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ACT

Case Management Practice and the ACT Child, Youth & Family Services Program

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CONTENTS

1. INTRODUCTION AND BACKGROUND

This report documents current research knowledge about case management approaches used to assist vulnerable people negotiate complex service systems. It details qualitative research undertaken to provide an understanding about the practices and experiences of case managers working in the Child, Youth and Family Services Program (CYFSP) in the ACT. The project's objective was to collect information to inform the development of a position paper and a proposed case management model that can be used in the context of the CYFSP for future development of policy and practice directions on case management.

The research questions were:
- How are CYFSP service providers conceptualizing and implementing case management activities?
- What is good case management practice in early intervention with vulnerable children, young people and families?
- What features of case management activities do service users feel they benefit from?

ACT Government Child, Youth and Family Services Program

The introduction of the Child, Youth and Family Services Program (CYFSP) in early 2012 was premised on the intention of simplifying the service system maze for people with clearer referral and intake pathways to secondary services. The service system landscape is fragmented, often features narrow, program-driven approaches, and for service users, a complexity of response is required in order to get what they need. The *Service Delivery Framework 2011-2014*, in merging and reforming youth and family support programs, set out to:
- Decrease the complexity of the service system by streamlining the number of intake, referral and information pathways and stand-alone service providers;
- Improve the capacity of funded service providers to work in partnership with primary service providers, particularly education and health, and specialist/targeted services (ACT Govt, 2011:6).

The service components that make up the CYFSP include case management, Child, Youth and Family Gateway (Information, Engagement and Coordination service) and network coordination services. The target group for the case management component is vulnerable children, young people and their families who require medium (more than three months) to long term assistance. The Service Delivery Framework does not provide a definition of case management or details of the purpose and model/s of case management being funded.

Providers of case management services are:
- Belconnen Community Service;
- Uniting Care Kippax;
- Woden Community Service/Southside Community Services/Anglicare Consortium;
- CatholicCare;
- Canberra Police Community Youth Club;
- The Smith Family;
- Gugan Gulwan Youth Aboriginal Corporation;
- Barnardos – Outreach Family Support, Intensive Intervention Service.

2. LITERATURE REVIEW

The scope of this rapid literature review is to report on dominant, contemporary models of case management, and draw together features of these models which are considered good practice and/or supported by evidence. This includes the perspectives of people who use case management services.

Methods

The literature was searched explored to identify articles and reports relevant to this review. The search strategy was conducted to identify peer reviewed and grey[1] literature incorporating qualitative and quantitative evaluation and research. Literature was obtained through key electronic databases including: Academic Search Premier, APAFT, Australian Family & Society Abstracts, Health Source Nursing Academic, JSTOR, Sage Journals Online, and Google Scholar. Government websites, clearinghouses, and Cochrane and Campbell Collaborations Libraries were also used. These searches were supplemented with scans of the reference lists of included articles and grey literature, and hand searching of a few journals.

Database searching was initially conducted using combinations of the following terms: "case management", "care coordination", "family", "children", "young people", "evaluation", and "outcomes". Papers were prioritised for review when they summarized a body of literature, and were most recent and relevant to the scope of the review.

Limitations of the literature review

The current existing evidence base on case management is dominated by research conducted in the United States, which has a strong emphasis on case management for people experiencing serious mental illness. Generally, there are a low number of experimental studies of case management regardless of the target population or field under investigation (Gronda, 2009). In Australia, there is a scarcity of research on case management, and the small number of studies that do exist are generally descriptive or program evaluations which lack in-depth qualitative analysis, or randomisation and a control group (Gronda, 2009).

2.1 WHAT IS CASE MANAGEMENT?

Exponential growth in the area of case management within community based services in Australia reflects the changing role of government from direct service delivery to people with complex circumstances to the procurement of services from non-government agencies services (Gursansky et al, 2012). Case management service provision arrangements are widespread and occur in social work, health, aged care, disability, correctional services, education, immigration settlement programs and other human service settings. This diversity in practical application has led to variations in Australian case management practice amongst both professionals and non-professionals who are engaged as case managers (Cooper & Yarmo Roberts, 2006). As such, the concept of case management is fluid, and there are various definitions and models in use resulting in a lack of standardization in understanding and utilisation ((Hall et al, 2002). Correspondingly, differences in its application have resulted in a lack of compelling evidence and consensus on the outcomes for service users, particularly in relation to its longitudinal effects (Vanderplasschen et al, 2007; Zwarenstein et al, 2011).

The widespread, and sometimes indiscriminate use of the term "case management" in policies, programs and procedures has created a situation whereby, as one author states, " it can seem that it means whatever one wants it to mean" (Schwartz et al cited in Moore, 2009:30). Gursansky and colleagues (2012) in their account of contemporary case management practice in Australia observe that significant diversity and inconsistency exists in terms of the design, application and practice of case management.

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[1] Grey literature refers to information produced by governments, academics, non-government organisations, etc. in electronic and print formats that is not produced by publishing companies.

The risk with this lack of clarity is that practitioners and service users do not grasp the purpose and processes of case management (Moore, 2009). This diversity in the types of models being implemented often leads to confusion over who is doing what and to what end (Gursansky et al, 2012).

Amidst the confusing array of definitions and models, there are some common themes within the application of case management in the human services. It is generally viewed as an approach to human service delivery and characterised by a series of logical processes. It can provide a framework with the aim of ensuring that people with multiple, complex and often chronic and lifelong needs receive a range of coordinated services (Moore, 2009). The emphasis is on "trying to make human service delivery work better" (Moxley, 1997:4) so that people can access a range of supports and services in the context of a highly complex and fragmented service system. To this end, it has been described by the Case Management Society of Australia (CMSA) as "a boundary spanning strategy to ensure that service provision is client rather than organizationally driven".

Moore and colleagues (2009) expand on the boundary spanning theme with their definition of case management:

> *An approach to practice that ensures vulnerable people with multiple, complex and sometimes lifelong needs are provided with a mix of personal, health and welfare supports and services, which enable them to establish and sustain their optimal independent personal and social functioning* (2009:101).

Gronda (2009) provides a similar purposeful definition of case management with an emphasis on people's self-care capacity:

> *An intervention which does not simply meet this or that need, but develops a person's capacity to self-manage their own access to any supports they need* (2009:7).

In contrast, the ACT Children, Young People and Families Program Practice Framework (FACT, 2011) provides a definition that focuses on the distinct functions of case management:

> *Case management* *is a collaborative process of assessment, case planning, case work and case coordination, facilitation and advocacy for service options to meet the individual needs of clients.*
>
> *Case work* *is the regular direct, contact with people that supports them to implement their case plan.*
>
> *Case coordination* *is a feature of case management and reflects the role often adopted by the case manager in the lead agency. Their role is to collaboratively manage and coordinate the multiple services that a client may require* (2012:9-10)*.*

One of the tensions between different types of case management approaches is the extent to which they are 'provider or system driven' or 'client-driven' (Moore, 2009). Efficiency lies at the heart of provider-driven approaches with case managers determining the nature, mix, intensity and duration of services. Common ingredients of this approach include:
- Use of standardised needs assessment tools to ration expensive services;
- Restricted range of services options to which practitioners match service users' needs;
- No opportunities for service users to have a voice in need identification and goal setting;
- Service coordination to maximize efficiency and reduce duplication;
- High-cost professional support is replaced by lower-cost informal supports (Moore, 2009:40).

In contrast, client-driven case management places a stronger emphasis on service effectiveness. Of significance is the collaborative relationship between the service user and case manager whereby the service user is viewed as the expert in terms of their needs and resources. Case managers work *with* service users on all case management processes, from identifying needs and strengths to monitoring the outcomes of action plans.

The role of the case manager is to provide "information, encouragement, support, mentoring, linkage to formal services, access to other resources and advocacy to overcome barriers to accessing services" (Moore, 2012:42). The concepts of client self-determination and empowerment inform all aspects of this approach.

The core characteristics of client-driven case management are illustrated by Gursansky and colleagues (2012:21):

- Case management is a form of individualised service delivery that emphasises the needs of the individual in their particular social situation.
- Consumers/clients and their carers are actively involved in building an understanding of their situation, their preferences and the plans that are determined as relevant to achieving their goals.
- Case plans are developed with the client and are expressed in terms of goals and objectives that acknowledge the responsibilities of all parties to the plan.
- The case manager carries particular responsibility for implementing the case plan with services drawn from a range of service providers, both formal and informal. The goal is to find the 'best mix' to meet the needs of the client, and where necessary create new options that better serve the client's needs.
- Case managers maintain an active role in monitoring the case plan, adapting it as necessary, and being responsive and timely in their actions.
- Case managers are mindful of the costs involved in the case management service arrangements, and are oriented to getting the best value from those service arrangements.
- Throughout the case management process, the case manager acts as an advocate to ensure that the plan is implemented.
- The case manager uses practice knowledge to improve practice, build knowledge about practice and contribute to system advocacy.

2.2 CASE MANAGEMENT MODELS

In the Australian and USA literature, particularly in the mental health arena, five models of case management dominate. These are clinical, broker-referral, intensive, assertive community treatment and strengths models. Within this literature there is a "blurring of models" and muddy distinctions between traditional models of case management and newer ones (Gursansky et al, 2012:27). This lack of standardization is the result of agencies implementing case management programs to meet local contexts and concerns relating to service user needs, the philosophical basis of clinical or social welfare programs, service system requirements and political environments (Hall et al, 2002). In relation to service users needs, Hall and colleagues (2002) assert that no single model alone is likely to be appropriate or effective for all client groups.

Delineating the differences between these models of case management is difficult (Bland et al, 2009). The core functions of case management (assessment, planning, linking, monitoring and advocacy) usually apply to a range of contemporary case management models. However, the distinguishing features of these models lie with the amount of service provision, service user participation and extent of case manager involvement (Vanderplasschen et al, 2007). Most of the models stress the need for effective team leadership, specific training for case managers and regular supervision. A brief outline of contemporary models of case management is given in this section of the report.

Clinical case management model
The clinical case management model is characterised by a combination of direct therapeutic work with other components of case management such as engagement, assessment, planning and intervention. It is the most common model of case management used in Australia (Moore, 2009). It integrates key elements of clinical expertise, personal involvement underpinned by a sustained relationship, and environment-centered interventions. The latter element refers to case managers linking people to community resources, consulting with family members and other carers, assisting people to maintain and expand their social networks, collaborating with health professionals and advocacy (Kanter, 1989).

The principles of this model (Kanter, 1989) are:
- Continuity of care;
- Genuine partnerships with people, their families and carers;
- Leveraging social supports and formal services to suit people's changing needs;
- Flexibility – tailoring frequency, duration and location of interventions to people's wishes and needs;
- Facilitating people's resourcefulness.

Its distinguishing features include the following (Morse, 1999; Simpson et al, 2003; Vanderplasschen et al, 2007):
- The case manager has a therapeutic role and is a role model;
- Use of outreach;
- Centrality of client-case manager relationship;
- Provides direct services and coordination of other services;
- Average case load is 10 people;
- Long-term relationship with clients.

Strengths Model

The purpose of the strengths model of case management is to assist people to recover and change their lives by identifying their personal goals, and acquiring and sustaining the resources they need to live in the community. Resources are those that are both external (e.g. relationships, opportunities, material resources) and internal (e.g. confidence, aspirations, competencies). This is in contrast to those case management models, for example the brokerage model, which focus solely on external resources. The strengths model emphasizes client self-determination and strengths rather than pathologising people's circumstances (Rapp & Goscha, 2006). The focus is on "resilience, rebound, possibility and transformation" (Saleebey, 1996:297) and working in partnership with service users. Central to this model is the understanding that all people have strengths and abilities including the ability to build their competence. This requires service systems to be designed to give service users the opportunity to display, use and build such strengths (Bland et al, 2009).

Rapp and Goscha (2006) advocate that the following six principles should underpin methods used in the strengths model:

1. People can recover, reclaim and transform their lives.
2. The focus is on individual strengths and abilities rather than deficits. This is not the same as just using a pathology orientation and "add strengths and stir". It means working with people in terms of what they have achieved so far, and their knowledge, talents and aspirations.
3. The community is viewed as an oasis of resources. This principle is the corollary of the one above as attention is focused on the strengths of the community. Natural community supports and resources such as family, neighbours, friends, volunteer opportunities, sports and other clubs, art groups are the priority as opposed to only accessing formal, professional services.
4. The client is the director of the helping process. Case managers should do nothing without the client's approval unless there are significant concerns about their safety and the safety of others. People should be involved in every step of case management activities.
5. The case manager-client relationship is primary and essential.
6. The primary setting for work is the community.

The distinguishing features of this model (Morse, 1999; Vanderplasschen et al, 2007) are:

- Practitioners implementing strengths-based case management need to continually emphasize strengths throughout their relationships with people. Brun and Rapp (2001) suggest that practitioners need to integrate the emphasis on strengths on a continuous basis especially during assessment and when setting goals with people;
- The use of assertive outreach;
- Client-case manager relationship is important;
- Low caseloads to ensure quality provision of service, with an average case load of 15;
- Case manager provides direct services and service coordination;
- Duration of support is ongoing.

Assertive case management model

This model of case management is sometimes referred to as assertive community treatment or intensive case management. It is clearly defined and has explicit criteria for implementation, i.e., fidelity standards, to ensure that better outcomes for people can be achieved. These standards necessitate specific uniform structures or services be in place. Although the increasing focus on recovery-oriented approaches that strive to create individually tailored service responses for people may potentially raise tensions with assertive case management evidence based practice (Salyers & Tsemberis, 2007).

It has undergone more rigorous and extensive evaluation than other models of case management (Coldwell & Bender, 2007, Vanderplasschen et al, 2007). Originally developed for community mental health, this model has been adapted for people who are both homeless and have severe mental illness (Salyers & Tsemberis, 2007). It is distinguished from other models by the following features (Coldwell & Bender, 2007; Lehman et al, 1997; Salyers & Tsemberis, 2007):

- Teams of multidisciplinary practitioners;
- All team members provide comprehensive practical support and services rather than having individual responsibility for clients;
- Low caseloads, client-staff ratios of 10:1, to enable more frequent and intensive contact;
- Access to staff on a 24 hour basis allowing for a rapid response to emergencies;
- The direct provision of community-based services, in most instances, as opposed to brokering these from other organisations;
- Contact with people is in their homes or other community settings;
- Assertive outreach for people who are reluctant to use services with an emphasis on relationship building and providing concrete assistance, especially with finance and housing;
- Unlimited support duration.

Intensive case management model

This model of case management shares many features of assertive case management although it is less standardized in its implementation (Moore, 2009). The most significant difference between the two models is that intensive case management services are provided by a single case manager in contrast to the sharing of caseloads amongst teams in assertive case management (Smith & Newton, 2007).

A well know adaptation of intensive case management is the Wraparound model for children and young people with complex emotional and behavioural support needs. Developed in the 1980's, it is increasingly being used as an alternative to detention or residential treatment (Walker & Bruns, 2006). Implementation has occurred in a broad range of community based settings, and typically involves a multidisciplinary approach that is both family focused and strengths-based. Designated care coordinators knit together the involvement of numerous formal services and interventions, as well as informal, natural supports (Suter & Bruns, 2009; Bradshaw et al., 2008).

The following set of principles inform how wraparound processes are implemented (Suter & Bruns, 2009):

- Family voice and choice;
- Team based;
- Natural supports;
- Collaboration;
- Community based;
- Culturally competent;
- Individualised;
- Strengths-based;
- Unconditional;
- Outcome based.

Proponents of intensive case management models recommend that caseloads do not exceed 12 (King, 2009: Suter & Bruns, 2009).

Brokerage Model

The brokerage model, sometimes referred to as standard or generalist case management, is underpinned by the primary values of efficiency and cost reduction. The primary goal is to ensure that people are able to access appropriate services in a timely fashion. The central role of the case manager is to assess people's needs, develop a service care plan for people, and then coordinate and monitor the delivery of required services by external agencies (Grech, 2002; Huber, 2002; Simpson, 2003). This coordination responsibility necessitates case managers engaging in advocacy on behalf of their clients. Service system costs are contained by preventing 'inappropriate' access and use of services by people, and the duplication of services is minimized.

Grech (2002) notes that this model of case management is based on the assumption that case managers do not require specific disciplinary skills as their role as a broker necessitates only the ability to match needs with available resources.

The essential characteristics of this model (Morse, 1999; Vanderplasschen et al, 2007) are:

- The focus of the case manager's role is on service coordination;
- No outreach work is undertaken;
- Contact with service users tends to be office based and less intensive;
- Average case load is 35;
- Duration of support is shorter compared to other models.

Joined-up case management model – YP4

YP4 was an Australian randomized controlled trial of joined up services and programs for young people who were both homeless and unemployed that aimed to create sustainable employment and housing outcomes for young people. The YP4 joined up case management model was intensive and client-centred, and underpinned by the following principles (Grace & Gill, 2008:6-7):

- Housing, employment and personal support must be interlocked and delivered as an integrated package of assistance;
- The integration of housing, employment and personal support assistance must happen at every level, not just at the level of casework but also at systemic and structural levels;
- Sustainable employment is understood as the over-arching goal, which must determine the way that other forms of support are provided;
- It is relationships, and not transactions, that count;
- Solutions must be locally specific, and joined up locally too;
- Coordinated case management is the key and it must be well resourced enough to ensure individualized, timely and flexible responses.

The features of this model of case management include the following (Grace & Gill, 2008; Grace et al., 2012):

- Resourced case management – workers had access to a flexible pool of resources;
- Investment of significant periods of time to develop trusting relationships with young people;
- A strengths-based focus;
- Direct provision of services and brokerage of additional services through a single point of contact;
- Duration of support is 2 years;
- Significant effort in relationship building with other service organisations: each case manager had between 19 and 67 relationships with local services.

2.3 CASE MANAGEMENT OUTCOMES

The bulk of evaluation research on case management is in the mental health field with very little in human service settings addressing multiple social issues. The most rigorous evaluations have been done in the mental health and more recently, substance abuse arenas (Camilleri, 2000).

Attempts to evaluate case management services have been thwarted by various complicated factors. These include the use of different and overlapping models of case management, a lack of consensus on definitions of case management, and uncertainty about the degree of fidelity of practitioners to particular case management approaches (Hall et al, 2002; Simpson et al, 2003). These issues are further compounded by the reporting of heterogeneous outcome measures in studies which makes any attempt at comparisons between different interventions problematic. Attributing client or program outcomes to a particular service-delivery approach such as case management can also be problematic (Gursansky et al, 2012). A summary of the findings of several reviews of the evidence is given below.

One review of eight published literature reviews of community mental health case management explored whether case management services that provided direct service delivery (both clinical and support services) compared to brokerage/referral and hybrid models made a difference to outcomes for service users (Bedell et al, 2000). The hybrid model classification incorporated different types of intensive case management and 'personal strengths' approaches. The brokerage model provided minimal direct services and relied on securing services from the wider community mental health system.

This review found that 'full service case management' was associated with better outcomes in relation to treatment retention and compliance, reduced hospitalisation, positive client satisfaction and modest reductions in service expenditure. Hybrid models incorporating a greater proportion of full service case management characteristics also produced better outcomes compared to those with fewer of these characteristics. In contrast, brokerage models failed to retain people in treatment, increased hospitalisation rates and incurred greater costs. The authors recommended full service models of case management as best practice and suggest that:

> It is probably time to abandon the other models of case management that rely heavily on brokering of services since they were associated with inferior outcomes (Bedell et al, 2000: 189).

A meta-analysis of 44 studies by Ziguras and Stuart (2000) compared outcomes of assertive community treatment and clinical case management. Study designs included randomised controlled trials and match-control studies. Both types of case management resulted in small to moderate improvements for people using mental health services.

The authors conclude that both models of case management have similar effects in improving symptoms, the level of people's social functioning, and satisfaction levels as well as their family members' satisfaction with services. Assertive community treatment was more effective than clinical case management in reducing rates of hospital admissions.

To assess the effects of intensive case management in comparison with those of non-intensive case management and standard community care for people with severe mental illness, Dieterich and colleagues (2011) undertook a meta-analysis of 38 randomised controlled trials. Studies of intensive case management were included where there was a

case load of 20 people or less, and for non-intensive case management, a case load of more than 20 people. The authors observe that there is a moderate risk of bias in the trials examined, and therefore a corresponding risk of an overestimate of positive effects.

Dieterich and colleagues conclude that intensive case management, compared to standard care, can result in fewer and shorter hospital admissions and increase people's retention in care. It also improved people's housing and employment status. The authors found that there was no compelling evidence to indicate that intensive case management was any more effective that standard care in improving people's mental health and quality of life. Also, there were no significant differences between intensive case management and non-intensive case management in terms of reducing the length of stays in hospitals, improving people's mental health status, and employment and housing circumstances, or quality of life.

A meta-analysis conducted by Coldwell and Bender (2007) appraised 10 randomized controlled trials and 4 observational studies to assess the effectiveness of assertive community treatment for homeless people with severe mental illness. The authors conclude that assertive community treatment offers significant advantages over and above other case management models for homeless people with severe mental illness. People receiving this type of case management experienced a 37 per cent greater reduction in homelessness compared to the housing status of people in the control groups. It was also associated with a significant reduction in psychiatric symptom severity. The limitations of this meta-analysis relate to its small sample, however it does contribute to a growing consensus about the usefulness of this model of case management.

Hwang and colleagues (2005) conducted a systematic review of effective interventions for improving the health of homeless people. This review examined forty-five studies, the majority of which involved homeless people with mental illness or problematic substance use. Only a few studies focused on families and children as well as young people who were homeless. Seventeen of these studies incorporated case management as the sole intervention or alongside other interventions such as the provision of subsidized/supported/temporary housing, access to drop-in centres, or rehabilitation services. Study designs included randomized trials, longitudinal studies with non-randomized allocation to different treatment groups and retrospective studies which compared health outcomes of groups involved in different interventions. The authors report mixed evidence in terms of improvements to people's health, although they conclude that case management linked to other interventions (for example, supported housing) improved psychiatric symptoms and assertive case management decreased psychiatric hospital admissions. A reduction in substance use was also reported for those people receiving case management.

A meta-analytic review of case management for people with substance use problems was conducted by Vanderplasschen and colleagues (2011). This review examined 15 randomised controlled trials that evaluated the effectiveness of case management compared with another intervention or standard care for people with substance use problems. The authors note the limitations of the review in relation to the low quality of the design of some of the included studies and the heterogeneous nature of reported outcomes.

The review draws the conclusion that case management effectively links this target group to community and treatment services compared to other interventions or standard care. However, the extent of linkage varied between studies. The authors comment that the effects of case management are diminished if accessing services is easy or difficult.

Other factors influencing successful linkage include the availability of training and regular supervision for staff, particularly intensive initial training, the type of case management approach utilised and the extent to which case management is integrated in local service networks. The authors tentatively suggest that the strengths-based model shows the most promise with the caveat that only 2 studies in the review implemented this approach. They also observe that efforts to homogenize how implementation occurs, for example, by the use of protocols and manuals, result in more effective linkage.

This review did not find any compelling evidence that case management is effective in reducing drug or alcohol use compared with usual treatment. On other related outcomes, there is no conclusive data associating case

management with an improvement in employment, housing or legal status (e.g. number of days in prison, proportion of people charged with a drug related offence).

Overall, in considering the evidence on the effectiveness of the dominant, contemporary models of case management and in light of the methodological hurdles highlighted, caution needs to be exercised in making any absolute claims about the superiority of one model over another with the exception of the brokerage model. Those models that provide direct service delivery (comprehensive clinical and practical support) appear to be more beneficial for people on a range of measures.

2.4 SERVICE USERS' EXPERIENCES OF CASE MANAGEMENT

Until recently, very little attention has been given to the views and perspectives of service users of coordinated provision of early intervention and family support services in Australia (Tregeagle, 2010). This section of the literature review highlights some of the findings from this small body of research, in particular, Tregeagle's study (2008, 2010) of participants' experiences of two case management systems in NSW (Looking After Children (LAC) and Supporting Families and Responding to Children (SCARF)), and recent research and evaluations of family support and home visiting programs (Allen, 2007; McArthur and Thomson, 2011; Hoagwood et al, 2010, Swick, 2010; Daro et al, 2005;). This is followed by a discussion of the core characteristics of case management that young people find helpful.

What families valued about case management:

- A good quality relationship with a case manager; this is seen by families as the most important process of case management;
- The needs of all family members (children and parents) are considered in assessment processes;
- Family members' strengths are recognised and further developed;
- Concrete practical assistance, for example, food vouchers, transport, help with housing;
- Emotional and social support from case managers;
- Genuine opportunities of greater participation and having more of a say in decisions that affect families. Being listened to, supported in expressing views and having these views taken into account contributes to a growing belief in their ability to make decisions and solve their problems. Although it can take time to develop and negotiate a satisfactory participatory relationship with workers;
- Teamwork with everyone, including parents, working together to achieve set goals;
- Help with negotiating the service system maze and being linked to formal supports;
- Opportunities to gain more insight about the development of their children or their own lives;
- Case managers enabling families to increase their informal social supports and networks, e.g. other parents, caregivers, support groups;
- Case coordination is combined with brokerage funding, especially to access fee paying services or pay for educational support, household goods or extracurricular activities for children.

Aspects of case management that families found unhelpful include:

- Limited assessment and planning processes that do not pay attention to families' priorities or comprehensively cover family circumstances, e.g. poverty and the enduring impacts this has on people's capacities and quality of life;
- Barriers to communicating with workers such as questions about drug and alcohol use, a perceived threat of the loss of tangible assistance with housing and food, or not feeling comfortable or trusting of workers can influence the extent to which families participate in decision-making processes;
- Cultural unresponsiveness of case managers;
- The distribution of case management documentation to all members of families creates privacy related concerns. The volume and format of documentation can also be intimidating, and assumes a certain level of literacy;
- Simple case management services that rely solely on the brokering of required services;
- Duration of case management services does not always match the ebbs and flows of change, and setbacks experienced by families.

A qualitative study (Sawrikar, 2011), that included interviews with 29 parents/carers of children from culturally diverse backgrounds involved in the NSW child protection system, explored case management practices and policies that families perceive or experience as effective, or otherwise, in meeting their cultural needs. Sawrikar identified several examples of culturally appropriate practices which include:
- consultation with multicultural caseworkers;
- culturally appropriate analysis for families;
- culturally sensitive engagement with families.

Family participants either preferred an ethnically-matched caseworker (e.g. for language reasons), a non-ethnically matched caseworker (to protect their privacy and confidentiality), or had no preference at all. The latter scenario was raised in instances where language was not a barrier and when participants believed all caseworkers were equally trained, skilled, or kind. Sawrikar notes that culture clashes are likely between the implementation of child-centred practice by case workers and collectivist family-centred values held by family members.

Young people's views on case management
An evaluation of the Peninsula Youth Connections program that works with young people at risk of disengaging from education and training, and utilises an intensive case management approach alongside other service components, highlights the significance of the individualised and personal support they received from their case managers to their successful engagement with this initiative (Barratt, 2012).

Participants in this evaluation valued how case managers adopted informal styles of communication styles to fit in with their norms as well as the individualised, personal and practical support, and encouragement provided by case managers that allowed them to progress towards tackling significant hurdles within timeframes that young people felt were appropriate for them. A noteworthy feature of this program is that young people are able to access case management for considerable periods of time, and can re-enroll if their circumstances change. This flexibility facilitates the development of strong relationships between young people and case managers, and for re-engagement work to occur when the time is right for young people.

A small qualitative study (Moore et al, 2008) of 12 young people who had been on a committal at a Youth Detention Centre explored their experiences of transitioning from detention back to living in the community. As part of this study, the question of what young people wanted from case management was examined.

Their ideas of helpful case management included being:

- Linked to effective AOD programs;
- Connected to education, training and employment;
- Helped with finding positive things to do during the day;
- Linked to sporting activities;
- Assisted with their health needs;
- Provided with someone with whom they could talk;
- Assisted with income support and accommodation when required;
- Helped to develop living skills.

The young people in this study felt that they were more likely to engage with the case management process if it has the following characteristics:

- Strengths-based;
- Realistic and responsive to their needs and wishes;
- Offers choice;
- Promotes continuity of care;
- Offers opportunities for participation.

The importance of giving young people a say in case management activities has been the subject of much attention in recent years. Research on young people's experiences of having a voice in case management processes indicates that they often do not have opportunities and a choice of ways to participate (Cashmore, 2002; Couch, 2007; Tregeagle, 2010). Although there are examples of empowering practices (Cashmore, 2002), there is room for improvement by youth workers and other service providers working with young people (Emslie, 2009).

Bessell's (2011) qualitative study of young people's experiences of participation in decision-making during their time in out-of-home-care describes how this group felt they were rarely consulted on decisions about their lives. The few times this occurred, young people reported that their views were not valued or acted upon. A common experience for young people in this study was not to be informed of major changes in their lives.

The types of issues that young people in this study wanted to have a say on were choice of placement, choice of worker, contact and on-going relationships with birth parents and friends, and choice of school. Bessell (2011) observes that participation for young people has both an intrinsic and instrumental value. In those instances when case workers or carers listened and acted, they felt valued and positive about themselves. When ignored, young people felt a diminished sense of self-worth and dignity. They also reported that if given more genuine opportunities for participation, their relationships with case workers, out-of-home-care placement and school experiences would have been more positive and successful.

2.3 FUNCTIONS OF CASE MANAGEMENT

Despite the plethora of case management models and contexts in which they are practiced, there is some consensus in the literature about the functions that come under the umbrella of case management. The number and range of functions varies according to the type of case management model being implemented. For example, the brokerage-referral model has fewer functions than more comprehensive ones such as intensive or clinical case management.

Moore (2009) provides a description of good practice for each function of case management, and in doing so, is guided by the principles of client centredness, strengths focus, empowerment, advocacy and a social ecological perspective.

A summary of these elements of good practice is given below.

Outreach: There are two strands of outreach. Firstly, community outreach, where a socio-ecological approach to practice involves identifying the natural supports and other community resources that may be accessible to people. Having a deep knowledge of not only formal services, but also informal resources and supports that exist in a service user's community is necessary.   Knowledge is also needed about who can access these and how they will help the development of a plan (Moore, 2009). A second strand to outreach is utilising strategies to find those people that 'services find hard to reach'. People who could benefit from services may not access them due to lack of knowledge, mistrust or fear, or previous experience of discrimination, having to repeat their story or being 'flicked' from one agency to another with no success (McArthur et al, 2010). A good knowledge of local community informal networks, and working with gate-keepers who have contact with people experiencing vulnerability, who can then introduce them to service providers, will increase access for this group of people (Moore, 2009).

Individual assessment: The process of collecting information about a service user determines their needs and identifies their individual strengths as well as those in their environment (Moore, 2009).

Key features:
- Assessment is a collaborative process – service users are actively involved. The principles of respect and collaboration are critical to relationship building and assessment.   Assessment details need to reflect people's strengths, needs and wishes.
- A more realistic and meaningful service plan will be developed if case managers draw on the service users' perspectives during the assessment process.
- Use of tools that provide a visual presentation of the person in their social context as assessed by the service user and case manager and will help to organise and clarify information on the supports and stressors in the family's environment.
- Consideration of the types of contributions needed from formal supports needs to occur hand in hand with an assessment of the availability and accessibility of these services.
- Baseline data is collected during the assessment process and is used to measure changes experienced by people.

Service Planning: Planning and resource identification requires matching information from the assessment and outreach functions. It needs to be done in collaboration with service users, in other words, they set the priorities for change.

Key features
- Use strengths and/or brief solution-focused approaches to avoid pathologising people. The latter approach explores the changes a person would like to occur, how they see the future without their problems/concerns in it and how they would know when their problems had diminished. The case manager then works backwards with the service user to develop a realistic plan to create that future.
- Effective service planning is linked with the assessment function in determining whether the required resources are available, accessible and acceptable to the service user.
- Service planning goals need to be mutually agreed, specific and realistic, and staged in a logical fashion. Some goals will be short-term or staged whilst others will be longer-term depending on the person's needs and the availability of services.
- The format and content of plans needs to cover an outline of people's needs, strengths, goals and details of planned interventions. Plans need to specify the services involved, agreed tasks, time frames and service providers and others responsible for the actions. Plans also need to clearly state who has responsibility for service coordination. These plans form the basis for monitoring and evaluating the intended changes for service users.

Linking service users with services: Some people who are vulnerable will require more than a referral to other services. They may need additional ongoing encouragement and support if they are to engage with these services. Without this support and follow-up of referrals, it is likely that people's use of formal services will be diminished (Alexander et al, 2007).

Key features
- Consider the emotional, physical or financial barriers faced by some people to accessing other services. Talk about the information that will be given to the other agency and if possible, link the person to a specific worker rather than the agency. Negotiate the level of control the service user would like over the linking process. Check whether they would like to make the initial appointment or if they would prefer to make the phone call together.
- Negotiations also need to occur with the service provider in terms of ensuring there is a match between what people need and what the service provides, and the steps involved in the referral and acceptance process.

Service implementation and coordination: This case management function aims to ensure that services are delivered so that a person's goals outlined in the service plan can be realised (Moore, 2009).

Key features
- The case manager's role of coordinating services, both formal and informal, needs to be done in consultation with service users so that the process remains client-driven rather than provider-driven.
- The timely and seamless delivery of services requires getting commitment from each service provider concerning their responsibilities in the service plan. This can be difficult if services are needed on a concurrent basis in order to achieve maximum benefit and agencies have long waiting lists.
- In keeping with a client-driven approach, the case manager needs to consult with service users about which parts of the coordination function they will tackle.
- Appropriate support for service users is needed so they feel comfortable participating in case conferences/meetings which can be intimidating for some people. An alternative is for a service user, together with family members and the case manager to have a separate meeting. The case manager then provides their input into a larger case conference. Using email can also be an effective way of ensuring optimal access to group discussions for service users.

Monitoring and evaluation: Monitoring involves using "methods designed to judge whether a program is being implemented as designed, is a quality program and whether it can be made more cost-efficient" (Beinecke cited in Moore, 2009:123). The purpose is to ensure that people receive the supports and services identified in the service plan, and that these are enabling them to make changes in their lives.

Key features
- The case manager needs to keep in contact with service users and contributing service providers, and identify and tackle problems early. Monitoring is an ongoing process while a service user is engaged with a particular service/s.
- Monitoring techniques can include observing the service delivery process, receiving feedback from service users and significant others in their lives and obtaining verbal or written input from service providers, and through discussions at case conferences.
- Evaluative feedback from service users is really pertinent when assessing the impact of the service plan.

- The frequency of monitoring is likely to change and depends on the type of service, the service user's familiarity with this service and the period of time that the service is being provided. More frequent monitoring is needed in the early stages so that any initial difficulties can be addressed. As familiarity sets in between the service user and provider, monitoring can become less frequent with more direct negotiation occurring between the two parties.
- During monitoring of the service plan, the potential for disagreement exists between service providers about people's needs and the best way to respond to identified issues, as well as related differences in professional cultures and values. The quality of relationships a case manager has with external service providers and the degree of networking undertaken, can help with understanding varying professional cultures and resolving any related tensions.
- Keeping records of monitoring is necessary to identify changing needs and emerging issues.
- Evaluating the service plan involves making an assessment as to whether the case management process is achieving the goals of the service plan. It is done in an informal way throughout the different case management phases, and then more formally at the end of the case management process. Priority needs to be given to service users' perspectives, and is an opportunity for them to think about how well their needs have been met, the kinds of skills they have developed, and whether they need to continue having a case manager.

In determining whether case management has been effective it is useful to incorporate 'follow ups' with people. Contacting them between three and six months after case management has ceased provides opportunities to understand if changes are being maintained, built upon or people's circumstances have deteriorated.

2.6 RELATIONSHIPS MATTER

Until recently, analyses of case management rarely explored the effect of case manager and service user relationships. Attention has now turned to the importance of the quality of these relationships, especially for those people with multiple complexities in their lives (Allen, 2007; Gursansky et al, 2012; Baulderstone & Button, 2011). Gursansky and colleagues comment:

> *The more complex the client's situation and the more vulnerable the individual, the more critical are the relationship and continuity of care* (2012:18).

Research on the effectiveness of case management in home visiting programs infrequently examines the quality of relationships between service providers and family members, although it does highlight the value of these relationships (Allen, 2007). Evaluations consistently report that the key to a program's effectiveness in engaging and retaining families is the development of a trusting and supportive relationship between parents and service providers (Daro et al, 2005; Gromby et al, 1999; McCurdy & Jones, 2000).

Gronda's (2009) synthesis of fifty three credible sources of empirical evidence takes this argument further in her analysis of *how* case management works for people experiencing homelessness. She finds that case management produces the best outcomes for service users when there is a relationship between them and the case manager or case management team that is characterised by the qualities of 'persistence, reliability, intimacy and respect' and delivers comprehensive, practical support (Gronda, 2009:55-66).

Gronda's synthesis included an analysis of thirteen qualitative studies conducted in the United States, United Kingdom, Canada and Australia and involving 665 participants, both adults and young people, confirms the value that service users place on persistent, reliable, intimate and respectful relationships with case managers. Participants in these studies came from a variety of backgrounds and included people with substance use problems, people experiencing homelessness, and those using community mental health and palliative care services. Those relationships that were persistent and reliable, and continued for a period of over six months, assisted people in engaging in case management and increasing their self-care capacity (Kirsh, 2006). Respect is central to an effective

relationship with this synthesis finding that deficit assumptions about people's capacities underlying case management approaches may be damaging for service users.

This finding confirms the importance of monitoring and limiting case manager caseload size to enable adequate investment in the case management relationship (Gronda, 2009), and at a policy level, this needs to be reflected in the funding base for case management.

The case management relationship characteristic of intimacy is identified as having two dimensions in the evidence reviewed by Gronda: 'the genuine emotional connection that creates a relationship' and the 'intimate nature of case management activities' (2009:9). Examples of the latter include shopping, financial management, attending doctor's appointments, providing transport and cleaning. Intimacy is inextricably woven into the types of activities undertaken by case managers when providing comprehensive, practical support. It is also the site of several challenging practice concerns such as power differences, professional boundaries, emotional ambiguity, and dissimilar views of service users and workers (Beresford et al, 2007; Dickson-Gomez et al, 2007; Angell & Mahoney, 2007).

The implications for agency practice is that organisations need to ensure case managers are provided with sufficient supervision and support to mitigate against the risk of losing professional integrity during the process of engendering genuine relationships. Maintaining respectful relationships can be challenging in service systems where the emphasis is on through-put and outcomes which can result in practices and procedures that contribute to disrespectful experiences for service users. In addition, the pre-requisites for effective case management relationships are highly skilled staff and access to resources and supports for service users (Gronda, 2009).

2.7 THE ROLE OF THE CASE MANAGER

One of the central controversial issues in debates on case management relates to the specific role of case managers (Hall et al, 2002). This debate concerns the extent to which a case manager should function as a primary provider of services. This is often not clearly "conceptualised and articulated" (Gursansky et al, 2012:12). Although in practice contexts such as mental health, public health and corrections there is often a fusion of clinical work and case management activities, particularly where there are significant concerns about safety and well-being of service users and others (Moore, 2009). Gronda (2009:91) concludes, on the basis of experimental comparisons of prominent case management models, that the combination of a 'persistent, reliable relationship' with service users combined with direct practical assistance generates better outcomes for people than those reliant on the broker-referral model of service provision.

2.8 LEVEL OF INTENSITY OF SERVICE

The extent of complexity of service users' circumstances should determine how intensely a case manager is involved. The effectiveness of a case management model that relies on multiple referrals to multiple service providers is compromised for some service users with enduring complexities in their lives (Rapp & Goscha, 2004).

Research from some practice contexts indicates that higher levels of contact with service users is associated with treatment retention (Jansson et al, 2005) and more positive views by service users of the quality of care received (Kopelman et al, 2006; Allen, 2007). Findings from the Australian YP4 randomised control trial, that evaluated two models of working with young people who were both homeless and unemployed, found that a minimum of 20 contacts with individual case managers during a 12 month period was significantly associated with better employment, education and housing outcomes (Grace & Gill, 2008).

In terms of the optimal level of case management service, more than 20 contacts are required. Those young people who had more contacts with their case manager had better access to Centrelink services plus education and training. They were more likely to find and keep a job, and with greater financial independence, were more likely to live in suitable housing. Greater contact with a case manager also resulted in a significant decrease in the proportion of young people with poor health (Grace & Gill, 2008).

2.9 DURATION OF CASE MANAGEMENT SERVICE

While often this is prescribed by funders, there needs to be a logical fit with funding imperatives, service users' characteristics and needs, case management model and the resources allocated to agencies to provide this service (Gursansky et al, 2012). Given the long-term chronic and relapsing nature of some issues affecting people, such as substance abuse, case management support needs to be sustained for significant periods of time to produce long-term effects (Vanderplasschen et al, 2007). The duration of support enables the development of a persistent and reliable case management relationship, a necessary mechanism for generating better outcomes (Gronda, 2009). For vulnerable people experiencing multiple types of disadvantage, it may take up to six months to establish a working relationship (Gronda, 2009).

In service environments where there are waiting lists and shortages of specialist services, chronic shortages of affordable housing and significant hurdles to obtaining financial independence, the duration of case management support is likely to be lengthened.

2.10 CASE LOADS

There are currently no reliable formulae for working out optimal case load sizes (King, 2009). However if a case management model prescribes direct service provision to service users with highly complex circumstances plus the requirement to link service users to other services, provide active outreach and nurture informal service user networks, then it is clear that small caseloads are prerequisite for this type of intensive work.

The converse is that larger caseloads are associated with less contact with service users, lower levels of timeliness, responsiveness and advocacy, and ultimately, less than optimal outcomes for service users (Gursansky et al, 2012). When faced with high caseloads, case managers are likely to deal only with crises and immediate problems (King et al, 2000).

One study (King, 2009) of 188 mental health case managers in Victoria highlighted that full-time case managers utilising the model of intensive case management had, on average, caseloads of 20 people. King maintains that caseloads of this size would allow for the provision of intensive case management to only a small number of people and routine care coordination to others. In this study, a central finding was that higher caseloads were associated with higher work-related stress and lower case manager personal efficacy. Greater use of strategies such as clinical supervision to monitor caseloads, team leader monitoring of case loads and the occurrence of this type of monitoring in performance appraisals was associated with higher levels of case managers' confidence and belief in their abilities. In terms of active management of caseloads, participants in this study expressed a preference for team leaders to be more proactive in both the allocation of new cases and monitoring of caseloads.

2.11 PRACTITIONER SKILLS

The challenging nature of case management work is such that organisational support and opportunities for practitioners to develop a diverse skill set are required in the adoption of a quality case management approach (Gursansky et al, 2012; Gronda, 2009; Kennedy & Kennedy, 2010)).

Practitioners need to possess a wide range of capabilities if they are to be effective in their case management role, regardless of the model and intensity of case management being applied, or the extent and range of vulnerabilities experienced by the people they are working with (Arnold et al, 2007; Essock et al, 2006; Dorsett & Fronek, 2009). As case management involves a complex and highly dynamic set of processes, practitioners also require critical and reflective practice skills, and the capacity for flexibility and creative thinking (Dorsett & Fronek, 2009).

However, there is currently a lack of consensus about the nature and range of core skills and competencies required for effective case management, and no agreed set of educational or training pathways to assist practitioners to achieve these competencies (Dorsett & Fronek, 2009). Gursansky and colleagues (2012) observe that many human

services organisations and some case management models do not have as a pre-requisite, specific, standardised qualification to practice case management. Several authors note that many practitioners arrive in a case management role from diverse educational and professional backgrounds with many not having formal qualifications in health and human services, and that there is frequently little focus by employers on providing training in case management core skills (Dorsett & Fronek, 2009; Kennedy et al, 2003). Dorsett and Fronek comment that:

> *There is an underlying assumption that undergraduate education in the various health and welfare disciplines teaches the necessary core skills required by a competent case manager, and that the skills of practitioners with or without qualifications can then be 'topped up' by on-the-job training and ongoing professional development* (2009:249).

On the basis of Case Management Society of Australia standards of practice, a series of competency domains associated with essential case management activities have been identified. The standards of practice are: case identification and assessment; planning; monitoring; and evaluation and outcomes (CMSA, 2008). The case management competency domains are client centredness, client process, cohesive systems, organisation, research and self-management (Figure 1). Dorsett & Fronek (2009) posit that agreement needs to be reached on the nature and range of competencies for each domain.

Figure 1: Case management competency domains

Client-centredness	Client process	Cohesive systems	Organisation	Research	Self-management
Client-centred approaches Responsiveness Cultural competency	Communication Engagement Planning Monitoring Assessment	Coordination Networking Collaboration Resourcing Advocacy	Documentation Non-discriminatory complaints management Risk management Quality assurance	Literature reviews Practice-based research Evidence base Program & policy evaluation	Self-care Time management Caseload management Leadership

Source: Dorsett & Fronek (2009:251)

Gronda's synthesis (2009) which demonstrates that the relationship between service user and case manager is the mechanism underpinning effective case management, and that this is dependent on advanced communication and relationship skills of case managers. One longitudinal randomised controlled study found that the quality of skills of practitioners was more important than the model of case management implemented, in terms of improving client outcomes (Essock et al, 2006). These outcomes related to psychiatric symptoms, substance use, global functioning and life satisfaction, and housing stability. Staff implementing assertive community treatment and standard clinical case management models of service delivery, were provided training and support in comprehensive assessment, individual motivational interviewing, and interventions based on the best evidence for integrated treatment practice.

An Australian qualitative study of the skills case managers required in YP4, a trial of joined-up services for young people experiencing both homelessness and unemployment, concluded that a high level of skill and experience was needed to effectively provide joined-up case management (Allen, J. et al., 2007). A summary of these skills is given in Figure 2.

Figure 2: YP4 case manager skills

Relationship Skills	Comprehensive & Practical Support Skills
An ability to empathise, understand & establish relations with young people	Advocacy skills
Assessment & referral skills	Highly developed communication skills at levels other than the interpersonal and client-focused
Highly developed interpersonal & counselling skills	Highly developed networking, negotiating & brokerage skills
Problem solving skills	Capacity to match clients with appropriate jobs
Capacity to think holistically	Capacity to work within & across the service delivery system
Capacity to promote & manage service system integration in respect of clients	
Capacity to translate knowledge developed via intervention to inform policy	
Time management skills	
Organisational skills	

Source: Gronda (2009:124-5)

The implications for funders and managers of case management services is that practitioners need to be adequately recognised and remunerated for the skills required to enable the case management relationship to function effectively. Regular professional/clinical supervision and support for case managers is also required (Gronda, 2009).

2.12 GAPS IN THE LITERATURE

Successful ingredients of case management implementation have been identified and include a comprehensive conceptualization and design of case management services, programme fidelity, robustness of implementation, use of manuals and protocols, training and supervision, a team approach, a focus on clients' strengths as well as planning and monitoring (Vanderplasschen et al, 2007, 2011). There is however, little credible evidence available about which case management model is most suitable for specific populations, particularly vulnerable children, young people and families. Also, greater investment needs occur in research of a high methodological quality that covers a variety of outcome measures over substantial follow-up periods of time. There are also knowledge gaps about the effects of different 'doses' of case management for different groups of people, and if and how these differences affects outcomes. Another area requiring attention is case management interventions that have a strong focus of linking people to informal supports (Allen, 2007).

3. CYFSP APPROACHES TO CASE MANAGEMENT

Methods

This component of the research project used a qualitative methodology to develop an understanding of how CYFSP case managers are conceptualizing and implementing case management activities. The study used semi-structured, in-depth interviews with case managers as the method for data collection.

Recruiting case managers

All community service organisations funded under the CYFSP to provide case management services to vulnerable children, young people and families were invited to participate in the study. A total of 14 workers from 8 agencies agreed to contribute to the research.

Interviews

Semi-structured, in-depth interviews with case managers were conducted between August and October 2012. The majority of interviews were one-on-one interviews and the remainder were small group interviews. The length of interviews ranged from 60 to 100 minutes. All interviews were audio taped and transcribed, and notes were also taken by the interviewer.

An interview guide was used to provide some structure to the interviews with the following areas explored in each interview:

- Case managers perspectives on case management processes and outcomes;
- Roles and responsibilities of case management within teams;
- Perceptions of good practice in case management;
- Agency specific client-load;
- Perceptions of funding adequacy;
- Qualifications and case management experience.

Data analysis

Interview data was coded using NVivo (a qualitative research software package). In the coding process, the researcher partially drew on the key theoretical concepts in the literature review. The data were then re-analysed for additional categories and concepts using constant comparative techniques.

3.1 QUALIFICATIONS AND CASE MANAGEMENT EXPERIENCE

The majority of participants (62 per cent) had a degree qualification, over half of which were social work, community counselling or social and community studies degrees. Other degree-level qualifications included teaching and science. Diploma and certificate level qualifications were held by 38 per cent of participants. Twenty three per cent (n=3) had a postgraduate diploma or masters qualification. All but one case manager (92 per cent) reported they had not received any formal training in case management.

Nearly a third of participants (n=4) had less than a year's experience doing case management work. Twenty three per cent reported they had between one and five years' experience. The remaining participants (46 per cent) stated they had been in a case management role for a period of 6 years or more.

3.2 WHO IS USING CYFSP CASE MANAGEMENT SERVICES?

Case managers identified a range of issues and concerns facing people who are using CYFSP case management services. Significantly participants highlighted that many families are presenting with multiple, interlocking needs that cross over health, poverty and social issues. It was noted that the profile of people using case management services has changed since the introduction of service reforms. The issues facing families most commonly cited by participants are: homelessness; insecure, overcrowded and expensive housing; poverty and financial stress; mental health, including but not limited to depression, and anxiety; family violence; substance abuse; family breakdown and on-going conflict; behavioural problems and/or disabilities experienced by children as well as parenting difficulties.

These case managers observe:

> It could be insecure housing, we are getting a lot of families that are homeless or who need bigger properties because of their children and their circumstances have changed. Or it could be applications to housing, they don't understand certain things. It is a mixture but it tends to be people with more complex needs including mental health, domestic violence (CM5).

> Often there will be factors related to family breakdown and on-going conflict between parents. Also lack of affordable housing, depression and poverty. All these issues are affecting the people I'm seeing. Several families are at risk of becoming homeless as they don't know how long they can afford the rent (CM9).

Another participant states:

> All the families that I'm working with, their children have disabilities – autism, speech delays, learning delays and none of that is being addressed by CPS or any other agency (CM1).

On the whole, case managers are working with families with younger children. Only a few reported providing case management to families with teenagers and if they were working directly with these young people, it was usually related to linking them into formal services or youth activities and groups. Those case managers who have a dual role of case management and youth engagement encountered some ambiguity and overlap between these roles. This participant explains:

> It does get a bit foggy. We're still trying to figure out what does it really mean if you go with a young person to the Junction's health service as they have an appointment and you talk to the doctor, and the doctor says you have to go and do this and this, and then you go and do that. Is that case management or is it youth engagement and it gets foggy especially, it doesn't really matter until you have to start recording that amount of hours.…. So when you spend an entire day with a young person, was it case management or was it youth engagement? (CM6).

Several case managers reported having a strong focus on working with Aboriginal families and with families who are refugees or recent arrivals to Australia. One participant reported working primarily with single fathers who have joint custody of children.

Over three quarters of participants reported they were working with families who have/had involvement with Care and Protection Services. This group of families include those where: notifications have been made and there is 'no further action' by Care and Protection services; a significant number of reports have been made and family support is being provided to prevent removal of children; and families who have had their children removed from the family home.

One case manager comments:

> *I work with them for restoration of the children so that is quite intense because, for example, with one particular client, there is inter-generational family violence, there's drug and alcohol stuff, there's a number of areas she has to work on before hopefully she gets her child back (CM5).*

The nature of some referrals of families with entrenched problems to more generalist case management service providers indicates that the CYFS program is at risk of moving away from an early intervention focus.

3.3 HOW DO FAMILIES ACCESS CASE MANAGEMENT SERVICES?

All but one of the agencies participating in this research operate a 'no wrong door policy' in relation to people being able to access case management services. People can use various pathways including self-referrals, referrals from government agencies as well as non-government organisations, and Youth and Family Connect. Overall, agencies tend to work with families who are already involved in the service system or who know about the agencies providing case management services in local areas where they live.

Examples of government agencies making direct referrals include Care and Protection services, ACT Housing, ACT Health, Child and Family Centres, schools, Youth Justice, and Centrelink. Non-government agencies include Salvation Army, St Vincent de Paul, SupportLink and Aboriginal agencies.

> *There is a no wrong door policy so people self-refer, they find out about us and ring us, and some are referred from Youth and Family Connect, CPS and SupportLink (CM3).*

> *About a quarter are self-referred. We get quite a lot from Care and Protection, maybe 50 per cent, and then we get a few from housing as well (CM6).*

Another referral pathway highlighted by a few participants is that of 'internal' agency referrals. This was most likely to occur when people had been involved in parenting or family based programs, obtaining emergency relief or participating in playgroups organised by agencies.

The use of outreach strategies to recruit families and young people that services find hard to engage was mentioned by a few participants. One planned example given will involve the case manager "hanging out" at a playgroup run by a Child and Family Centre in the near future to recruit parents not engaged with the service system.

3.4 DEFINING CASE MANAGEMENT

At the time of this research, the majority of participants indicated that their agency did not have a case management framework or guidelines in place that provided information on the definition, model or approaches to be used in their day-to-day practice. Participants were asked how they defined case management. There was considerable variation in their interpretations of what case management is.

For some participants, the concepts of client self-determination, empowerment and increasing people's capacity for self-care underpinned their interpretations.

> *Well the way I look at case management is it's looking at what goals someone wants to achieve and putting strategies in place or services in place to be able to achieve that. So it is very different and very individualised whether it being I'm homeless, I need to get on the housing list and try and find a secure roof over my head to Care and Protection have taken my children and I need to get them back. So it's looking at what the actual family want themselves, their goals (CM5).*

> *I think of it as a journey to work with this family to help them through this difficulty but they are driving it. I'm there to support them because I'm not always going to be there for that family so if I can help them to be*

empowered to 'okay this is a problem but once I've been supported through this I've developed skills to help me in the future to deal with other difficulties or other problems'. So to be empowered to be in charge of their own family and their own lives (CM9).

In contrast, several participants defined case management in terms of its different functions such as case coordination, advocacy and case work. The fluidity and confusion surrounding the meaning of case management and the distinction between different functions was highlighted by several participants.

It's hard because then there is the whole debate about what's case management, what's case coordination. I think case coordination is probably more things like setting up meetings between different agencies whereas case management that's part of the role but it's also about I think putting the person first, a person centred approach to linking them into services….. Case coordination you link the client into all the different services, case management you're being their advocate as well, going to their houses, speaking to Centrelink, going to a school. I find it hard to define, I guess just being somebody to give professional support (CM6).

Participants from one agency had a different interpretation of what case management is and suggested that case coordination and family support work, when required, is case management.

If someone only needs case management from a distance, to organise the different organisations that are involved, to bring them all altogether, that that's what I do. If it's a family that needs more than that then I go out to their home and I do that, I do the family support stuff. (CM7).

The absence of a definition and program guidelines in the CYFS Service Delivery Framework has contributed to a sense of uncertainty as to whether service providers should be providing family support based case work.

It is new and there is no definition around case management so everyone is working to try and find what everyone is doing. Some programmes say that it has changed from family support to case management. How is that change, what does it look like, how has it changed from a worker's perspective as well and the expectations? (CM7).

In addition to the variation with which case managers interpreted case management, it was generally agreed that professional groups from agencies external to CYFSP in the ACT did not have a good appreciation of their approaches, and that frequently there was no common language around case management.

3.5 CASE MANAGEMENT MODELS

The analysis showed that four models of case management are being applied by participants working in case management services funded by the ACT government. These models are distinguished from each other by the range and type of case management functions and the degree to which these are standardised. The application of a particular model was not restricted to agency operating contexts in that within one team of case managers, two models were being implemented. An overview of these models is provided in this section.

1. SCARF model
SCARF (Supporting Children and Responding to Families) is a standardised case management system in terms of goals and process. It lays out clear standards and expectations for Intensive Family Support services working with vulnerable families and children. It provides an assessment framework of 3 core domains concerning child development, parenting capacity, and family and community.

Highly structured electronic forms layout the planning processes for family support casework, for example, when to collect what types of information, when to make decisions and when to hold a review. An on-call 24 hour service is available for people if they need support. Service users can participate in decision making meetings.

The core case management functions of SCARF are:

- Assessment;
- Case planning;
- Case work including comprehensive practical support;
- Supported referral and linkage to services;
- Case coordination;
- Advocacy;
- Brokerage;
- Review and evaluation.

2. Comprehensive, practical case management model

This model, similarly to the one above, places a strong emphasis on providing direct assistance with the practical and specialist support needs of people. In delivering concrete practical support, case management responses are individually tailored to people's circumstances. Case managers provide direct assistance with parenting education and skills, daily living activities (e.g. budgeting, cooking), housing issues, as well as assistance with accessing material aid (e.g. food, income, household equipment, educational items, health care, legal). In some instances, depending on the qualifications of case managers, counselling is also available. Active practical support to access specialist services (e.g. drug and alcohol, mental health) and maintain this access through the provision of transport to appointments is also provided.

The core case management functions of this model are:

- Assessment;
- Case planning;
- Case work including comprehensive practical support;
- Supported referral and linkage to services;
- Case coordination;
- Advocacy;
- Brokerage;
- Monitoring.

3. Minimal service case management model

The distinguishing feature of this model is the emphasis placed on linking people to formal service supports. Advocacy and support are provided to ensure that people received adequate services and achieve the goals in their case management plans. Concrete practical support may be provided through organising transport to enable people to attend appointments. Brokerage funding is not available for service users.

The core case management functions of this model are:

- Assessment;
- Case planning;
- Supported referral and linkage to services;
- Case coordination;
- Advocacy;
- Monitoring.

4. Supporting children and young people's education model

The primary emphasis in this approach is on supporting children and young people from financially disadvantaged families in their education. Through the Learning For Life Program, scholarship funding is provided to help families afford the cost of their children's essential education items. The program's focus is on supporting children and young people throughout their education, from pre-school, primary and high schools, to tertiary education. Educational support is also provided through homework clubs, and peer support reading and mentoring programs. Learning for Life workers have close working relationships with schools and co-location arrangements with Child and Family Centres that enable workers to recruit children from families that services find hard to reach.

This approach does not implement the basic core set of case management activities.

3.6 CASE MANAGEMENT PRINCIPLES

Participants were asked what principles informed their case management practice. There were a range of responses and, with a few exceptions, these responses indicate there is some inconsistency in applying a cohesive set of practice principles across the CYFS program funded case management services. Around three quarters of participants highlighted strengths-based practice and client participation in case management processes and decision making. Working in partnership with families and young people and not going in with practitioner defined agendas, unless serious child safety concerns exist, was generally viewed as a critical success factor to people's engagement with case management services.

The principle of client centred practice was raised by several case managers. This principle was seen as relating to the provision of individualised support and ensuring service responses are tailored to people's needs and circumstances. It also involved recognizing people's right to self-determination, empowering people to make decisions regarding their own case management plans and striving towards sustainable solutions for the circumstances facing families. A few participants spoke about the importance of being child centred in their case management work.

Some participants spoke about the importance of the principle of social inclusion with specific reference to providing services that respect and value Aboriginal and Torres Strait Islander people, culturally and linguistically diverse groups, and people's spiritual and religious beliefs. Related to this is the principle of equity which was mentioned by a few participants in the context of treating people fairly and equally with regard to service provision and the allocation of agency resources.

Collaborative practice was identified by some participants as was the principle of client/case manager relationships that are build on trust, honesty, respect and non-judgmental attitudes.

The principle of professional practice was highlighted by a few case managers. This was discussed in terms of practitioners being accountable for their actions and engaging in ethical practice which includes establishing boundaries about their roles and practice.

3.7 WHAT DO CASE MANAGERS HOPE TO ACHIEVE?

The majority of participants tended not to have an ecological approach in terms of the range of their individual ideas about expected outcomes for families. This is not surprising given the absence of a shared vision and a set of holistic, coherent and realistic outcomes for case management services funded under the CYFS program as well as a continued reliance on outputs reporting by the ACT government.

The exception to this is the holistic outcomes approach used by participants from one agency that implements the SCARF model of case management. Case managers routinely measured outcomes using the Family Outcomes Star developed in the UK. This outcomes tool consists of a number of scales arranged in the shape of a star, and is used collaboratively between parents and workers to measure changes in attitudes and behaviour (MacKeith, 2011).

The outcomes areas are:
- Promoting good health;
- Meeting emotional needs;
- Keeping your child safe;
- Social networks;
- Supported learning;
- Setting boundaries;
- Keeping a family routine;
- Providing home and money.

In terms of those case managers implementing a comprehensive practical case management model compared with those using a limited case management model there was no difference in the type of outcomes that practitioners felt would be realized for service users.

The analysis showed that the most common outcomes identified by participants were increased parental knowledge of formal supports and how to access these services, followed by strengthened skills in parenting practices, and improved living and problem solving skills.

> *More independently able to source information, be empowered as parents, be aware of what support is available for them* (CM2).

> *They can walk by themselves* (CM3).

> *Skills to stand on your own two feet when issues arise in the future* (CM7).

One participant talked specifically about the benefits of case management for families who are refugees or recent arrivals to Australia.

> *Better understanding of how things are done in Australia, the culture in Australia. More confidence and knowledge of how to access local services and confidence to make the phone calls.* (CM3).

Less than a quarter of case managers felt that the case management service they provided would lead to an improvement in children's safety and an increase in the number of children and young people diverted from CPS and youth justice system.

Improved family living circumstances was raised by a few participants. This included a reduction in financial stress, appropriate and secure housing, and better social networks.

> *That the housing is adequate, that they are not going through unnecessary anxiety about bills or things because of poverty. I guess we're trying to keep an eye out for their capacity to manage their circumstances. There is a lot of adversity and complexity, and how well they are coping. And as soon as they are coping well we don't need to be in their lives and we make that really clear to them* (CM9).

A range of educational outcomes for children and young people were also identified. These relate to children accessing early childhood services, children and young people attending school, enhancing the capacity of parents to support their children's education and young people completing Year 12.

> *Learning about the importance of homework, how to set a routine for the kids to do homework, helping a child with homework or asking the school if they don't understand* (CM7).

> *Students stay engaged in education, they stay on in education through to Year 12 and then at the end of Year 12 either progress to an apprenticeship, a full time job or further education. This is what we tell parents, and if they manage to do this then we've succeeded* (CM8).

Several participants found it quite difficult to articulate the intended outcomes of the case management services that they provided to people. In a few instances this was associated with the developmental stage of the CYFS program, the time it takes to build trusting relationships and the lengthy period of time needed for change to occur for some families.

> *I've been here since April it's not that long, only 6 months* (CM5).

> *Its early days for the program and for me* (CM6).

This participant goes onto say:

> *Sometimes when there are a lot of complex issues happening at the same time, we might not necessarily be able to see any changes that have happened but the fact that they are talking to you like I know with some families my little triumphs are when they call me and say I'm struggling with this, can you help me. I think you have been so closed off up to this point and you've just opened up to me and we've been working for 4 months and yeah this is great, like* (CM6).

Also, it was thought that intended outcomes needed to be viewed in the context of what people themselves considered important and the changes they desired in their lives. As these participants explained:

> *For me to see them achieve their goals, that's my intended outcome. So an example is parenting classes as a lot of young single mums are very socially isolated, so linking them into groups* (CM5).

> *It's about working towards goals that they have identified and feel they can achieve, for example, reducing my debt a bit* (CM7).

3.8 CASE LOADS

Agencies participating in this research are contracted by CSD to provide case management to specific numbers of families. For case managers providing the Intensive Intervention Service, the target is between 7 and 12 families per case manager at any one time. The remaining group of case managers has targets of between 10 and 20 families at any one time with the exception of the Learning for Life worker funded by CSD, who provides educational support to approximately 300 students.

At the time of the research there were slight variations in the case loads of participants in terms of the model of case management being implemented. Case managers applying the SCARF model spent, on average, 4 hours per family per week. For those using the comprehensive, practical model and minimal service model, the average number of hours per family was 2.6 and 3.3 respectively.

Participants reported that the duration of case management support provided was for a minimum period of 3 months and could extend to one or two years depending on the type of issues facing families. The exception to this is those practitioners providing educational support to vulnerable children and young people throughout their education. In addition, a very small number of case managers said they provided one-off support to people.

The length of time families receive case management support is interlinked to the number and complexity of issues facing families and the availability of vital services such as housing and specialist supports (for example, mental health and drug and alcohol services).

As this participant explained:

> *For some of the clients it is related to the court order. It can be for 2 years which means that we work with them for 2 years as there could be a lot of issues to work on. If a client is at risk there are a lot of issues around that* (CM3).

Unrealistic/heavy case loads

Overall, case managers, regardless of the type of case management service funded by CSD, felt the contracted targets were unachievable.   The majority of participants are employed to undertake case management activities on a part-time basis ranging from 14 to 30 hours per week. They felt that their capacity to deliver effective case management services would be significantly compromised if they attempted to meet their agency contract requirements. Many participants felt working with families with multiple complexities in their lives warranted smaller case loads.

> *I work 4 days a week and have 7 families and I don't think I could take any more than that. It just depends because you could be running smoothly for a week and then 3 families can go into crisis and that is when you get stuck because you've got to prioritise which is difficult. It means other families can miss out* (CM1).

> *That depends on the needs, like I have 8 clients only but only 1 is not a high needs. So I'm constantly working with the other 7 families, just constantly, so I don't have space for anyone else* (CM6).

Those case managers who work full-time also expressed similar concerns. One participant whose agency is contracted to provide case management to 20 families at any one time by full-time staff commented:

> *We are providing quite intense case management. Time is a huge difficulty. At the beginning of a new relationship with a family you have to spend a lot of time, there is a lot of work initially. I have 12 families and I can't cope with any more. I don't think I have much capacity to work with any more* (CM3).

The contracted targets also mask the actual number of people that a case manager may be working with as this participant observes:

> *You also need to consider the whole family's needs and what has to be addressed. It is not just a case of 12 to 20 people, it could 48 to 80 people. Or you might have 3 families with 15 children* (CM7).

Some participants reported that their managers attempted to make case loads manageable by allocating families with a mix of needs and differing levels of complexities to individual case managers. In addition, negotiating with managers to ensure there was variation in the intensity levels required in working with families was a strategy used by a few participants. This case manager comments:

> *It's about having a mix of intensity levels required to make 18 families manageable – some new families, ones that are well on the way requiring minimal support and not at risk, and others that are shortly to exit the service. So if I have a mix then 18 is okay* (CM3).

However as demand for case management services increases in the context of active holding arrangements that have yet to be developed, it is possible that these strategies may slip off.

> *Should we be open to more people? That's happening as well, there's that pressure as well. These referrals come through, should we take it? You don't want people slipping through the gaps* (CM2).

Impacts of current case loads

The consequences of high case loads were highlighted by many participants and relate to the level of support provided, diminished job satisfaction and unsustainable workloads.

The quality and intensity of support provided to families was perceived as being compromised by several case managers.

> *I would like to see each one every week, with some of them more than that depending on what is happening. I'd say that I'm not providing the level of support that I should be* (CM5).

> *You do feel like you're letting your families down. Sometimes with that case load I'm not necessarily available in a crisis. I know we're not a crisis service but however if a crisis does occur for our families the first person they think to call is their support worker. That's what they do because we've provided them with information that's been reliable for them previously so their first port of call would be you* (CM2).

Falling behind with reporting requirements and case coordination tasks was also highlighted.

> *You come in on days off to catch up with the paperwork* (CM1).

> *I take work home. My notes get behind, my paperwork gets behind. I get tired* (CM2).

In a sector which experiences significant challenges in recruiting and retaining suitably qualified and experienced workers in the ACT, caseloads that are not manageable were perceived as a potential major contributory factor to a constant churning of workers.

> *I think 20 is ridiculous and that is how you're going to get your burn-out and high staff turn-over* (CM7).

Suggestions about more realistic case management targets were made by several participants.

> *There should be a relationship between the degree of complexity and the number of people in someone's case load* (CM7).

> *I think 12 if you are full-time as you will have a mix – those that are really complex and those that only need coordination or a catch up once a month but still need that on-going support* (CM7).

Another participant who works 20 hours a week on case management activities stated:

> *Three hours per person per week would be my absolute limit, so 7 people* (CM2).

3.9 CASE MANAGEMENT ACTIVITIES

The different phases or functions of case management activity are not discrete entities, nor implemented in a linear fashion. Before a person's case management plan has been finalised, there may have been an emergency or high risk situation warranting some active intervention. In a similar vein, the implementation phase maybe fluid with reassessment as well as action plan review and amendment occurring as people and their circumstances change.

ASSESSMENT

The Common Assessment Framework (CAF) is used by the majority of agencies providing case management services. The aim of this assessment tool is to promote more coordinated working with families, and is used to identify family members' needs and minimise the burden for families of having to re-tell their stories to multiple agencies. The majority of agencies utilise the CAF as a means to acquire background information and supplement this information with an additional assessment. Several participants noted that they use their agency's own assessment tool to do this.

The CAF, when used as an initial client assessment tool, was seen as beneficial in terms of knowing which other services were involved with a family or young person. However as a tool to reduce the necessity of people having to repeat their story many times, which can be frustrating and serves as a disincentive for some people in seeking assistance, it was perceived as having limitations. The re-telling of stories is seen as important particularly in terms of engaging with people and actively involving them in determining their priority concerns.

> *You may have a background from the CAF but you have got to build a relationship with this person and work out how they want you to work with them. So the first appointment is basically however long they need, it could be a couple of hours for them to say okay thank you for coming. And how can we help you and what would you like us to work with on. So unfortunately there is a bit of them having to retell their story. If you're coordinating other agencies, they don't have to tell their story over and over if you're doing the overall coordination (CM3).*

A few participants observed that the CAF is a deficits-based assessment tool, and in getting people to re-tell their stories, this was an opportunity to take a more balanced approach and explore their strengths as well as needs and barriers. This participant explained:

> *Normally the client will tell us their story, we listen using our skills as social workers, having empathy. By clients talking it can help them to heal. That way we can discuss, we can discover where their strengths are. We work with clients, not for clients. So we have to discover their strengths and see what deficits are. We empower through using their strengths to overcome the deficits (CM3).*

It was also recognised that assessment is an on-going process in that some people may be unwilling to raise sensitive issues due to distrust, embarrassment or lack of confidence; resulting in disclosure of limited information to referring agencies such as CPS, Youth and Family Connect and initially to case management service providers.

> *You get your answers for the assessment firstly from the referral from CPS and also as you get to know the family, they slowly open up as to what has happened (CM1).*

> *We get the common assessment framework. That in itself is just a snapshot. For instance we might get a referral from ACT Housing that says this person needs help with transfer of their property. And so we go in thinking okay so we just meeting this person for a housing transfer. But then it ends up being you've got relationship problems, behavioural issues with children, it can snowball (CM5).*

> *We can get a referral from anywhere which says they just need some help accessing a mediation service because they're having issues with their neighbours, or something like that, and when you start to talking to the family you realise that is the only thing that they weren't ashamed to share. There are other things going on that they are ashamed of, or weren't confident enough to tell you or just didn't trust you…You work on one level of accessing mediation services and then through that maybe I can trust this person, they are hearing what I'm saying and they are doing something about it, maybe I could tell her that I'm struggling with sending my kid to school (CM6).*

ENGAGEMENT STRATEGIES

A range of strategies to engage and retain families were reported by participants. At the heart of these strategies was a strong emphasis on developing a quality relationship based on trust and support with service users, and trying to ensure that people's concerns and priorities take centre stage in assessment and planning processes of case management. Although the latter approach was not always considered feasible or desirable in those instances where there were child protection issues.

Meeting with people in places where they feel comfortable, usually their homes, was seen as an instrumental first step to building relationships with service users by the majority of participants. The importance of investing time, which in some instances may take several months, was also viewed as an essential component of developing relationships by several case managers.

> *So I'm taking very little steps and try and build up a personal rapport with them and provide them with a bit of background about myself. I can speak with a bit of the jargon that they understand so my approach is very easygoing* (CM1).

> *After you've met them for a few weeks, you build that rapport and they start putting in more. Have a safe place where they can open up* (CM7).

Being respectful was highlighted by one participant as critical to forming and maintaining good relationships.

> *I think we are very tentative as we enter their lives. Is it okay if I talk to you, is it okay if I talk to you now…..Is this a time when you would like some support. Really let them feel that we are equals, I'm not in crisis now and you are but that is the only difference between you and me. I really think that level of respect and not an us and them mentality is so vital* (CM9).

Responding to families' concerns and issues was considered a vital strategy by most participants to engage those families, particularly those who are fearful, distrusting and/or resistant to the involvement of formal services.

> *In the context of clients being scared of CPS and possible removal of children. We go in and say what can we do to help you. We don't go in with an agenda. Care and Protection might be saying your child is not in school, we've got that back here but what else is going on. How are you financially, how are you with your mental health? So we try and be a bit more holistic* (CM1).

This participant describes how she was able to build a good rapport with one person that several government agencies had been unsuccessful in engaging with.

> *I'm not going in there telling her this, this and that. I'm just going in saying I'm supporting you regardless which I think she has never had anyone do before…I'm going in there saying what are we going to do now, what do you need for support so I'm not going alienate her. That seems to be working* (CM1).

Recognising that all people and situations are unique, particularly during assessment processes, was also considered important as one participant comments:

> *You're listening to their story, what they have to say, having in the back of my mind what the referral may have said. This is what we can do, how do you think we can support you? Tell me what you think your needs are. Every body's ideas are different when we are having this conversation* (CM2).

In those instances where people have significant levels of fear and mistrust of formal support services, the need for persistence and commitment is clear as this participant explains:

> It's about you know, I guess I've had a few experiences where it has been quite horrific for me. I've arrived and I've been sworn at, I've arrived and there's been blood over people, it's been quite scary. But for me it's about well I'm going to go back anyway (CM1).

Being clear and transparent about their case management role, and realistic about what can be offered, was signalled by a few participants as also essential to building a trusting relationship.

> Explaining this is what I do, this is what I can offer, no matter what, don't offer anything you can't hold yourself up to (CM4).

PLANNING

A consistent theme in the interviews is that practitioners attempt to use case management processes in a flexible way so that interventions are tailored to individuals and their circumstances. To do this successfully requires a case management plan that is adaptable and can constantly be modified to fit in with changing circumstances.

Most participants reported that they use a structured planning template that clearly identifies goals, actions, who is responsible for these actions and timeframes. Actively involving people in identifying their preferences and priorities during the development of action plans was identified as important by many participants.

> It's coming up to the actual problem, what they want to achieve. They identify that. It is client led (CM5).

> Where they aren't child concerns where the whole family have the same need it's about what the family thinks is important. Do they want to do the housing stuff first or do they want to talk to Centrelink first? What is more urgent for them? What do they define as a priority because you have to respect the wishes of the family, how they see their family function (CM6).

> Always discuss these with them. If they think the issue B is the most important that's the one we go with. I think we all have to check ourselves if we think we have a special barrow that we're pushing. We can't be pushing a particular barrow (CM9).

In those situations where child protection or other safety concerns exist, some participants explicitly said that they made these issues a priority for parents to address.

> A family can have a lot of problems but we sort it out one by one. If there is an important risk, have to do this first (CM3).

> But also taking into perspective, if this puts anyone in danger, or if you can see that it is a child protection matter obviously I would address that. You are not dictating to them unless someone is in danger. I have a mum who doesn't have CPS involved at the moment but we are doing last resort stuff. She has addressed some things but there are others that she hasn't', so I have had to say you do need to do this or else this will happen (CM7).

Only a few case managers used a strengths based planning template. In addition, the use of visual tools to facilitate people's involvement in understanding their situation and working out their preferences was highlighted by a few participants.

> I use a whole lot of different things like artwork and drawings. Looking at pathways they might want to take and where they need to be, what needs to happen and who do you need to contact. Doing it very visually (CM2).

1. Case work – comprehensive practical support

Participants in this study had different perspectives about their roles as case managers in terms of providing comprehensive practical support to families and young people. These different perspectives are partially the result of the absence of an agreed definition of case management and clearly defined outcomes of the CYFS case management service. This leaves space for considerable flexibility in how agencies interpret and apply case management activities.

For several participants, putting plans into action to bring about desired changes in people's circumstances entails providing direct family support work alongside case coordination, linking and advocacy. Examples of concrete practical support include direct assistance with parenting education and skills, daily living activities (e.g. budgeting, cooking), housing issues, as well as assistance with accessing material aid (e.g. food, income, household equipment, educational items, health care, legal) and finding education, training and work.

One participant describes the types of family support that she provides:

> *Helped tidy up the house, helped people with removing head lice from their children's hair, teaching them how to cook, going through a simple recipe with them and shopping, budgeting. Parenting skills there's a lot of that* (CM2).

This participant goes onto say:

> *The parenting information is a constant drip feed. Little bits here and there, this is what you can expect from a two year old. How did that work for you, don't expect the same reaction every time* (CM2).

Another case manager describes the types of support that she has given to people:

> *Counselling, education, for example, if a client is really anxious I'll talk to her about CBT and talk about the physiology of what is happening with anxiety and we might do some mindfulness to help her relax. Information and advice on parenting skills, information on developmental needs of the children, help with budgeting, advice on housework, so getting a regular routine. And borrowing a Ute to organise a tip run, taking a client to a service to get a food hamper as Centrelink cut her payments* (CM3).

In contrast, those case managers implementing a limited model of case management indicated they had a more restricted role.

> *The only direct service we provide is advocacy, to summarize it roughly, advocacy and linking* (CM6).

Another participant expressed her dissatisfaction with this limited role:

> *My frustration as a counsellor is there is nothing really therapeutic that happens here. As a case manager I'm meant to just refer them onto other counsellors* (CM9).

Unfortunately this inconsistent approach to the provision of comprehensive practical support translates into inequitable delivery of case management services to service users. Not all families who sign up for case management may actually receive the practical family support they need.

Active practical support to access specialist services (e.g. drug and alcohol, mental health) and maintain this access through the provision of transport to attend appointments is provided regardless of the model of case management being implemented. Similarly, this was also the case with the emotional support provided by case managers.

> *You've got someone crying that their children are being taken away. That just comes with the job. It's like accidental counselling. Someone will ring me up and say they have had a fight with their mother or they've rung up to talk about a conversation they've had with care and protection or whoever* (CM5).

Another case manager emphasized the significance of the one-to-one support relationship:

> *Just being a person in the your community who's visiting you regularly is what keeps people going. I truly believe for one of my clients in particular if they didn't have myself and someone from another agency providing that regular visiting, caring and listening I don't think she would be able to carry on* (CM9).

2. Linking

A key role of case managers is supported linking of vulnerable families and young people to local services and networks. Generally, case managers were of the view that this required a differentiated response related to people's willingness to engage with multiple services and levels of confidence to do so. Initially in some instances it may involve case managers doing all the foot work, making the calls and accompanying people to their first appointment or arranging for mutual home visits with other agency workers. In other cases, it may be more appropriate to negotiate with people the level of control they would like over the linking process and/or make 3 way phone calls, as these participants explain:

> *Having that option around supporting them as well. Who would you like to start the conversation, would you like me to call and then put you on the phone, or would you like to do that yourself? Having that supportive option for the young person* (CM4).

> *And who is responsible for this, well I can call but then get the client to do the conversation. I put them on loud speaker, I can be there as they're talking and if they feel stuck, I can support them* (CM6).

One suggestion to facilitate people's sense of independence is to make the CAF a document that families can use to make their own referrals. As they become more confident in accessing the service system they would then be in a stronger position to refer themselves, as opposed to the current practice of some external agency workers insisting on getting the referral and CAF from CYFS case managers. Clearly, this practice has the potential to disempower and diminish people's sense of self reliance.

A key finding is that only in a small number of instances do case managers invest time and energy on developing individuals', particularly young people's, natural support systems. Effective linking is dependent on case managers being a resource and having an extensive knowledge of what local formal and informal services and networks are available, and how these can be accessed. A few case managers acknowledged that it was not only service users who experience difficulties in navigating the service maze but that they themselves did not always have the capability to work through the system on their behalf.

3. Case coordination

Participants were asked to outline their approach to case coordination, what they thought worked well and some of the impediments encountered in their case coordination work. It should be noted that a few participants were not familiar with the term case coordination and found it hard to articulate this case management function. As such they talked more generally about their support and advocacy roles.

The tangible benefits for service users of joined up working were acknowledged by a few participants.

> *We are all working together to support this family and the family becomes empowered because they are being supported instead of not being able to cope. And you can see that things are improving and everybody is doing much better* (CM3).

Analysis shows that the extent to which case management plans clearly specify details concerning service coordination is varied and can depend on the number and type of services involved with people. Service relationships, roles and responsibilities as they relate to families' goals are not always clearly delineated in action plans, in particular, who has responsibility for service coordination and building other services into the plan with explicit detailing of how other services will make a practical contribution to the achievement of goals.

The question of who has formal authority and responsibility for the role of case coordination when there are several case managers from a range of agencies involved with a person or family was raised. Analysis shows that there did not appear to be system-wide protocols in place addressing responsibility for all aspects of service coordination, so that where effective coordination occurred, this was mostly due to informal relationships and agreements between service providers. In these situations, participants reported responsibility for the role of case coordination was often decided on the basis of who had the longest involvement with the service user or who sees the client the most frequently. The exception to this is when CPS is involved with families with this agency taking some responsibility for case coordination. This participant explains:

> A lot of the time it's been care and protection that may call case conferences and things like that for families. But then again overworked, under paid, not enough hours in the day, don't have the time to follow up so the families get let down......they are not always obviously the best person to be their case worker if you want things to change (CM2).

One case manager reported that she has been able to negotiate a co-case coordination role with a CPS worker.

The current arrangements for case coordination as described by several participants are service system centric with an emphasis on case managers for services and not case managers for families or young people. That some families have multiple case managers from several agencies and multiple case plans is a recipe for confusion and duplication around roles and responsibilities. This was highlighted by several participants.

> I just think sometimes there is a lot of confusion about people's roles, who is doing what (CM1).

> If someone else came along, for example Care & Protection, do they do case management? That might be the problem I'm having with this particular case, this person thinks she is the case manager (CM9).

One case manager cited an example of a family receiving case management from two CYFSP case management funded services. When there is no clear division of responsibilities across all sectors, the potential for inefficiencies for all involved services is clear.

> I feel it is a double up. We're both trying to work on the same thing with child care for the client and then we're calling all the same services. It's not efficient and the client gets confused, do I call A or B? (CM6).

A very different stance is taken by a few case managers who use a more client-led approach and where feasible in the context of workloads, let families decide who they would like as their case coordinator, although this is not always straightforward.

> I try to give them the choice. Once again, over time people don't always tell you who's working with them. There is that service dependence or that some families like that over servicing thing (CM2).

Individual case managers are attempting to exercise authority in negotiating and advocating for people's rights in a service environment characterised by differing professional or organisational values and expectations, unequal status levels, and occasionally, competition and mistrust. Collaborative practice in this context can be inhibited.

A common experience of participants was inadequate communication and sharing of information by some government agencies.

> *It's very frustrating when CPS don't disclose things to me. I found out yesterday that a family had 14 reports. I had no idea. If I'd maybe known that, I may have taken a bit of a different approach* (CM1).

> *You can get really good care and protection workers or you can get some where you ring, email constantly, constantly and you won't get any response at all. And they are usually the ones where they are not on orders but have involvement or they were previously* (CM5).

Irregular and infrequent attendance by a few agencies at case conferences was another source of frustration for several participants. As was a clash in expectations about what families were able to achieve in terms of case plan goals and the pace of these achievements. Several participants thought that CPS sometimes had unrealistic expectations in the context of families experiencing significant vulnerabilities, and workers did not apply a family focused approach. They thought there needed to be a greater emphasis on working with what families think they can achieve rather than meet the expectations of CPS.

> *CPS have said, A,B,C needs to be done to a very high standard, and that family is not capable of doing it; it's okay to have a dirty floor* (CM7).

Perceived differentials in status were cited by a few case managers as another factor that obstructed collaborative practice.

> *It's always them and us, it's never together. Ownership and control. They're the authority figure and we're just the community. We should work together* (CM1).

This participant gives an example of the conflict that can arise in the absence of respectful working relationships and cooperative team work:

> *Unfortunately with the new workers that they've recruited, I've been in meetings and they've sat there and yelled at me 'don't you dare tell me how to do my job'* (CM1).

BROKERAGE FUNDING

Practitioners utilising both the comprehensive practical case management and SCARF models of case management had access to brokerage funds. This funding is used to support people realise the goals identified in their action plans in those instances where services and goods are not available from other sources or service providers. Under the CYFS program, brokerage funding can be used for a range of purposes including:

- Education, training and employment;
- Sport and recreation;
- Child care;
- Specialist support;
- Home care and maintenance.

MONITORING AND EVALUATION

Analysis shows that monitoring or reviewing is integrated throughout the implementation of action plans using a mixture of formal and informal processes that directly involves service users. Some participants emphasized the value of formal processes such as regular internal case conferences as well as those organised by CPS, or other lead agency, involving all relevant service providers. Others commented that reviewing occurs on an on-going, informal basis.

> *We assess it, re-evaluate it all the time. That doesn't happen officially, more informally with a phone call to a person to see how they got on talking to their counsellor about something and could find that they were pre-occupied with another matter so the counsellor action will be deferred and I will change the plan* (CM6).

A few participants commented that they tend to conduct strengths based reviews that focus on achievements rather than failures, increase people's confidence and motivation to achieve goals, are client-centred and give people a voice.

> *My evaluation with the young person I find more important probably than any of the other steps we have completed. It's look at what we have done, this is absolutely fantastic. Look at where you are. Do you remember where you were? and this is where we've come up to* (CM4)

Some case managers, although not all of them closely monitor the responses of other services to people and challenge those services, if necessary. One participant highlighted how she uses case conference reviews organised by CPS to monitor agencies' responses delineated in service plans.

> *They are very useful because it gives you a clear indicator of where you are headed and if there are any gaps. So when we get a client that's one of the first things I do, I highlight where there may be gaps and what hasn't been done by every other service. Then I take it on myself to follow that through because otherwise it doesn't happen* (CM1).

The adverse impacts on people, when agencies do not deliver, renders this case management function a priority as this participant explains:

> *So people give up when these organisations don't get back to them. It's so demanding, overwhelming for someone in their situation to follow through when they are feeling like death warmed up. That's where the case manager comes in, 'it's okay I'm with you, we'll get through this. Hang on just keep going'. That's what the case manager's role is* (CM9).

In contrast, a few participants were unsure of their monitoring role and the expectations associated with this case management function.

> *I'm only just starting to touch on that area with the length of time I've been involved with the families. I guess that is something I'm unclear about as a case manager as to who picks that up. And do I have the right then to say 'hang on a minute, this other service you said you were going to do that, why haven't you? That is something that is quite unclear* (CM7).

Due to the developmental stage of CYFSP case management services, several agencies have not put in place formal evaluation strategies. A few participants use specific tools such as the Family Outcomes Star to routinely measure outcomes. The value of using visual tools such as the Star for people is highlighted by one participant:

I did it with a man last week and his star is now like nines and this massive difference in the 3 months. They can then look at that and go yeah I'm doing really well (CM1).

A few case managers also reported that they relied on informal feedback from clients. In addition, one agency had plans to distribute client satisfaction surveys to identify deficits in how services are delivered and gaps in the type of available services.

3.10 WHAT CONSTITUTES GOOD CASE MANAGEMENT PRACTICE?

Case managers identified various case management processes and types of organisational support that they perceived as enablers to providing better quality case management support to families, children and young people. A summary of these contributory factors are given in this section of the report followed by a discussion on the inhibitors to better quality case management.

Duration of support: Under the Service Delivery Framework OCYFS funds agencies to provide case management services to people requiring medium (more than 3 months) to long term assistance. Case managers strongly valued the unlimited time frame and thought this feature of the service is likely to be a major influence on the attainment of positive outcomes for families. Participants acknowledged that a trusting relationship, particularly with people who have been 'burnt' by previous experiences of formal services, is critical and takes time to develop. The unlimited time frame allows case managers to work at a pace determined by clients. In doing so, case managers are able to provide individualised, responsive and flexible support that addresses the full range of issues faced by families.

Using visual tools: during planning and monitoring activities with people, the use of visual tools such as the Family Outcomes Star was considered invaluable in involving people in decision making. These tools clearly indicate to people what they have achieved and the changes that have occurred in their circumstances. From an agency perspective, data from the Family Outcomes Star also gives other organisations at case conferences an idea of what has been achieved.

Critical success factors for joined up working: when done well collaborative practice is viewed as one of the key principles for successful case management. Case managers were of the view that extensive cooperation exists in the community sector, and that more needs to be done by some government agencies. Good collaborative practice involves applying a range of strategies which include:
- making it a priority for all team members in all relevant agencies;
- establishing and nurturing close working relationships with other agency staff;
- being open and setting up good channels of communication;
- valuing and drawing on each others' areas of expertise;
- having a clear, common plan specifying who has responsibility for case coordination and details about what services have agreed to do;
- ensuring all case managers/workers are clear about roles and responsibilities that stakeholders have agreed to;
- ensuring people have given informed consent for their situation to be discussed with other service providers;
- convening regular case conferences with families and key case workers;
- supporting service users to participate in case conferences;
- keeping families and young people informed of what each case worker is providing in the case plan;
- frequent, good quality communication - keeping everyone involved up to date on what is happening;
- being persistent in following up services who have agreed to deliver.

Regular professional supervision: supportive supervisors who are available on a regular basis, and who recognise that case management for people with complex and entrenched issues in their lives is 'hard work', was felt to be a necessary buffer to prevent 'burn out' and promote workforce retention. It was suggested that supervisors need to have previous service delivery experience and be able to provide suggestions for working with more challenging people as well as well as the ability to facilitate effective reflective practice. Case managers also thought that if needed, they should have access to professional external supervisors (e.g. psychologists). The reasons given were inadequate time in supervision sessions to discuss issues of concern and fear of being viewed as an employee who is failing.

The absence of professional supervision for some case managers was seen as a significant barrier to providing quality case management services.

Teamwork: peer support from other case managers was identified by participants as another source of effective support.

Professional development opportunities: some case managers felt they had been able to participate in ample training opportunities to improve their professional practice. However training inequities appear to exist in that several case managers have not had access to training courses. A lack of access to funding provided by CSD for training purposes and available time, particularly for part-time workers, were the reasons given. The critical importance of having a skilled case manager workforce is highlighted by this participant:

> *They've identified the need to have skilled staff. They've identified the level that we're sitting at. We're sitting at the high need people really. The issues that they present with and come with, you want your staff trained to deal with that* (CM7).

Qualifications and/or experience: the employment of case managers with social work qualifications was viewed by some participants as instrumental to promoting quality practice. In contrast several case managers thought that personal experience should be counted as this assists workers in relating to service users. Overall, there was acknowledgement that the sector needs to move more towards employing practitioners with professional qualifications. At a minimum level, it was thought that workers required Diploma and Certificate qualifications.

> *I think having field experience is really important. I really think that having that practical experience is crucial. But I also think there needs to be a theoretical base of some sort for everyone. When you are working with traumatized people, for example, we have workers here who don't know how to deal with a situation when there is a crisis, someone discloses a rape, someone disclosed self-harm or suicidal thoughts, that's dangerous* (CM6).

Self-care: the risks associated with being regularly exposed to the trauma experiences and stories of clients were recognised by case managers. Taking measures to prevent these, at both an individual and organisational level, was considered important to mitigate against workers getting burnt out.

MAIN BARRIERS TO EFFECTIVE CASE MANAGEMENT

The most commonly cited impediments to carrying out case management activities relate to the dual role of some participants, gaps in ACT services, a lack of a coherent model of collaboration across all relevant government agencies and the community sector, recruitment of experienced staff and inadequate agency resources.

The dual role of case management and youth engagement was thought to be problematic by those case managers with this additional responsibility. Concerns were expressed about the two roles requiring different qualities and skills with some participants feeling ill equipped to do youth engagement work.

> *With youth work I doubt my skills constantly. I don't think that is very good for team morale. And for personal and professional development, burn out is such a big risk factor when you're feeling dissatisfied with your personal skills all the time* (CM6).

> *The skill sets are different. Youth engagement is about running programs…. It's just totally different, it's just a totally different mindset as well. You're going from restoration of children, the court whatever it maybe to going to the youth centre and doing drop-in* (CM5).

In having to work in very different ways in each of these roles, several participants also felt their effectiveness in working with vulnerable families was diminished.

> *I feel so exhausted, so frustrated sometimes. I feel like I'm so drained and if I have a client after being with young people I'm compromising the quality of care, not intentionally, like I'll still be very attentive, I'm so much more mentally tired* (CM6).

They also questioned whether youth engagement strategies, such as street outreach, were actually achieving anything. It was suggested the time could be used more productively working with isolated, vulnerable young people living at home with whom they had access through their case management work.

Gaps in basic services in the ACT serve as significant hurdles to the achievement of people's goals in their case management plans. While a number of case managers work across different service systems, there are gaps in direct service provision in some areas. A prerequisite for effective case management is access to resources and supports for service users. Participants observed that some people miss out on concrete practical assistance, for example, emergency food relief, transport to service appointments, access to school holiday programs and respite care (for those families with children who have disabilities). The pool of brokerage funding that some CYFS case management services have access to is inadequate to cover the costs of these services.

> *One of the biggest issues is funding. Whilst CPS can do a referral to us, there is no funding to support the needs of that family. You are just told no constantly, no, the parent has parental responsibility here..... No-one wants to pay for anything anymore...... no-one can help anyone with the basics* (CM1).

Children and young people are not able to access counselling services when needed. For some families, particularly those experiencing poverty, the lack of affordable housing remains an insurmountable barrier that no amount of case management can resolve. Also, a shortage of childcare services means that some parents are denied education and training opportunities that may well contribute to their families' future self-reliance and well being.

High case loads were seen as a significant barrier to building relationships directly with children due to time constraints. This was cited as a major reason that precluded case managers taking more of a child centred approach in their work. For many participants, the part-time nature of their case management role combined with high case loads also presented some significant challenges in being able to respond to people's needs and circumstances.

The barriers to joined up working have been detailed in previous sections but are worth summarizing here:

- Lack of consistent policy and practice responses across different service systems;
- Lack of understanding by case managers about how different service systems work in practice;
- Absence of formal/informal mechanisms for sharing information and building trust;
- Absence of an agreed reporting framework which has a focus on outcomes in terms of client wellbeing outcomes.

Adequate organisational infrastructure such as enough cars was seen as a priority. It is difficult for workers to do home visits, a funding requirement under the SDF, without access to appropriate transport.

Recruitment of experienced staff at both a practitioner and senior level is an ongoing challenge for some agencies, and has repercussions for existing staff workloads and the quality of supervision available to workers.

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