on with the client as part of the coordination process.

Summary

- Case management is proactive and identifies issues before they arise or cause more issues.
- Different case management models are used but they all should be outcome-focused, person-centred and evidence-based.
- Assessment outcomes and information gathered during the assessment phase are used to develop client plans.
- Developing the client plan is the foundation for setting up services.
- An effective client plan includes SMART goals, strategies, specification of roles and resources, time frames and review dates.
- A case manager makes the best use of services and supports available to the person.
- Information about the person and their eligibility to access services and funding is part of the client plan.
- Before making referrals, options need to be explored and discussed and consent obtained.
- Negotiations on working arrangements will occur and be formalised in planning meetings to ensure clarity.

Learning Checkpoint 1

Establish coordination function

Part A

1. Match each term about principles of case management to its description.

Advocacy	Client diversity is respected and valued and there is no discrimination on the basis of clients' personal characteristics.
Holistic	Services and support activities are carried out by appropriately trained and qualified staff.
Dynamic	Service providers support clients to understand, access and claim their legal rights and entitlements to funding and service options.
Inclusive	Services are planned and delivered to support the whole person, including physical, social and emotional needs.
Competent	Revision of goals, strategies, resources and outcomes is ongoing throughout the process of case management to accommodate a client's changing circumstances.

2. Which of the following statements relate to organisational and regulatory requirements for case management? Tick all that apply.

- ❑ Legal and ethical requirements are embedded into workplace policies and procedures to direct and guide staff behaviour.
- ❑ Standards govern service delivery in aged or disability supports and are monitored by the relevant state/territory and/or Commonwealth regulatory bodies.
- ❑ Digital discussions are not considered to be part of the privacy principles.
- ❑ Aspects of the Equal Opportunity Act cover discrimination in employment, education, accommodation, clubs, land sales and local government.
- ❑ The Sex Discrimination Act makes it illegal to discriminate against a person on the grounds of their sexual orientation.
- ❑ It is the client's responsibility to identify hazards and assess and control risks as outlined in the WHS Act.

3. Suggest at least three requirements that may need to be considered for a funding arrangement.

4. Which of the following statements are correct? Select yes or no for each one.

a. In the clinical model of case management, the focus is on referrals.	Yes / No
b. A strengths-based approach focuses on what the person can do, rather than what they cannot do.	Yes / No
c. In the consumer-directed care model the funding is assigned to the service provider, which distributes the funding to resources to support the client.	Yes / No
d. Organisational policies are underpinned by legislation and regulatory standards set for the sector.	Yes / No
e. When a client has given their consent to share information, the case manager can distribute personal information freely as long as they believe it is in the client's best interest.	Yes / No

5. Provide three ways a case manager works collaboratively with clients and other people and services as part of their role.

Part B

Read the case study and answer the questions that follow.

Case study

Divina has presented to your service after being referred by her GP. Divina disclosed her home situation during a visit to her doctor. She has a 12-year-old daughter, Anna, and she wants to go somewhere where they can be safe.

Divina has no family or friends who can help her because all her family members live miles away and since she has been married, her husband has fallen out with all of her friends and they never talk anymore. Her partner has limited her social outings and Divina is only allowed to visit her mother or pick up her child from school.

Divina was the carer for her mother in her home until her mother had a fall and is now in respite care for at least the next six weeks.

The GP referred her to your organisation where you have been appointed as her case manager.

You call Divina to have an initial conversation about her situation and priorities.

1. Give three examples of the type of information you will need to give to Divina about the service provision she can receive.

2. Briefly outline the different evidence-based approaches or models that might be used as part of case management with Divina.

3. Suggest three places you can find information on the requirements and boundaries of your role as case manager to Divina.

4. Why is it important that you use evidence-based approaches when providing case management for Divina?

5. Suggest at least two types of case management approaches that should underpin the supports offered to Divina.

6. Give two examples of the types of working arrangements that may need to be negotiated with Divina.

7. Outline the information that will need to be included in Divina's plan if she agrees to service delivery offered by your organisation.

8. You need to share Divina's personal information with others in your team and some external service providers. Briefly outline the importance of informed consent and why consent from Divina is necessary.

9. Identify four things to consider before referring Divina to other services.

10. List two types of services that may be suitable to discuss with Divina.

Topic 2: Support the person to access multiple services

2A Identify, implement and maintain duty of care responsibilities

2B Provide information to suit communication requirements and preferences

2C Work with the person and other services to access services

2A Identify, implement and maintain duty of care responsibilities

Duty of care requires workers to act in a reasonable way that keeps themselves and others safe from harm.

Duty of care
A moral or legal obligation to ensure the safety and wellbeing of other persons.

Dignity of risk
A person's right to dignity and choice, upheld in legislation and service standards, to ensure that duty of care or safety is not used as a reason to limit a person's freedom of personal choice.

Sometimes **duty of care** rests on the need to report an action or behaviour to a manager, or other professional or authority. At other times it might involve protecting yourself and others around the person by helping others to leave the area, or in extreme situations even calling police.

The rights of people to dignity and choice, upheld in legislation and service standards, state that duty of care and safety concerns must not be used as a reason to limit a person's freedom or personal choice. All people have the right to make choices for themselves, even if you do not agree with that choice, and even if that choice might be harmful to the person. This is called **dignity of risk**.

The key to whether that choice is acceptable lies in the potential for harm. The person's dignity of risk must be balanced with your duty of care.

People you support can take risks that might put themselves at risk of harm, but only if they understand the risk. The person does not have the right to cause harm to others. A case coordinator must respect the concept of dignity of risk, which means that a person has the right to make their own choices and to take certain risks as part of their personal freedom.

Video: Duty of care in mental health support

View this video from the Mental Health Recovery Institute specialising in mental health supports: aspirelr.link/yt-doc-v-dor

Consider the following questions when you are viewing:

- Why was duty of care brought in?
- What is the value of having choices and making mistakes?
- What are the three exceptions when we take duty of care over dignity of risk?

Example

Duty of care and dignity of risk

A person who can understand that smoking is bad for their health has the right to smoke, in a designated smoking area or outdoors as often as they like, as long as they are not putting others at risk. This means that they are *not* allowed to smoke inside a facility or supported house, because of the risk of fire. They cannot smoke in indoor spaces near workers or other clients, because of the risk of passive smoking.

A person who uses an electric wheelchair might wish to go shopping alone, even though you are concerned about the risk of them being vulnerable to abuse or theft. If the person is able to understand this risk, and has the cognitive ability to travel safely, they must be permitted the dignity of risk. In this situation, your duty of care might be to take steps to help keep the person safe from potential theft, such as helping them to keep their money hidden.

Responsibilities relating to duty of care

Case management occurs across all sectors of community services and health.

Clients present with a range of needs for support. The role of a case manager is to connect clients and give them access to services. In addition, this means implementing duty of care responsibilities and ensuring the actions of clients are within the boundaries of dignity of risk.

Following is a discussion of duty of care responsibilities to specific groups in the community.

Children and young people

When children are involved, consider their safety and mandatory reporting requirements.

Some of the risks to children and young people can be:

- accidental harm caused by an unsafe physical environment, poor supervision, high-risk activities
- physical abuse such as the use of punishment or assault
- psychological/emotional abuse such as inappropriate words, bullying, threats, isolation

- neglect through lack of supervision, not meeting the needs of children such as food, sleep, shelter, education
- sexual abuse such as direct or indirect sexual exploitation and/or grooming
- cultural abuse including lack of cultural respect, racism.

Source: https://childsafety.pmc.gov.au/what-we-do/commonwealth-child-safe-framework/requirement-1

Duty of care and risk management responsibilities can include these examples:

- working with the family using a strengths-based approach
- working with families according to the terms of court orders
- carrying out mandatory reporting obligations (know your state or territory legislation)
- supporting supervised access visits
- enabling family mediation
- monitoring children for indicators of abuse
- monitoring families for risk factors associated with child abuse
- trauma-informed practices.

To ensure you provide a duty of care to children and young people, work cooperatively with others to ensure a healthy and safe workplace by following your organisation's policies and procedures.

As a case manager, you can demonstrate your duty of care by:

- providing care and protection to all children and young people
- ensuring every child and their family is treated with respect and understanding
- keeping up-to-date with current child, adolescent and family issues, including legal and ethical issues
- using positive communication and behaviour guidance strategies
- using support strategies which suit the child or young person's developmental stage, language ability and skill level.

You can read more about ways to work with children and young people at the Australian Government's Australian Institute of Family Services: aspirelr.link/aifs-working-with-children

Australian child protection legislation

As a case coordinator, you must be familiar with legislation that applies in the state or territory where you work. Australian child protection legislation varies between states and territories. This includes **mandatory reporting** requirements relating to a range of child safety issues.

Mandatory reporting
The legal requirement of people in certain job roles and industries to report suspected or actual abuse to the police.

Here are some resources on ways to respond to disclosure of child abuse: aspirelr.link/khl-responding-disclosure-child-abuse

Legislation in each state and territory have differences in:

- who has to report (mandatory reporter)
- the types of abuse and neglect that must be reported
- the reasons for reporting such as 'suspect', 'have a concern' or 'reasonable grounds'.

The age of young people for mandatory reporting varies across jurisdictions. In most states and territories it is up to the age of 18. The two exceptions are New South Wales, where it applies to children under 16 years old, and Victoria, where it is under 17 years of age.

Different types of abuse have to be reported according to legislation in each state and territory. In most cases it is all five recognised types of abuse and neglect (i.e. physical abuse, sexual abuse, emotional abuse, neglect, and exposure to family violence). In some states and territories, it is mandatory to report only some of the abuse types.

In some cases, workers and professionals are also required to report instances of exposure to sexual, domestic and family violence, in recognition of the seriousness of this type of harm to the developing child.

For more information about mandatory reporting go to: aspirelr.link/state-child-abuse-authority

To find details about the type of abuse that must be reported in each state and territory, visit: aspirelr.link/mandatory-reporting-child-abuse-and-neglect

Example

Making observational notes

Vera thinks that two-year-old Stan is being abused and is at risk of being harmed. She made the following notes, which she will use to write a report.

General details	• Stan is two years and three months old. • He lives with his grandmother, and his mother visits on the weekends. • He and his grandmother live in an apartment in Sydney.
Description	• Stan cries when he is picked up at the end of the day by his grandmother and is very unsettled when he comes to the service on Mondays. • Stan's grandmother calls him 'trouble' and jokes that he will be just like his mother. • If Stan makes a sound or does not leave his activity immediately when his grandmother tells him, his grandmother smacks him. She usually smacks his legs, but today Stan was slapped across the face.
Family information	• Stan's mother has a drug addiction and Stan was addicted at birth. • Stan is living in poverty.

Family and domestic violence

Family and domestic violence can happen in many different ways and is not just about physical abuse from a partner. The Australian Government states that family and domestic violence is:

> 'Any behaviour that is violent, threatening, controlling or intended to make you or your family feel scared and unsafe'.

Source: www.servicesaustralia.gov.au/what-family-and-domestic-violence?context=60033

Video: Family and domestic violence

Watch this video from Services Australia and answer the following questions: aspirelr.link/yt-family-and-domestic-violence

In what kind of relationships can family and domestic violence occur?

What are five services you can refer a person to in a family and domestic violence situation?

As a case manager, you can demonstrate your duty of care for people experiencing family and domestic violence by:

- providing immediate first aid or medical treatment
- collaborating on a safety plan with the person
- listening non-judgmentally to the person's story
- following confidentiality protocols and privacy procedures with personal details of the person
- following reporting as per organisational obligations and protocol, which might include involving a more senior staff member or specialist professional
- following state/territory mandatory reporting legislation when minors are involved
- referring to legal rulings on protection orders from the courts
- referring the client to appropriate services
- relocating the client to a 'safe house'.

For more information about how to recognise and respond to family and domestic violence (FDV) situations visit the Domestic Violence Prevention Centre website: aspirelr.link/dv-support

Video: Family violence

Watch this video about children in family and domestic violence situations: aspirelr.link/yt-family-violence

Consider the following questions:

Programs like Young Hearts send a hopeful message that the cycle of abuse can be broken. What are some of the consequences children can suffer from witnessing FDV?

What are some of the strategies used in the Young Hearts program?

How is this program an example of proactive care?

People at risk of suicide

When someone discusses thoughts about taking their own life, you can make a difference by considering your response.

No matter what area of community services you work in, you should have an understanding of how to identify and give effective support to a person at risk of suicide.

It is important to recognise the signs of when a person is at risk of self-harm and to refer them to the appropriate support service. One way a support worker can identify the person at risk of self-harm is through effective communication skills.

Suicide ideation
Having thoughts of suicide.

Suicide ideation

Tragically, these feelings stop some people from getting the support they need. Sometimes there is no obvious trigger or life situation that leads a person to have ideas to end their own life. Other times, there can be clear reasons for the person's feelings of desperation, despair or hopelessness. They can be triggered or complicated by events and situations such as relationship breakdowns, unemployment, complex grief and loss, ill health or loneliness.

Suicide is not always openly discussed, often because it is tied to feelings of embarrassment and shame.

While suicidal thoughts can affect anyone from any section of society, there are some groups at greater risk than others. People who have made previous attempts to end their life are often one of the highest risk groups.

Other risk factors can include:

- people with a mental illness
- young people
- people who identify as lesbian, gay, bisexual, transgender, or intersex (LGBTI)
- men in rural communities
- older people
- First Nations peoples
- people with social problems such as gambling.

Responses to suspected suicidal ideation

The purpose of asking a person about thoughts of suicide is to assess the risk of harm by ascertaining whether suicidal thoughts are present and, if they are, the risk of immediate harm.

People are often concerned about raising the issue of suicide with someone who may be at risk, fearing that discussion may encourage a vulnerable person to act on thoughts of ending their own life. In fact, a troubled person may be relieved that somebody has recognised that living has become difficult for them.

Always take talk of dying or suicide seriously, no matter how many times the person may have threatened suicide in the past. However difficult, it is usually best to ask directly if the person may be contemplating ending their life. You might say something like: "When you made that joke before about dying, I felt concerned that you might have meant it. Are you considering taking your own life?"

Your question in itself will not contribute to it happening. Not asking the question, however, will prevent you from ruling in or ruling out possible courses of action that may save a life.

If the person agrees that your suspicions were correct, or if their response gives you continued or further cause for concern, show them that you care what happens to them.

Some questions that you might ask now include:

- When did these thoughts begin?
- How often are you having these thoughts?
- Do you feel able to control them?
- What has stopped you from acting on your thoughts so far?
- Have you made any plans?
- How often do you think about this plan?

If you have established rapport with the person and they feel they can trust you, they are unlikely to react to your respectful concern with anger. However, if a person does become angry, this may be a strategy to hide deeper feelings that they are having difficulty expressing.

For more information about seeking immediate assistance in suicide visit: aspirelr.link/lifeline

Video: Suicide prevention (Beyond Blue)

Watch the *Life Changing Conversations* video to view real people talk about suicidal ideations they've had in their life: aspirelr.link/bb-suicide-prevention

Why do videos such as this one make the discussion about suicide feel more valid and real?

When there is immediate risk

If there is an immediate risk, or if you are unsure, do not leave the person alone. Contact a mental health crisis team or, if it is an emergency, call an ambulance. Inform a supervisor about your concerns and seek further assistance from them. If the person insists on leaving, calling the police might save the person's life, especially if they leave in a distressed state.

Your organisation should also keep you up to date with information and training and links to sources for further information including specialist support.

Find out more about crisis assessment and treatment team (CATT) services: aspirelr.link/hd-catt

Manage risks of self-harm and harm to others

Self-harm
Causing deliberate physical harm to a person's own self, with or without the intention to end their life.

Some groups or people with certain experiences are more at risk of **self-harm** than others.

All groups of people can have thoughts or actions relating to self-harm. However, there are statistics that show it to be more common in certain groups. Here are some examples.

- People with mental illness, such as depression and anxiety, may be at higher risk of self-harm.
- Young people with traumatic upbringings, such as a history of physical or sexual abuse, bullying, family history of mental illness or other trauma, are among the groups at highest risk of self-harm.
- Certain personality types can be a factor in the tendency to self-harm. This includes people with addictive personalities, such as those who use alcohol and other drugs, people with low self-esteem, and people who define themselves as perfectionists.
- Younger females are more likely to self-harm than younger males, but they are also less likely to carry out suicidal thoughts than male young people or men.

The most common methods of self-harm among young people are cutting parts of the body and deliberately overdosing on medication (self-poisoning). Other methods include burning the body, pinching or scratching oneself, hitting or banging body parts, hanging and interfering with wound healing.

Indicators of self-harm

Indicators of self-harm fall into several categories such as:

Behavioural signs including:

- dressing inappropriately for the weather, such as wearing long-sleeved tops in the summer
- washing clothes separately
- interacting less or performing activities less well at home, school or work
- having unexplained wounds or unlikely justifications for injuries
- hiding potentially dangerous objects, such as razor blades or cigarette lighters.

Psychological signs including:

- expressing feelings of anxiety
- expressing feelings of depression.

Psychosocial signs including:

- lack of interest in hobbies that were once enjoyed
- disengaging from social interactions
- having difficulties communicating with loved ones
- having drastic mood swings
- changes from their usual eating and sleeping schedule.

Physical signs including:

- complaining of headaches or stomach pains with no explanation
- overdosing on medicine and requiring medical attention
- physical signs of self-harm on the body such as open wounds or cuts.

Source: www.healthdirect.gov.au/self-harm

People at risk of elder abuse

Elder abuse can occur when:

- there is improper use of the person's finances or property
- a person is restricted in their freedoms for no good reason
- pain or injury is intentionally inflicted
- sexual activity occurs without permission
- verbal intimidation occurs
- the necessities of life are withheld.

Elder abuse
Harming an older person using financial, physical, sexual or emotional means, or through neglect.

Common risk contributors for elder abuse are:

- physical frailty
- diminished independence
- dementia
- isolation
- loneliness
- stories of abuse or neglect (take these seriously and investigate).

Duty of care and risk management responsibilities include:

- responding according to service protocols
- increasing service, if possible
- discussing with the person protective behaviours and strategies
- developing a safety plan

- supporting the person to make a complaint
- monitoring the situation
- seeking feedback and information from the person
- seeking consent from the person to discuss the situation and solutions with trusted people
- discussing rights and options with the person
- reporting to emergency services when there is concern for safety.

Read more about elder abuse: aspirelr.link/what-is-elder-abuse

Video: Signs of elder abuse

Watch this video from the Australian Human Rights Commission on recognising the signs of elder abuse: aspirelr.link/yt-signs-elder-abuse

Identify three ways in which older people can experience abuse.

Impacts of generational abuse

Generational abuse can happen when someone continues the abuse that was done to them onto others in their family or environment. This is a vicious cycle and one that is hard to break. Mistrust and hopelessness can fuel this cycle.

Examples are when:

- an adult repeats the same physical punishments to their children as they experienced from their parents
- a child who grew up being controlled by their parents and limited in their freedoms to the extreme takes this controlling attitude into their adult relationships
- a person who has experienced sexual abuse by trusted adults in their life repeats this behaviour with people in their care.

Not every person who experienced abuse ends up abusing others: never presume that someone will be an abuser because they were once the victim of abuse. People are at risk of continuing abusive cycles when they have not acknowledged what has happened to them in the past or when they feel resentful about their past. It may be that they minimise or even deny their experience.

People who have been abused in the past are vulnerable to becoming victims of abuse again in the future. Research from the University of South Australia shows that there is a clear link between parents who were the victims of abuse and the likelihood of their children experiencing abuse.

According to the Australian Institute of Family Studies, the long-term consequences of child abuse and neglect can lead to:

- physical health problems
- mental health problems
- suicidal behaviour
- eating disorders and obesity
- alcohol and substance abuse behavioural issues
- aggression, violence and criminal behaviour
- high-risk sexual behaviour
- homelessness.

Read the research produced by the Australian Institute of Family Studies on the effects of child abuse for adult survivors: aspirelr.link/aifs-child-abuse-adult-survivors

Ways to support people receiving services to break the cycle may include:

- connecting them with peers such as talking groups for survivors of FDV
- connecting a person to positive role models such as older people in their community
- referring clients to specialist services and support such as a psychologist
- reporting situations of concern where needed, following state/territory mandatory reporting legislation.

People of cultural and linguistic diversity

Clients must receive support services that are culturally appropriate.

The ability to express cultural traditions and needs is a key factor in maintaining emotional and psychological wellbeing.

Anti-discrimination laws and regulations make it illegal to discriminate against anyone because of their cultural, religious or racial background.

Community services organisations must have policies and procedures that result in the provision of culturally competent support. These include needs identification and assessment processes that identify the client's cultural and spiritual needs, and services that recognise and accommodate these needs. **Cultural competence** is more than simply accepting differences.

Cultural competence Having awareness, respect and understanding of the cultural diversity around you.

Cultural competence begins with:
• genuinely valuing diversity, resulting in clients experiencing cultural and emotional safety • factoring cultural needs into support services in a genuine and meaningful way • not expecting clients to relinquish their cultural beliefs and practices to receive support services • not stereotyping people based on their cultural backgrounds • practising self-reflection in relation to your own attitudes, biases and prejudices.

Culturally competent case coordinators are flexible and can work with the cultural requirements of their clients. Significant cultural needs can form part of the overall picture of a client's 'complex needs'.

Identifying cultural needs can occur during assessment and should be recorded in the person's plan. Here are some cultural aspects of a person's life that are important to them and must be considered as part of the case management and coordination of services.

Food preferences
Clients may have dietary requirements of cultural or religious significance, such as halal, kosher or vegetarian meals.
Dress and adornments
Clients may have cultural or religious/spiritual needs such as women wearing a hijab, niqab or burqa, or men wearing a head covering. Some faiths require specific jewellery or adornments to be worn.
Gender of staff
In some cultures it may not be appropriate for a person to be supported or cared for by a person of a different gender.
Religious and cultural observances
Clients may observe festivals or sacred days such as Ramadan or the Sabbath. They may spend time praying, fasting, avoiding certain activities or visiting a place of worship. Examples of service requirements are: • arrange a private space for prayer or rituals • change service/appointment times to accommodate religious and cultural practices • link people with cultural or religious leaders (e.g. healer, priest, rabbi, Elder) • link people with relevant groups.

Decision-making protocols

People accessing services may have cultural preferences to liaise or communicate with male personnel in regard to decision-making, or giving or receiving information. Some cultures and faiths require that a senior male family member makes decisions regarding medical treatment.

Examples of service requirements and responsibilities are that the case coordinator may need to:

- monitor to ensure that no disempowerment occurs (e.g. other family members being forced to relinquish their rights to make decisions due to this protocol)
- consult with cultural experts and arrange cultural mediation if needed
- provide non-judgmental practice.

Recently immigrated

Clients who arrived in Australia recently may need specialised support to adjust to a new culture and deal with the experiences they have been through in getting here. You may need to support a client who:

- has or is applying for refugee status
- has been in detention
- has experienced trauma
- has culture shock
- has been separated from their family
- faces discrimination or ostracism.

The case coordinator may need to:

- foster links to local cultural and community groups
- provide language support
- organise services to support with experiences of trauma
- help the client to understand laws and acceptable practices in Australia to prevent engagement with the criminal justice system
- connect the client with training and educational opportunities
- consult with cultural advisers and interpreters.

Diversity of family structures

Family structures may work differently across cultures. In First Nations cultures, the family is often seen as a wider construct and aunties, uncles and grandparents can be closely involved in the care of children. It is important to realise and respect this and not to assume whom to address.

All family structures must be respected – except in situations that breach Australian law, such as underage marriage. If you are concerned about the legality of a situation or a person's safety, follow organisational procedures and mandatory reporting requirements to alert the appropriate authority.

Considerations when working with First Nations peoples

Case managers need to understand the history, protocols and systems of First Nations cultures.

Acknowledging the history of First Nations peoples, particularly the effects of colonisation, gives non-Indigenous people an insight into the contemporary, physical, mental, social, economic and political situations of First Nations peoples.

Post colonisation history
• White settlers robbed First Nations peoples of much of their connection to the land, their spirituality and their culture. Conflict with settlers, forced relocation, massacres, inhumane treatment and introduced diseases such as smallpox dramatically reduced the population. • The European way of 'managing' First Nations peoples was to remove them from their traditional lands and force them to live on reserves, stations or missions. Assimilation was a government policy that saw forceful attempts to absorb First Nations peoples 'not of full blood' into white culture. These actions left long-lasting emotional and cultural scars.
The stolen generations
• The term 'stolen generations' refers to the implementation of Aboriginal child welfare policies from the 1930s, most notably during the 1950s, up to the 1970s. Over this period around 100,000 Aboriginal children were forcibly removed from their families in the mistaken belief that they would be better off living in a white community. The children were raised by church organisations, fostered or adopted by white parents, or placed in state institutions. Because they were so young when they were taken and there was little documentation kept at the time, many grew up not knowing who their parents were, and were denied their heritage and culture. • The legacy of the stolen generations has had an enormous impact on First Nations communities. In 2008, the Australian Government formally apologised for past events as a first step in reconciliation leading to the social, economic and political inclusion of First Nations peoples in Australian society.

To learn more about First Nations peoples' history, visit the Australian Institute of Aboriginal and Torres Strait Islander Studies website: aspirelr.link/asa

First Nations peoples' interactions with services

The dominance of Western culture in our institutions – along with the ongoing effects of European settlement and racism and discrimination – can impact on First Nations peoples' engagement with services.

Australian institutions such as hospitals, schools, community services and government organisations mostly operate according to Western beliefs and values. For example, our healthcare systems are built on a biomedical model which focuses on the physical and biological aspects of disease and illness. It is associated with the diagnoses, cure and treatment of disease.

The biomedical model contrasts with non-Western holistic understandings of health, which consider the physical, mental, spiritual and social factors that contribute to health and wellbeing.

Western views are also embedded in the way Australian institutions operate. For example, hospitals often have policies regarding 'close family' – only a person's close family, for example, might be able to visit. From a Western perspective, close family is partner, parent or child. However, a person who might be considered 'distant family' in Western culture – such as a second cousin – might be 'close family' for a First Nations person.

Critical factor that influences communication and relationships	Description
Language	Hundreds of First Nations languages and dialects are spoken in present-day Australia and for some people, English is not their first or second language. Interpreters for people who speak First Nations languages are often not available, even in situations where they are clearly essential – such as serious court cases and medical emergencies.
Cultural rules, norms and values	Cultural rules, norms and values affect how people communicate. For example, some First Nations people and non-Indigenous people may have different attitudes and responses to silence. During a conversation, a First Nations person might be silent because they want to listen to others' opinions before they offer their own. A non-Indigenous person might interpret that silence as an indication that they have not understood what has been communicated. An awareness and understanding of local First Nations cultures can help service providers communicate effectively and develop positive relationships with First Nations peoples.
Trust	Trust is key to effective communication and relationships between First Nations peoples and non-Indigenous services. First Nations peoples may be wary of non-Indigenous services because of previous disempowering or negative or harmful experiences of those service systems. Some First Nations peoples will be reluctant to talk to service providers they do not know.

Critical factor that influences communication and relationships	Description
Respect	Demonstrating respect facilitates effective communication with clients, but people from different cultures show respect in different ways. Actions which are especially important for demonstrating respect when communicating with First Nations peoples include the following: • being mindful of your nonverbal communication • being mindful of the other person's body language (e.g. modify your eye contact if they are avoiding eye contact with you) • avoiding discussions in open or public spaces • being conscious about personal space – standing too close to someone you do not know or of the opposite gender may make them feel uncomfortable • seeking permission and explaining why you need to touch a client • being prepared to leave the room if a matter needs to be discussed in private by a family • respecting the critical role of Elders and paying appropriate respect to their status.
Empowerment	Empowerment is a critical aspect of effective communication and relationships with First Nations peoples. Like any other client group that you work with, First Nations peoples have the right to participate meaningfully in decisions that impact on them. In fact, this is even more important when working with First Nations peoples, because in the past their right to self-determination has been consistently denied. Do not make assumptions about what a First Nations person wants or needs. Respect that First Nations peoples know what is best for them, their families and communities.

Sources: www.sahealth.sa.gov.au/wps/wcm/connect/b9a2f58042371fd89d6ffdef0dac2aff/SA+Health+Guide+to+Engaging+with+Aboriginal+People.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-b9a2f58042371fd89d6ffdef0dac2aff-nKPZv-t; https://theconversation.com/the-state-of-australias-indigenous-languages-and-how-we-can-help-people-speak-them-more-often-109662

Practice Task 4

Question 1

Which of the following indicate that the worker has followed their duty of care responsibilities? Select yes or no for each one.

a. Li-Mei is speaking to Jessie, who is 8 years old and has a single parent with an intellectual disability. Li-Mei notes that Jessie's parent has trouble emotionally self-regulating and often gets angry at Jessie. Li-Mei realises that Jessie has an elevated risk of abuse. Li-Mei completes a report and discusses this with her supervisor. She brings together Jessie's family and support staff to support Jessie and speak to her mother about a positive parenting program. Li-Mei will continue to monitor the situation.	Yes / No
b. Jeremy is coordinating care for Sarah, who is experiencing family and domestic violence. He organises immediate first aid and completes organisational referrals for emergency housing. Sarah's adult son calls the service and asks to speak with Sarah's case coordinator. Jeremy tells him that Sarah is at the safe house and gives him the address.	Yes / No
c. Alison is a case coordinator for Ahmad, who has become isolated from his family as a result of a dispute over a parenting agreement for the couple's children. Ahmad's distress over his situation has escalated. Ahmad says, "This is getting too much for me. I'm not sure how much more I can take." Alison discusses mental health support with Ahmad, who agrees that talking to someone would be helpful. Alison refers Ahmad to a mental health service and notes that support is urgent because of the high-risk situation and completes a referral according to service requirements.	Yes / No
d. Kendal is the case coordinator for Prisha, who is 84 years old. Kendal notices that Prisha is having trouble reading and asks if she has forgotten her glasses. Prisha reluctantly takes her glasses out of her purse. They are broken. Kendal asks if everything is okay at home, and Prisha starts to cry. "Sometimes my son loses his temper with me over money, but I don't want to get him into trouble," she says. Kendal develops a safety plan with Prisha. Prisha does not want to report her son and does not want support services involved.	Yes / No
e. Kamaria is a case coordinator for Sam, who has a history of self-harm. Sam (pronouns 'they/them') is saving for sex reassignment surgery. They live at home with their mother, who is against the surgery and is embarrassed by Kamaria. One afternoon Sam is on the phone with their mother and is vigorously scratching their skin with a sharp object and it is beginning to bleed. Kamaria calls an ambulance and reports the situation to her supervisor. She continues to keep in close contact with Sam and monitors the situation for signs that suggest escalation and increased risk.	Yes / No

Question 2

Briefly outline how cultural competence can help a coordinator uphold their duty of care responsibilities to people from culturally and linguistically diverse backgrounds.

Question 3

Provide two examples of the impacts of generational abuse.

Question 4

Suggest how learning about First Nations histories can improve the way a worker supports First Nations peoples who are accessing services.

2B Provide information to suit communication requirements and preferences

Clients need information on service options so they can give informed consent.

Clients also need to know about the coordination role so they understand the process. This is part of a person-centred approach where clients have the information they need to be able to participate in decisions that affect them.

Clients need to know about:

- the case coordination role, including the limits and boundaries of the role
- the case coordination process
- the purpose and process of case meetings and the intended outcome of the meeting
- how and when they will be communicated with
- the complaints process in the service
- their rights and responsibilities when using the service.

Establish communication requirements and preferences

Communication needs will be identified at the intake and as part of the person's initial needs assessment. In all client contacts, the case manager must make reasonable attempts to identify and address communication needs as early as possible, and use the communication methods that are most appropriate to the person receiving services. For example, people who have English as a second language (ESL) have the right to access communication in their first language, and to be heard and understood.

Clients' communication requirements can include:

- using alternative or augmentative communication, such as communication boards or communication apps
- using family members or others to support clients with diminished communication abilities
- engaging with a client's guardian (a person who is appointed to make decisions on their behalf)
- inviting a chosen family member to facilitate emotional or cultural safety
- providing information about the client's rights and responsibilities in audio, braille, plain English or another accessible format
- finding a support person representing the person if the person cannot provide informed consent
- arranging a person to interpret using sign language
- organising interpreting services for clients who have ESL.

Some barriers to communication can be addressed.

Communication impairment
Changes to a person's ability to use, process or understand verbal or nonverbal communication as the result of a physical, sensory or neurological disability.

Communication barriers due to communication impairment

If you think that the person accessing support does not always understand what you are saying or they are having trouble responding to you, an assessment from a speech pathologist could be recommended. It is important to check with the person and in their history (if available) that this has not happened yet before referring.

Cues that this may be the issue:

- Previous or current diagnosis of learning or intellectual disability
- Person talked about issues in school (e.g. left school at early age)
- Person asks you the same question repeatedly
- Person does not follow directions
- Certain activities seem to evoke escalation (e.g. person has outbursts during reading activities

Strategies that you can use to communicate:

- Using plain English and avoiding jargon
- Using **augmentative communication**, such as communication boards or tablet-based communication apps
- Providing resources in audio format or access to print or website resources the person can read in their own time
- Using family members or others to support clients with diminished expressive and/or receptive communication ability
- Checking that the person understands by asking questions before moving on
- Engaging with a client's guardian (a person who is appointed to make decisions on behalf of the client)
- Working together with specialists like speech pathologists or occupational therapists

Augmentative communication
A method used to supplement speech, when the person has some speech, in order to make it easier for them to use speech or to be understood when speaking.

Communication barriers due to cultural protocols or needs
Cues that this may be the issue: • Person appears uncomfortable when in the same space as you • Person does not engage with you Strategies that you can use to communicate: • Asking the person about their culture and protocols, if appropriate • Checking if there is a staff member available from the same culture • Inviting a chosen family member to facilitate emotional or cultural safety • Including a family member or Elder to respect cultural protocols • Seeking advice or support from a relevant cultural support group or cultural broker • Allowing for time to negotiate with family members for decision-making
Communication barriers due to trauma
If a person has recently experienced trauma or is still in an abusive situation, the support network will need to be aware of this and potentially adjust their communication. For a person who has experienced trauma, their brain may be in permanent flight/fight/freeze mode and this may mean they have limited capacity to take on and process new information. Cues that this may be the issue: • Person takes longer than average to reply • Person seems preoccupied during conversations • Person often appears to be daydreaming or has trouble focusing Strategies that you can use to communicate: • Inviting a chosen trusted person to facilitate emotional safety • Giving the person time to respond • Engaging in short conversations and addressing one issue at a time • Working on establishing a trusting relationship before having intrusive conversations

Example

Upholding cross-cultural communication

Genevieve is developing a set of community request cards that Tran can take with him when he is out in the community. Tran speaks Vietnamese, with only a few words of English. Genevieve speaks to Tran's sister, Hon, about how she could personalise the cards to meet Tran's cultural and language needs. Hon makes a series of suggestions that include:

- creating cards with a range of specific Vietnamese foods that she knows that Tran enjoys
- including both English and Vietnamese words on the cards, so that they can be used to communicate with people who speak either language.

Tran helps with the translations, and to locate images of favourite Vietnamese foods that Genevieve has not heard of or seen before.

Example

Confirming the person's communication capabilities

Jelena is supporting Mark, a 20-year-old man who has autism. Mark has difficulty understanding abstract ideas, and he is slow to understand and communicate using language. Jelena is working with Mark's speech therapist to help create new methods to help him to communicate more effectively. The speech therapist asks Jelena to help assess and confirm Mark's capabilities.

Jelena records the following information about Mark:

- Mark is reluctant to use eye contact or to observe gestures used by others.
- Mark has good fine motor skills.
- Mark has difficulty understanding the meaning of words, and he has a preference for pointing to objects rather than naming them.
- Mark likes to look at photographs, naming people and objects as he points to the image.

Although the therapist was considering teaching Mark to use key word sign to support his language development, this information has indicated to her that Mark's preference lies in using photos and pictures to support language.

Assess needs for interpreter and translation support

Interpreter
A person or technology that translates speech from one language to another to assist another person's understanding.

An **interpreter** or translator can help if there is a communication barrier and decisions about support need to be made.

Interpreters can be used in different ways, including face-to-face, and through phone and video call conversations. They must understand exactly what the worker wants to communicate to the person receiving services.

An interpreter's role is to translate the spoken word in a live context.

A translator is responsible for translating text and this is often not done in 'real time'; that is, in front of others.

By using an interpreter or translator, people accessing services may be able to direct their own care, self-advocate, make a complaint, request or suggestion, or make their own legal, medical and financial decisions more appropriately and effectively.

Tips when using an interpreter include:

- Always speak to the person you are supporting, not the interpreter.
- Allow the interpreter to finish before you start to talk again.
- Do not use medical terms the interpreter may not understand or be able to explain.

The following groups of people may benefit from the services of a translator or interpreter.

Workers	Workers who support people may need to use an interpreter to ensure the organisation has the correct information about each person; for example, the person's health issues, ability to self-direct their own care, mobility needs and any other support requirements.
Clients	People accessing services may benefit from using an interpreter or translating service so they fully understand the service provided to them. All people must understand any documents they need to sign.
Family	Family members and/or carers also need to understand the service provided to the person, particularly in regard to specific care and/or medication.

Choosing an interpreter

There are many factors to consider when selecting an interpreter for a client.

Interpreters from the same culture
Workplaces that provide care to people from more than one culture often have a register of interpreters that includes names, contact details and the languages they speak. An interpreter from the same culture can make a client feel comfortable.
Interpreters of the same gender
Workplaces usually try to use an interpreter of the same gender as the person accessing services. This may help the person relax when personal questions are being asked. For example, a woman who has a urinary tract infection may not want to talk about this with a male interpreter.
Allow time
Interviews and conversations may take longer when you are using an interpreter, as everything needs to be said twice – by the support worker and then by the interpreter.

Professional interpreters and translators
Ensure the interpreter or translator you engage is fully accredited. The following organisations can help you find accredited interpreters and translators: • The Translating and Interpreting National Service can link you with accredited translators and interpreters. • The Department of Immigration and Border Protection has a translating and interpreting service you can use. • The Australian Institute of Interpreters and Translators has more than 750 interpreters, who speak over 30 languages. • The National Auslan Interpreter Booking Service provides bookings to sign language users. Also consider the costs – using a professional interpreter from an agency may cost money.
Other interpreters
Sometimes a professional interpreter is not accessible, and you may need to ask support from someone else, such as: • other staff members • a community group • volunteers • the client's friends and family members. Consider any privacy or confidentiality breaches that may arise from using non-professional interpreters.

Sign language interpreters

People who are hearing impaired may use an interpreter to help them communicate with others.

Auslan is the official language of the deaf community in Australia. It is a form of signed communication using hand gestures. Auslan interpreters can be booked by phone or online via the National Auslan Interpreter Booking Service, which is funded by the Australian Government. People can use the service if they require Auslan to communicate and would like an interpreter to book healthcare providers. The service also provides resources for service providers.

You can access the Auslan interpreting service booking website at: aspirelr.link/nabs

When booking an interpreter, keep in mind that some people may use Signed English or another signing method as an alternative to Auslan.

Auslan Signbank provides an online video dictionary at: aspirelr.link/auslan-dictionary

Example

Recognise and support communication needs

Joseph is deaf and uses sign language. Joseph's 70-year-old mother, Ming, emigrated from China and speaks Cantonese. Both Ming and Joseph use limited English, and in-depth communication can be difficult. Several significant conflicts have developed between Ming and Joseph, and there is confusion and resentment about the options for aged care for Ming. Danielle is the case manager working with Joseph and his family.

Ming and Joseph agree to have a meeting to resolve some of their difficulties. Danielle books an Auslan and Cantonese interpreter. Danielle allows extra time for the meeting as using two interpreters may mean the meeting will take longer. It will be a complex discussion. There must be enough time for Ming and Joseph to express their views without feeling pressured.

Danielle allows for two and a half hours. The meeting is very successful. Ming says she has never had an opportunity to talk like this before. Both Ming and Joseph express their concerns and fears as well as their needs. The issues are not resolved in this one meeting, but good progress has been made.

Family structure and dynamics consideration in communication and decision-making

Family structure, and the dynamics of a family, can affect communication and decision-making processes.

When case coordination involves a family or a carer, the coordination will be influenced by the way that family network works. For a person receiving services, this will depend on them giving their consent for family to be involved. For example, negotiations need to include family if family members are needed to drive the person to appointments or if it is a young person or child.

Family structure and roles vary. In patriarchal cultures, the most senior man is the head of the household and is responsible for the family and decision-making. In matriarchal cultures, the grandmother or mother is the head of the family. In some families, the grandparents or guardians make the decisions; in other families, all members are consulted. This can influence decisions made by the person receiving services or as a group or by a single person who is considered the head of the family.

Tips for working with family dynamics:

- Remember who is the client and that you are their advocate.
- Always check with the person accessing support on who they want involved. Set up safe spaces for meetings with family members when there is conflict or unresolved issues where you or another service act as a mediator/facilitator.
- Take into account cultural considerations and learn about the family structure and protocols.
- Create opportunities for private discussions where needed; for example, if you notice the person is hesitant to speak up in front of their parents or an elder.

Practice Task 5

Question 1

Identify at least three types of information that a client should be given about the role and responsibilities of a case coordinator.

Question 2

Suggest three things a coordinator can do to identify and support the communication preferences of their clients.

Question 3

Briefly outline a situation where a translator and when an interpreter would be needed with a client whose first language is not English.

Question 4

Suggest two strategies a case coordinator can use to show consideration of their client's family structure, family dynamics and ways decisions are made.

2C Work with the person and other services to access services

Case management involves a continuous cycle of identifying, analysing and addressing the person's needs.

A case manager shares information with the client and collaborates with other services or professionals on the client's behalf on the delivery of services to meet their goals outlined in their plan.

In some cases, a person accessing services describes situations or finds it difficult to meet their goals because of the barriers they face. Here are some examples of the types of barriers that cause issues or can prevent or delay the person attaining the outcomes identified in their plan:

- fear for their safety (e.g. the person may have been told "you will be found" if they dare to leave)
- fear for safety of their loved ones – often children or other loved ones are threatened for the abuser to have 'power' over the person
- belief that they deserve the situation or circumstances they find themselves in and are reluctant to make a change
- distrust of authority based on intergenerational issues or experiences
- fear of not being believed due to not being believed in the past
- distrust of the system or what will happen next such as children being removed
- fear of unknown (e.g. preferring abusive father over unknown foster family).

Here is a list of specific barriers that can hinder a client attaining their goals and outcomes.

Barrier

- Alcohol and other drugs (AOD) issues

Ways to address barrier

- Include strategies for AOD use in plan.
- Suggest harm minimisation strategies to support safety of the person.
- Apply organisational policies for clients attending appointments or services while intoxicated.
- Encourage the person to access services and support that will help them reduce substance use.
- Support the person to find medical support, such as a GP they feel comfortable with.

Barrier

- Mental health issues

Ways to address barrier

- Develop an understanding of the person's mental health issues and how this impacts them.
- Do not assume there is limited understanding or capacity.
- Work with the person's mental health services to optimise support for mental health needs.
- Optimise funding opportunities for mental health support.
- Engage with the person's representatives, advocates or decision-makers where needed.

Barrier

- Lack of natural support (family or friends)

Ways to address barrier

- Explore funding opportunities for transport if it is hard to attend appointments.
- Source the most effective services to meet the person's needs.
- Access services provided by volunteers, such as interest or support groups and transportation to appointments or other social support through sport.

Barrier

- Financial pressures make it difficult to get to appointments or purchase essentials

Ways to address barrier

- Help the client to access Centrelink welfare services.
- Access services provided by volunteers, such as transportation to appointments or social support.
- Arrange community assistance with food, clothing and furniture.
- Link the person with supports to increase skills in budgeting.
- Refer the person to a financial counsellor (free service).
- Explore the possibility of waiving fees, if appropriate.

Barrier

- Negative experience with a staff member or service

Ways to address barrier

- Acknowledge that something went wrong and apologise on behalf of the service.
- Find out what the problem was and seek a solution in collaboration with the person.
- Take corrective action in the organisation to prevent future occurrence, if applicable.
- Follow up with performance management of staff concerned, if applicable.
- Support the person to make a complaint.

Barrier

- Loss of trust in the system

Ways to address barrier

- Acknowledge past experiences.
- Work with the person to plan and select services in a way that optimises their interest and buy-in.
- Follow ethical and codes of conduct and keep professional boundaries at all times.
- If mistakes are made, acknowledge the error and apologise.
- Identify areas of loss of confidence in service provision.
- Follow through on commitments made to clients.

Barrier

- Unrealistic expectations of case coordinator or service

Ways to address barrier

- Make sure the person accessing services understands the roles, responsibilities, boundaries, processes and funding limits that apply to their client plan.
- Be clear about what you can help them with and the scope of the service.
- Provide information in the most appropriate format for the person accessing services.

Barriers to escaping disadvantage

Traditionally, advantage and disadvantage have been equated almost solely with economic factors such as income and levels of unemployment.

It is now understood that disadvantage comes about from a complex interplay of circumstances and not just low income. Poverty, deprivation, capabilities, lack of opportunities and social exclusion are all used to view and measure disadvantage. Many of these factors, when combined, can have a compounding effect and can result in it being difficult for the person to break the cycle of disadvantage.

People more likely to experience persistent disadvantage include: lone parents; First Nations Australians; people with a long-term health condition or disability; and people with low educational attainment.

According to a parliamentary report, there are other groups in Australian society that are more vulnerable to poverty and disadvantage in addition to those listed above including people living with a mental illness, single parents and newly arrived migrants (particularly those without English).

Sources: www.pc.gov.au/research/supporting/deep-persistent-disadvantage; www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Income_Inequality/Report/c04

The probability that any one person will experience disadvantage is influenced by:

- their personal capabilities and family circumstances
- the support they receive
- the community where they live (and the opportunities it offers)
- life events
- the broader economic and social environment.

Recent research with young Australians shows that those who experience more severe disadvantage are less able to engage and participate in school and report lower levels of life satisfaction, less positivity about the future and feel less safe than their peers. The link between child poverty and poor educational outcomes shows how the impacts can be felt well into the future.

Prioritise needs and communicate to service providers

Part of the development of the client's plan involves establishing goals and setting time lines for the achievement of those goals. The person accessing services may have identified several short- and/or long-term goals. As mentioned previously, too many goals can be overwhelming and unachievable. Applying the SMART framework is more likely to lead to achievable and realistic goals being set. If there is more than one goal or some goals are more urgent than others, then they may require prioritising.

To support a person in determining what their needs and priorities are you can ask questions like:

What is important to you at the moment?
What would it mean to you if you achieved this?
What would you need to achieve this?
Are there any major concerns or worries that you have at the moment?
If you could change one thing to your situation right now, what would it be?

The client's needs will need to be communicated and shared with other service providers so they are all aware of the person's wishes and can help support them to meet their goals.

As an advocate for the person, the case manager needs to ensure that the person's needs and priorities are respected. This may involve sharing information with health professionals, family members and arranging for crisis assessment if required, either in face-to-face meetings and documenting information in the person's plan, or case notes.

Example

Alex's story

Alex has not seen his daughter Susan for eight years and his priority is to restore his relationship with Susan.

Alex's case coordinator has an ethical obligation to work to support Alex's wishes to have a relationship with his daughter, while at the same time addressing his immediate physical health needs and need for more permanent accommodation so that his daughter would be able to visit him.

Alex and his case manager discuss making arrangements for Alex to meet with a family counselling agency to assist him to reconnect with his daughter.

Facilitate meetings to coordinate roles and responsibilities

As part of the coordination role, meetings are held for many reasons. For example:

- to share information about the client's priorities with other people involved in providing services for the person
- to check in regularly with the person receiving services and their network to review the plan
- to meet with a client and their family to follow up on a complaint, or to review the plan when there has been a change in goals, needs or priorities
- to confirm and clarify roles and responsibilities of the services and supports involved.

Here is an outline of a process to identify and prioritise needs in a meeting with the person accessing services and other service providers with different roles and responsibilities.

1. **Identify needs and priorities of the person.**

   It can be overwhelming for the person to work towards goals across many aspects of their life at the same time. Identify what the main issues (two or three at a time) are and focus on those.

2. **Collaborate on strategies to address needs.**

   Work with the person to assign several strategies to one need and have a mix of strategies including those that the person can do independently. For example, if a person wants to work on their physical health, you can refer them to a GP, nutritionist, physiotherapist and others. To empower the person to take control of what they can do, discuss other strategies such as going for a daily walk, eating two pieces of fruit per day and keeping a health journal. It can be important to identify any barriers the person may raise and to discuss how these will influence the outcomes the person is working towards.

3. **Assign roles to each strategy.**

   For each strategy, there may be one or several people responsible and different roles needed to make the strategy work.

4. **Review the plan and get agreement from the client and others involved.**

   Check and confirm that the most urgent needs are addressed and that all evident barriers have a strategy assigned. If other needs or any practical issues arise, go back to step 1.

Example

Alex's story continued

The case coordinator and Alex make a plan together and negotiate priorities and services.

Need	Strategy	Responsibility	Time frame/ priority
Feelings of depression	1. Family counselling	• Case manager to provide referral and set up first appointment. Case manager to contact Susan • Alex to show up and participate	• Set appointment in next three months
	2. AOD group	• Case manager to accompany Alex to weekly group	• Review in four weeks to see if Alex is ready to go independently

Need	Strategy	Responsibility	Time frame/ priority
Check on health issues	1. GP health check	• Alex to book appointment • Case manager to provide transport	• Within two weeks
	2. Access meals at the community centre	• Alex to have two meals per week at the community centre	• Ongoing. Review in four weeks to see if Alex likes it
	3. See dentist	• Alex to see free dentist at the community centre	• Within three months
Homelessness	• To be discussed at next meeting. Alex does not see this as a priority at the moment.		• Discuss within three months
Unemployment	• To be discussed at next meeting. Alex does not see this as a priority at the moment.		• Discuss within three months

Minimise confusion and concerns of the person, their family or carers

Accessing multiple services can cause confusion for some people.

The process of sourcing and coordinating multiple services can seem overwhelming for those outside of the sector. Bureaucratic processes and paperwork can be confusing even to staff. Service eligibility and funding can be complicated, and many clients struggle to understand these.

With a range of people and service providers involved, the person accessing services can feel overwhelmed by waiting times, choices and decisions they are required to make, and the range of different people they need to communicate with. Case managers need to be mindful of this and regulate the coordination of communications and paperwork. They need to set themselves up as the central hub for the person and their family.

Using multiple services can cause confusion and also create barriers to the client achieving their goals. Here are some examples:

- the use of complex terminology, acronyms and abbreviations
- funding complexities
- waiting times for services
- service eligibility requirements
- multiple appointments
- referral procedures
- case coordination process
- staff changes and turnover.

Sometimes a person accessing services or their family may not fully understand the need for or benefits of the services they have agreed to. This could be due to unclear explanations or information that is complex and difficult to understand. Confusion could also be due to an impairment such as an intellectual disability, a neurological condition, an acquired brain injury or mental health issue that affects concentration. Clients could also be affected by fatigue, pain, side effects from medication, effects from AOD, poor sleep or stress arising from trying to manage their symptoms and personal situation.

Information that is presented in a clear and straightforward way can help avoid confusion and help set realistic and reasonable expectations for the person accessing services and their family about the type and range of services they will receive. Here are some suggestions for ways to minimise any concerns:

- Use terms that can be understood by a layperson.
- Use **active listening** and reflective listening to check for understanding.
- Provide a fact sheet or glossary that explains terminology.
- Give as much information as necessary in a format that is suitable for the person.
- Refer the person to websites of funding bodies or encourage them to ask you questions at any time.
- Source user-friendly or plain English versions of information.
- Focus on clarifying the critical information.

Active listening
Concentrated listening and nonverbal encouragement indicating an understanding of what is being said.

- Help the person to keep a diary, calendar or reminder system in their phone to keep track of in-home or community appointments, dates and locations.
- Send reminders using the person's preferred method, such as a text message, email or phone call.
- Minimise changes to appointment times.
- Enlist a friend or family member to remind the person about appointments.
- Explain why there are meetings, assessments and forms to be filled in, focusing on the meaning or outcome for the person.
- Encourage the person or family to ask questions at any time.
- Give the person rosters showing which support staff will be attending.
- If a key support staff member is leaving or being taken off the person's services, give the person as much notice as possible and begin introducing the replacement.

Issues for the family and carers with multiple services

For many people, their family, partners and friends (natural network) may take on a caring role.

According to Carers Australia, carers are people who provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an AOD issue or who are frail and/or aged. It is estimated that carers make up nearly 11 per cent of the population.

When people in the client's natural network take on a caring role, the focus will often centre around the person's needs. This could be attending appointments, monitoring medication and providing personal care. This can leave little time for relaxation, family activities, or for other members of the family to have their needs met. It can also change family dynamics and the role of carer impacts on many other aspects of a person's life including financial, emotional and physical.

Here are some links to support services for young carers such as those caring for their parents: aspirelr.link/ycn-support-services

Read more about who carers are and the roles they fulfil: aspirelr.link/who-is-a-carer

Example

Manage service provision

Trevor uses a wheelchair because of a neurological condition. He has two dogs he cares for and has family support. Trevor's family usually check in daily and are able to take the dogs for a walk. His sister has just moved house, which means that there are a few days that Trevor doesn't get a visit and the dogs don't get a walk.

Trevor agrees for his case coordinator to contact Paraquad South Australia (PQSA) and after an assessment Trevor is eligible to receive services.

A meeting is organised with PQSA, his daughter and the case coordinator.

The three of them meet and agree on the following plan:

- PQSA volunteers will attend on Tuesdays and Fridays between 10am and 12pm.
- The main focus will be to take the dogs for a walk and check that they have water and food.
- If weather permits and Trevor feels like it, he will come along for a walk.
- PQSA volunteers will check in fortnightly for an informal phone chat.

Natasha, the case coordinator, writes the outcomes of the meeting in a plan and produces a weekly schedule that she sends to Trevor and his daughter. Natasha also prints and laminates a weekly schedule to hang on Trevor's fridge. This schedule has the number for PQSA in case he has any questions.

Formalise the meeting processes

The outcomes of some meetings are recorded in the client's case notes as 'records of contact'.

Case coordinators must ensure they understand and follow the processes required by their organisations. Minutes are used in meetings to safeguard against issues or actions being forgotten. In a formal meeting process, the minutes of a meeting will be accepted at the following meeting if all agree that they accurately reflect the meeting contents. This gives them credibility as a legal record of meetings.

The following processes can be followed in a formal meeting such as a case conference meeting where other service providers and/or specialist professionals attend.

Notice and agenda

These are often sent together to all who are expected to attend.

The notice:

- allows people to respond with their availability to join the meeting and how they will attend (in person or virtual)
- gives invitees adequate time in advance of the date so they can plan their attendance and prepare for the meeting.

The agenda:

- is sent to all invitees before the meeting so they can add the points they wish to discuss at the meeting
- lists items in the order they will be discussed
- states who is responsible for each item
- includes the date, time and duration of the meeting.

Chairperson (this may or may not be the case manager)

The chairperson:

- opens the meeting and welcomes the participants
- runs the meeting according to organisational standards
- keeps discussions on track
- keeps the meeting to the set time frame
- closes the meeting and thanks the participants.

Minute taker

The minute taker:

- takes notes in the meeting
- types up the minutes (a record of the meeting) using the appropriate workplace template
- sends out copies of minutes to attendees
- stores the minutes document in the allocated place.

Meeting guidelines

It can be recommended to set guidelines or ground rules for a meeting. This can happen in a short discussion at the start of the meeting and allows expectations of the meeting and participants to be set. Examples of guidelines are:

- Do not raise your voice.
- If you need a break, raise your hand.
- Share the space and time (let others talk).

Below are some tips for facilitating a meeting to ensure collaboration between all parties:

- Enable participants to contribute via phone or video link if they cannot attend in person.
- Ensure the client is central to the decision-making and participates in the discussion that affects them.
- Make sure the client feels 'safe' and everyone has a chance to contribute.
- Identify the priorities of the meeting.
- Explain the topics that are to be discussed in the meeting.
- Keep participants focused on the issue at hand.
- Give participants, particularly the client, enough time to discuss issues.
- Summarise the end of a discussion to clarify and confirm what has been said.

Practice Task 6

Question 1

Match each potential barrier to an effective strategy to support the client.

Loss of trust in the system	Include harm minimisation strategies and support clients to find medical support.
Unrealistic expectations of case coordinator	Optimise funding for support and do not assume that the person has limited understanding or capacity.
AOD issues	Help the client to access Centrelink services and link the person to assistance with food, clothing and furniture.
Mental health issues	Acknowledge past experiences and follow up on commitments made to the client.
Financial pressures	Explain the roles, responsibilities and processes that will be followed and the scope of the service being provided.

Question 2

Identify two examples of situations or circumstances that make a client more likely to experience persistent disadvantage.

Question 3

Provide two reasons why a client may find it helpful to prioritise their needs.

Question 4

List at least two groups that might need to be informed about the person's priorities for accessing services and supports.

Question 5

Identify three examples of features of a formal meeting.

Question 6

Identify at least one issue that may cause confusion to clients and their family/carers when accessing multiple services.

Summary

- Duty of care requires you to do whatever is fair and reasonable to prevent serious harm or injury to a person or their property.
- Part of person-centred care means explaining the coordination role to clients so they understand the process.
- Communication barriers and other barriers need to be identified early in the coordination process so effective strategies can be identified to meet the communication requirements of the client.
- An interpreter or translator can help if there is a communication barrier during a meeting or in written information.
- Family structure, and the dynamics of a family, can affect communication and decision-making processes.
- Some clients find it difficult to meet their goals because of the barriers they face.
- It is now understood that disadvantage comes about from a complex interplay of circumstances and not just low income.
- Prioritising needs and setting roles and responsibilities will allow for efficient care coordination.
- Sometimes a client or their family may not fully understand the need for or benefits of the services they have agreed to.
- The care coordination process can cause confusion for people. With the right strategies, this confusion can be minimised.

Learning Checkpoint 2

Support the person to access multiple services

Part A

1. Give at least three examples of duty of care processes that must be followed as a part of your job role.

2. Match each responsibility for duty of care to its description.

Impact of generational abuse	Carrying out mandatory reporting obligations required in the relevant state or territory
Barriers to escaping disadvantage	Referring to legal rulings on protection orders from the courts
Considerations of First Nations peoples	Asking the person about their thoughts of ending their life to assess the risk of harm including the risk of immediate harm
Children and young people	Discussing protective behaviours and strategies with the person
Family and domestic violence	Making a presumption that a client who experienced abuse will abuse others
Suicide	Recognising that combined factors can have a compounding effect and result in a cycle of disadvantage
Elder abuse	Understanding that the ongoing effects of European settlement and discrimination impact on First Nations peoples' engagement with services

3. Identify three things that need to be considered when arranging for an interpreter.

4. List four indicators that may mean a client is self-harming or harming others.

Part B

Read the case study and answer the questions that follow.

Case study

Sally works as a case coordinator at a centre that provides AOD services. Her client is Tamara, a married mother of two. One of her children has a physical disability and requires support with daily tasks and personal care. Tamara's mother-in-law lives in a small house at the back of the property and helps with meals and transporting the children to school and other activities.

Tamara has a highly stressful job which contributes to her dependency on alcohol as she knows she uses drinking as a coping mechanism. Tamara grew up in a large extended family with a close affiliation with a Greek Orthodox church since moving to Australia from Greece. Tamara still attends church services and events with her family. She is upset at the idea that her family will find out about her issues with alcohol and she finds it stressful to hide this personal information from them.

Tamara wants to minimise her alcohol use because she can see how it is negatively impacting her family. She has had three failed cease attempts in the past and is not confident she will ever be able to stay sober.

Sally has arranged a case coordination meeting with Tamara, her partner and two other staff members to discuss a case management plan.

1. Briefly outline Sally's duty of care responsibilities to Tamara.

2. Suggest how consideration of Tamara's cultural diversity relates to Sally's responsibilities of duty of care.

3. Give two examples of how the structure and dynamics of Tamara's family could influence the way she communicates and makes decisions.

4. How can Sally identify Tamara's preferences for ways to communicate case management information?

5. Identify at least three types of information Sally needs to give to Tamara about the coordination role and process for accessing services.

6. Give two examples of barriers Tamara may face in reaching her goal of minimising her alcohol use.

7. Identify at least three things Sally needs to do to prepare for the case coordination meeting with Tamara and the other support providers.

8. Why is it important that Tamara prioritises her needs and that she communicates these to the other service providers during the case coordination meeting?

9. Tamara's partner is confused about the roles of the different people in the meeting. What can Sally do to minimise his confusion?

Topic 3: Monitor the person's progress

3A Facilitate communication between services and manage duplication

3B Monitor progress towards goals and obtain feedback about services

3C Complete documentation according to policies and procedures

3A Facilitate communication between services and manage duplication

Coordination means streamlining the delivery of services to meet the needs of the person accessing support to avoid duplication.

Service duplication occurs when more than one service provider or person is unintentionally providing the same service as others. It can happen due to poor planning, coordination or monitoring. It can also occur because of a change of roles or responsibilities in the case coordination process. The result is wasted funding or over-utilising of resources. For example, if one organisation is being funded to provide a service, and another is duplicating the service, two allocations of funding are effectively being channelled into providing the same service. This can result in funding being used and not being able to be used for other essential services to meet the client's needs and goals.

Here are examples of the possible impacts of service duplication on client services.

Compromised future funding	Federal, state/territory and local government funding is allocated to clients to address specific needs that have been determined through a formal assessment process. Funding bodies require reports from service providers outlining how funding has been used and whether client goals have been met. If significant service duplication has occurred and goals have not been met, funding bodies may withhold future funding because existing funding has not been appropriately managed.
Increased client confusion	People accessing multiple services may struggle to understand or keep track of when a particular service is being provided, and by which service provider. Service duplication can increase this confusion when the person does not understand which services they have been allocated.
Outcomes not achieved	If one service is being duplicated, it is possible that another service is not being provided. It is possible that all the focus is on one need of the person and that their overall wellbeing or other urgent needs are not addressed.
Client loss of faith in the service	If the services are not producing the desired outcomes or duplication is causing confusion and stress for the person accessing services and their family, the person may lose faith in staff and cease to access the services, negatively affecting the person's health and wellbeing.

Prevent service duplication

Preventing service duplication requires effective communication between service providers.

There are several reasons why service duplication can occur:

- Staff may misunderstand or forget to consult the client plan.
- New services or supports are not given the client's plan and therefore do not have important information about the person accessing support.
- New staff have come into the role and have not had an adequate handover.
- There are changes in service provision or different service providers.
- There is a mix of formal and informal supports that are not being monitored, such as that a neighbour is helping in a particular way (informal support).
- Not enough time was allocated for initial planning and information was missed.
- The client cannot communicate or remember certain supports or services already in place.
- The client has had a change of needs and older supports no longer needed are still in place.

Communication between service providers and the case manager is essential for identifying and managing duplication. Poor communication and coordination between services can mean:

- The various roles and responsibilities of different providers have not been clarified and formally recorded in the client's plan.
- Service providers are not providing information to the person accessing services on how their funding is being spent.
- There are weak reporting requirements in place for monitoring the progress of the person towards their goals and the funding being provided to support those goals.

A well written client plan with actions and clear dates for review can prevent duplication of services. This includes monitoring each of the following aspects of the client's plan by:

- seeking regular client feedback on the delivery and quality of services received by the person
- documenting the tasks and responsibilities of each service and updating as needed
- communicating changes to the client's plan to all services involved

- establishing written and verbal reporting requirements for all service providers
- conducting regular review meetings and liaising regularly with service providers
- thinking critically about services and supports provided (what purpose do they serve?).

Example

Identify and manage service duplication

Trevor has recently had a stroke and needs extra services to support him with daily living skills and medical care. He has been receiving services from a volunteer group who meets with him, and together they walk his dogs. However, now Trevor is recovering from a stroke, he is unable to walk the dogs or accompany the volunteer dog walkers.

Staff from the volunteer organisation have contacted Trevor's case coordinator to say that several times they have arrived to find that the dogs are out because they are out with Trevor's neighbours.

Trevor admits that he is quite confused about all the services and is unsure who visits when. The case coordinator asks Trevor for his permission to arrange a meeting with all the people providing supports to discuss the support Trevor is receiving. Trevor agrees.

As a result of the meeting, they establish that there is a duplication of services.

It is decided that:

- The volunteer group will continue to provide dog walking services as Trevor wants this to continue and enjoys the company of the volunteers.
- The case manager will develop and communicate a walking schedule with the neighbours in the times when the volunteers are not coming.
- A communication system is arranged with the case coordinator as the central person receiving information from all of the groups and Trevor and his daughter.

The notes of the meeting are recorded in Trevor's plan and a copy is uploaded into Trevor's file.

Practice Task 7

Question 1

List two possible impacts on clients of service duplication.

Question 2

Which of the following are the possible causes for service duplication? Tick all that apply.

- ❑ The client's family has not been told to stop supports.
- ❑ The client is being difficult and wants to set up services themselves.
- ❑ The client's plan is not being followed.
- ❑ The client's plan is incomplete or not up-to-date.
- ❑ The client cannot remember certain supports or services already in place.

Question 3

Which of the following are ways to manage service duplication? Tick all that apply.

- ❑ Ensure regular review meetings and communication between service providers.
- ❑ Change supports so new providers can offer new ideas.
- ❑ Document the tasks and responsibilities of each service and keep information up-to-date.
- ❑ Seek client feedback as the user of services.
- ❑ Find suitable volunteers to take over some of the support tasks.

3B Monitor progress towards goals and obtain feedback about services

Monitoring goals confirms if services and supports being provided are meeting the needs of the person.

Case managers are responsible for monitoring the implementation of the client's plan. The person receiving services and other stakeholders such as family and carers should contribute to this process, and individual practitioners will monitor their own service area. The person's progress, any difficulties, funding allocations and any other aspects that have implications for the ongoing success of the plan need to be monitored. If there are issues or difficulties, they can be identified before they escalate into major issues. If changes need to be made to the plan, such as the priority of the client's needs, these can be made and the relevant services alerted to the changes.

Monitoring is done through a range of mechanisms, including observation, reporting and documentation, and client and stakeholder feedback. It may also involve testing in some situations, such as drug tests to monitor clients' use of illicit drugs.

Monitoring a client's progress towards their goals happens by:

- observing through engagement and discussion with the person and their family or other supports
- reviewing documentation such as reports from support staff or attendance at programs
- facilitating regular review meetings with the person receiving services to review goals and outcomes
- gathering feedback from the person and other stakeholders such as specialist services, supports and family and carers.

Monitoring involves acknowledging and celebrating milestones reached. The person should be encouraged to monitor their own progress and difficulties. They may use a diary or journal to keep track of improvements they have made and problems or worries that have arisen.

Monitoring the progression towards a goal requires the case coordinator and the person accessing services to work through the following questions:

- Have priorities changed?
- Is the current funding providing the services that are enabling the person to reach their goals?

- What evidence is there that short- or long-term goals are being met (or not being met) such as medical evidence and feedback?
- What outcomes are described in the plan? Have they been met or partially met?
- Are the time lines for achievement of goals realistic? Do they need to be adjusted/reviewed?
- Have services been available to support the person? Has there been a lack of staff or availability, or extended waiting times for specialist appointments?
- Who is responsible for collecting and analysing the indicators and monitoring the plan?
- How often are reviews and when will the next review be scheduled?

Example

Evidence indicators and monitoring mechanisms

Here is one example of how to monitor client progress in relation to the goals in the example from Topic 1: SMART goals.

Goal: Maintain blood glucose levels (BGL)
Evidence indicators • BGL readings • Client's feedback – Is the person managing the injections and BGL monitoring? Monitoring mechanisms • Client to record daily BGL readings • Dietitian to monitor • GP to monitor • 'Plate waste' – Is the person eating the Meals on Wheels food? • Client's feedback on meals • Review meeting in one month

Goal: To be able to move around independently
Evidence indicators • Can the person accessing support use a manual wheelchair with more ease, or for longer distances/time periods? • Client's level of functioning at home may improve, such as completing tasks that they could not do previously • Progress on electric wheelchair application **Monitoring mechanisms** • Physiotherapist: data collection of the client's progress at the sessions • Plan review meeting in one month • Client's feedback • Application outcome
Goal: Reduce social isolation
Evidence indicators • Attendance at Men's Shed • Interactions from meeting new people such as evidence of friendships **Monitoring mechanisms** • Client's feedback • Attendance patterns • Plan review meeting in one month
Goal: To work through depression and grief
Evidence indicators • Client not feeling in control of grief • Client feeling hopeful for future • Client feedback that sessions are helpful **Monitoring mechanisms** • Client's feedback • Feedback from psychologist • Plan review meeting in one month

Obtain feedback about services

Feedback about the services a person is receiving is a key element of effective service monitoring.

Client feedback will give information on the effectiveness of services and identify issues and barriers the person experiences. It can be collected using several methods such as a written hard copy document, online survey posted on the website or accessed by a weblink. Feedback may also be collected face-to-face or via video conferencing as part of regular meetings, 'check-ins' and other monitoring activities. The comments can be documented and recorded in the person's file. Sometimes carers or other family members or support people can give feedback about the person, especially if the person gives consent or is unable to communicate for themselves. Service providers will also be a good source of feedback and can give information on the person's interaction and engagement with services and progress towards their goals.

Clients can be encouraged to give feedback by:

- asking them regularly how they are feeling about supports and services
- communicating to the person that their feedback is valued and will be acted on
- acting on feedback and sharing results or progress with the person
- facilitating an open and transparent culture where clients feel safe to share their feedback including those things they are unhappy with
- supporting clients and their families/representatives to give feedback in ways they are comfortable and confident with, such as a written feedback form, an anonymous online survey or in a formal setting such as an interview
- organising regular review meetings where seeking feedback is part of the process.

Feedback is also important after a significant event or if there is an increased risk to the person. Feedback after an event can help prevent accidents and can provide important information on what went wrong and what went well. It should include the following:

- listening to their perspective of the event
- sharing your observations and explaining why you or someone in the service took action
- brainstorming what could be done differently next time or in a similar situation
- completing a safety plan (also known as risk management plan or crisis plan) to document and agree on what actions to take in certain scenarios
- documenting feedback from the person and sharing this with your team or organisation.

Planned reviews

Reviews occur within a scheduled time frame indicated in the person's plan.

Depending on the client situation, support requirements and organisation, regular review meetings will occur about every three months. Extra review should be held if there is a significant change in the person's circumstances. Review dates should be set at the formal planning meetings.

Depending on the changes, the review may be a full or partial plan review. Sometimes only a specific area of a client plan will need to be reviewed before the scheduled review date, as there has only been a small change.

Full plan review
Occurs when there has been a significant change to the circumstances, needs or preferences of the person **Example** A person has experienced a stroke, and their support needs have significantly changed. They are no longer receiving services in their home. Review through medical assessment and client feedback concluded that for the next six months the person will trial living in a residential service.
Partial plan review
Occurs when one aspect of the plan has changed and no full review is needed **Example** A client's daughter has been taking her father to his physiotherapy appointments, but can no longer do so. The client now has a need for a transport service. The case coordinator will determine if funding can be acquired for this, then source this service and add it to the client's plan.

Depending on the outcome of the review, there may be new goals or strategies. Applying the cycle of assessment, planning, monitoring and review ensures that changes to aspects of services will occur as needed, in response to the client's changing needs and preferences.

When a new client plan starts there may be changes to:

- goals
- strategies
- support staff, service providers
- resources (e.g. funding)
- support or appointment times
- venues/locations
- frequency of services.

Further support to meet changing needs

In some cases a case coordinator might identify or have evidence that a client is not engaging with services, seems frustrated or uninterested or shows other behaviour that suggests the current plan is not meeting their needs.

There can be multiple reasons for this and it is unhelpful to put the problem onto the person. It is the plan that needs to be reviewed and amended accordingly. A discussion needs to occur where the client and their network can work to explore what the barriers are. It is possible that changes to goals, services and/or extra supports are needed.

Examples of what may be happening for the person:

- The person was not central to the decision-making in the plan and the goals are not meaningful to them.
- The goals in the person's plan are no longer relevant or are not realistic.
- The time lines are too ambitious.
- The services being provided are not meeting or no longer meeting the needs of the person.
- The person has lost motivation and is no longer focused on their goals.
- Other needs have arisen that are more urgent such as finding housing instead of starting study.
- There are barriers that are making it difficult for the person to meet their goals and they are experiencing setbacks.
- The services are not culturally compatible or appropriate.

Exit from a service

Clients can exit from services because of a change in preferences, circumstances or funding arrangements. Some people transition to other services. In these instances, you will need to facilitate the transition with introductions, referrals and other appropriate strategies to make the transition easy for the person.

A client may exit a service because they:

- no longer require services that addressed a temporary need
- have met their goals
- are no longer eligible to continue receiving services
- find the service is no longer able to meet their needs
- have reached a certain age
- need to access different funding sources
- have moved away from the area in which they were receiving services
- have moved out of their own home into residential care
- have found another service that better suits their needs
- are not happy with the service.

Example

Identify and meet changing needs

Jan is a non-binary person (pronouns 'they/them') and is 23 years old. They have been with their youth mental health service for four years and have built up good rapport with their case manager, Pricillah. When they turned 22, they were referred to a housing agency that supports young people with mental health struggles to live independently. When Jan moved out on their own, they started to disengage from Pricillah and their family. The goals that they had previously to study at university and work in mental health were no longer important.

Pricillah recognised that something had changed and she called for a review meeting with Jan and their parents (with consent from Jan).

During the meeting Pricillah and Jan's parents talked about what they were observing from Jan: they seemed unhappy, disengaged and lost motivation to achieve their goals. Jan clarified that they were no longer their goals and that they were unsure of what they wanted to do. They said they had been feeling really lonely since moving out and that maybe they weren't ready to work in mental health because they still struggled with their own mental health.

From this, the group recognised and acknowledged that Jan was feeling lonely when living on their own. They brainstormed ideas and Jan liked the idea of a housemate. Pricillah and Jan made the plan to reach out to the housing agency and discuss options. If the housing service couldn't meet their needs, they would look at other organisations or private rentals. In the meantime, Jan would spend weekends back at home with their family or organise weekend activities with friends.

Practice Task 8

Question 1

List two ways a case manager can monitor a client's progress towards their goals.

Question 2

Which of the following are ways to encourage clients to give feedback? Tick all that apply.

- ❑ Sharing feedback provided by clients to their family
- ❑ Providing options for ways to give feedback such as online and in an interview
- ❑ Asking that clients give feedback on the fees charged for case coordination services
- ❑ Ensuring people receiving support feel comfortable providing negative feedback as well as positive comments
- ❑ Valuing feedback and demonstrating how it will be acted upon

Question 3

Give two examples of situations where further support may be needed to meet the changing needs of a client.

3C Complete documentation according to policies and procedures

Case coordinators are required to complete a wide range of documentation related to their role.

Documentation is a written record of all aspects of services delivered to clients, and the client's responses to the services. It may be in paper or electronic form, depending on organisational protocols.

Examples of documentation you may need to complete:

- case notes, progress notes and file notes
- assessment tools
- incident reports
- referral forms
- client plans
- funding applications
- hazard identification and risk assessment forms
- inter-organisational correspondence
- charts showing use of funding

Documentation protocols

Case management documentation must be completed in line with the protocols and principles for professional reporting. Organisations have their own policies and procedures for how and where to complete and store documentation. Workers need to understand these procedures and follow them to uphold the responsibilities of the role, particularly the confidentiality and privacy principles.

Most organisations have protocols for storing personal and private documents so they are secure and unable to be accessed by unauthorised people. This might include having password-protected access. Some protocols warn staff about leaving personal information in places where it can be read by others such as on computer or iPad screens or in physical folders.

There are also general principles for completing documentation that are the same across organisations. Implementing the following five principles will lead to best practice in documentation.

Objective
Documentation must be: • free from the influence of personal feelings, interpretations or prejudice • factual and not contain speculation (including speculation or suggestion about diagnoses) • free of judgment and bias.
Clear
Documentation must be: • easy to understand • logical • legible • concise and relevant (avoid writing lengthy and story-like notes) • written using professional language • free from unauthorised abbreviations or jargon.
Timely
Documentation must be completed: • according to organisational or legal time requirements (e.g. within 24 hours of an incident) • as soon after the events as possible, to ensure accurate recall.
Legally compliant
Documentation must comply with: • privacy legislation • human rights • any other relevant legal provisions such as anti-discrimination or work health and safety legislation.
Compliant with organisational requirements
Documentation must be: • in an approved format or template • signed off with your name, signature, designation, date and time.

Legal implications of documentation

Organisational documentation may be used in a court of law if legal action is undertaken.

A party in a court proceeding may issue a subpoena, which is an order that includes the power to compel a person or organisation to provide documents to the court.

In general, an organisation needs documentation to prove that it has complied with financial, ethical and other obligations relating to government departments, anti-discrimination and privacy, and legislation and regulations that govern community services.

Documentation is legally required to:

- form a record of care
- inform the next steps to be taken in client support
- facilitate continuity of care/support
- substantiate/prove duty of care
- record client refusal of services
- access and substantiate funding
- substantiate the need for extra or adjusted services
- substantiate eligibility for services
- determine appropriate services
- monitor and review services for ongoing effectiveness.

Practice Task 9

Question 1

Match the documentation principle to its description.

Legally compliant	Free from the influence of personal feelings, interpretations, prejudice and assumptions
Organisationally compliant	Free from jargon, easy to understand, concise and relevant
Securely stored	Completed as soon as possible after the event
Objective	In line with relevant legislation
Clear	In an approved format or template, signed off with your name, signature, designation, date and time
Timely	Saved using password-protected or cloud-based storage

Summary

- Coordination means streamlining the delivery of services to meet the needs of the client to avoid duplication.
- Effective communication between the person, services and supports can decrease the chances of service duplication.
- A well written client plan with actions and clear dates for review can prevent duplication of services.
- The client's progress, any difficulties, funding allocations and any other aspects that have implications for the ongoing success of the plan need to be monitored.
- Monitoring involves acknowledging and celebrating milestones reached, and identifying issues or barriers to progress.
- Planned reviews inform the next course of action in terms of the services and supports the person will receive.
- A case coordinator might identify or have evidence that the client is not engaging with services that suggests the current plan is not meeting their needs.
- Depending on the outcome of the review, there may be new goals or strategies to implement in the client plan.
- Documentation needs to be created and stored in line with organisational policies and procedures, and must comply with legal frameworks.

Learning Checkpoint 3

Monitor the person's progress

Read the case study and answer the questions that follow.

Case study

You are working as a project officer at a rural service that provides health and community services to First Nations peoples. You have been working with Sharon and her family since a bushfire went through the area that caused extensive damage seven months ago. Sharon used to work in town but the office is still being rebuilt and she has not been able to work. She has been experiencing anxiety since the fire and is keen to return to her job.

Recently, Sharon's partner lost his job and has started gambling, leading the family to move in with Sharon's aunt.

You connected Sharon to several support services including mental health supports such as an Aboriginal health service for her anxiety and food bank set up as a result of the fire. Sharon's extended family have been supporting her and she has a close relationship with her aunt. However, the stress of the large number of people living in the aunt's house is starting to build. Sharon says her aunt would never ask her to move as "we are family". Sharon would like to live in her own home and begin to establish herself more independently.

1. With several services and supports to coordinate for Sharon, how can you ensure there is no duplication of services?

2. Identify two ways you can monitor Sharon's progress towards her goals.

3. Identify two reasons for a review of Sharon's plan.

4. Suggest three ways you can get feedback about the services Sharon received.

5. How have Sharon's needs changed and what extra supports might she need to help reach her goal of having her own home?

6. Your supervisor wants a report on Sharon's plan and progress towards her goals. Suggest two things that you would need to consider when writing the report.

Glossary

Active listening

Concentrated listening and nonverbal encouragement indicating an understanding of what is being said.

Augmentative communication

A method used to supplement speech, when the person has some speech, in order to make it easier for them to use speech or to be understood when speaking.

Capacity building

Helping people to develop and strengthen skills that enable them to maintain independence.

Case manager

A worker or professional who has the central role of liaising with other professionals, networks and services to help make sure the person can meet their needs and goals.

Communication impairment

Changes to a person's ability to use, process or understand verbal or nonverbal communication as the result of a physical, sensory or neurological disability.

Cultural competence

Having awareness, respect and understanding of the cultural diversity around you.

Dignity of risk

A person's right to dignity and choice, upheld in legislation and service standards, to ensure that duty of care or safety is not used as a reason to limit a person's freedom of personal choice.

Discrimination

The act of excluding or treating a person differently based solely on an attribute such as disability, age, gender, race or sexual orientation.

Duty of care

A moral or legal obligation to ensure the safety and wellbeing of other persons.

Elder abuse

Harming an older person using financial, physical, sexual or emotional means, or through neglect.

Empowerment

The process of gaining strength and confidence to voice one's own opinion.

Evidence-based practice

Making use of real, current and validated research, data and information collected about the person and the industry to inform your work.

Inclusion

Providing equal access to opportunities and resources for people who might otherwise be excluded or left out.

Informed consent

A person's decision to agree to a healthcare treatment, having been informed about the intervention and any alternative options.

Interpreter

A person or technology that translates speech from one language to another to assist another person's understanding.

Lived experience

A person's personal knowledge about their own situation gained through direct, firsthand experience, or through cultural or generational exposure to discrimination, trauma or other experiences.

Mandatory reporting

The legal requirement of people in certain job roles and industries to report suspected or actual abuse to the police.

Person-centred approach

Providing tailored support for each person and taking time to learn about their individual preferences, needs and goals.

Self-determination

A person's right to have control over their own life and make independent choices about decisions that affect them.

Self-harm

Causing deliberate physical harm to a person's own self, with or without the intention to end their life.

Strengths-based approach

Recognises that all individuals are resourceful and resilient experts in their lives, and can progress in a way that enhances their quality of life.

Suicide ideation

Having thoughts of suicide.