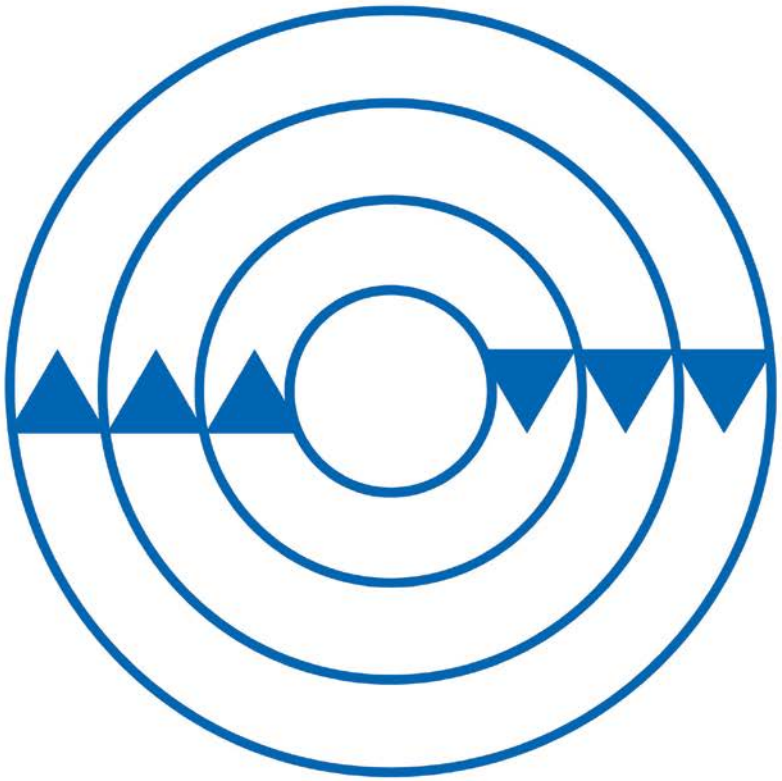
CHAPTER

2

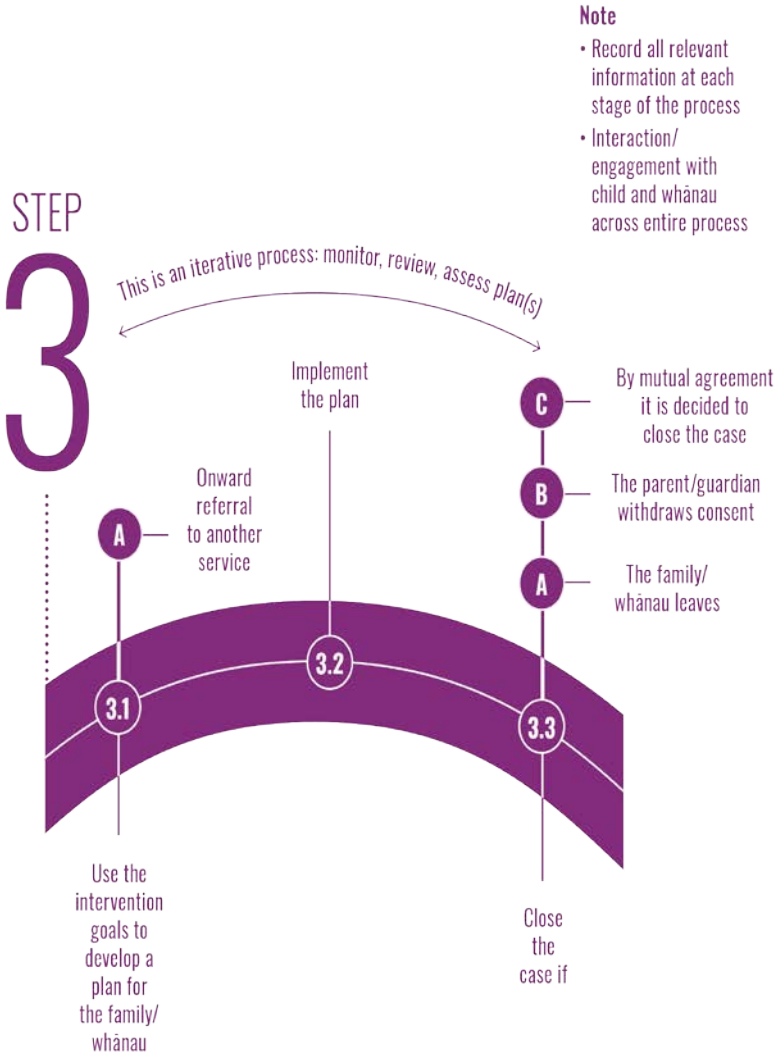
process



step 3
developing and implementing the plan

STEP 3. DEVELOPING AND IMPLEMENTING THE PLAN; REVIEWING AND ASSESSING PLAN PROGRESS

The first plan (Plan 1) is the means by which the child and parent/ caregiver and family/whānau will be empowered and receive help with meeting the identified needs. Subsequent plans may be required after Plan 1 has been reviewed.



our process

Key points:

- Work should begin on delivering services in the plan(s) as soon as the plan is complete.
- The social worker is responsible for delivering and/or coordinating the delivery of services as agreed in the plan.
- The social worker works directly with the child, parent/guardian, and family/whānau in a therapeutic relationship to achieve the goals outlined in the plan.
- Plans are regularly monitored and reviewed to ensure services are appropriately coordinated, focused, and achieving goals
- Records are kept of the processes and outcomes of the work.

THE PROCESS

Develop a plan

After the Strengths and Needs Assessment when you have clarified what the child, parent/guardian, and family/whānau aim to achieve, they will be ready to take these goals and aspirations and, with your assistance, formulate plans detailing how they will achieve these goals.

The plan is developed, and implemented, according to the desired outcomes and core values and principles of the SWiS service.

These values and principles are:

- Child-focused and centred on parent/guardian and family/whānau – using a strengths-based and empowering approach to service delivery.
- Partnership – a voluntary (non-statutory) relationship.
- Flexible, creative, and innovative – the service must be able to respond to the individual needs of the child and their parent/guardian and family/whānau.
- Holistic – takes into account the child's, parent's/guardian's and family's/whānau environment and needs – physical, emotional, cultural, spiritual, social, and educational.
- Culturally sensitive and responsive to all cultures in a way that recognises their diversity
- Complementary – rather than duplicating existing services
- Collaboration – with health, education services, and other agencies.

Developing the plan(s)

The plan is developed from the Strengths and Needs Assessment by focusing on how the strengths can be used to meet the needs. Where this is not possible, you will need to work out what other services are available to meet the needs.

The plan should be simple, achievable, task centred, and solution focused. While you will be working with the parent/guardian and family/whānau you will keep the child as the focus of all decision making.

The plan should be clear about what is to be achieved. At the same time, it should be viewed as a living document that is reassessed and evaluated as circumstances change.

You can create additional plans to achieve the desired outcome. You should continually review each plan and create a new one if required.

SMART

Use the following SMART checklist to help you develop plan(s):

Specific – be specific about the identified needs, always keeping the child at the centre of your thinking.

The Strengths and Needs Assessment should have shown the strengths of the child and parent/guardian and family/whānau. Focus on these as ways of addressing the current needs and ensuring that the child and parent/guardian and family/whānau move towards independence with less need for service delivery.

Measurable – the social worker needs to be able to monitor progress with the involvement of the child, parent/guardian, and family/whānau.

Assignable - discuss the service or intervention for each of the identified needs. Be specific about what services you can offer and what services are available from other agencies. The SWiS service should not do the work of other agencies, but, where appropriate, complement them.

If it is decided that service will be provided directly by, or coordinated by, the social worker, then this service will come from the plan negotiated and agreed by the child, parent/guardian, and family/whānau.

It may be decided that **further action** is required from specialised service providers. Be clear about the processes involved in referring the case to another agency or individual. The parent/guardian and family/whānau need to know, and be comfortable with, what this means in respect of monitoring outcomes and sharing child information. If you identify that an onward referral is required, you still need to record, implement, and review the plan. You will need to review the plan to ensure the other service has accepted or declined your referral.

Realistic – set realistic objectives and goals.

Time-related – set time frames to give a sense of progress and achievement. Keep time frames short and review them as a way of keeping the process on track.

Recording the plan

The plan is to be recorded in a way that is understood by the child, their parent/guardian, and family/whānau.

It should be in plain language, with goals, responsibilities, and tasks clearly identified.

All parties involved in the planning process should sign the plan. This should be explained as being symbolic of the partnership rather than as being a bureaucratic requirement.

A copy of the plan should go on the child's personal file (held by the social worker) and at least one copy should be given to the child and their parent/guardian and family/whānau.

Implement the plan

By now all parties have agreed to the plan. The plan serves as a record of the goals. The child and their parent/guardian and family/whānau should feel that they have strengths and resources that will enable them to achieve the goals specified in the plan.

You, the social worker, are ultimately responsible for delivering the plan. This may involve:

- keeping the child and their parent/guardian and family/whānau focused on goals and objectives
- working in a way that encourages independence and empowers the child and their parent/guardian and family/whānau, which will ultimately reduce the requirement for service.

Monitor, review and assess

You are also responsible for monitoring, reviewing, and assessing the plan. This should be done in a collaborative manner, with participation from the child, their parent/guardian and family/whānau, and others involved in the plan.

Monitoring is an on-going and informal process, but reviews will be formally written into the plan. A review date is assigned to each plan when it is created. At the conclusion of the review, the social worker, the child, and their parent/guardian and family/whānau will decide whether a new plan is to be created or the case should be closed.

Note: This may be a good time to implement the SDQ follow-up questionnaire. It can help inform the decision to continue in delivering the service, or to close the case. (If you close the case this becomes the post SDQ. If the service continues then you do not need to record the SDQ scores, as you will do another assessment when you reach the case closure process).

Both monitoring and reviewing are vital to the SWiS service. The purposes of monitoring and review include:

- Ensuring that focus remains on the well-being and development of the child.
- Ensuring that the needs of the child, parent/guardian and family/whānau are being adequately addressed and the

right mix of child-focused and adult- focused activities are being provided.
- Ensuring that the child's, parent's/guardian's and family's/whānau strengths are being used to address needs.
- Ensuring the child, parent/guardian and family/whānau are satisfied with the service they are receiving from the social worker and other agencies.
- Reviewing whether plan goals are being achieved and whether time frames are realistic.
- Enabling plans to be adapted to changing circumstances.

Monitoring happens every time you have contact with the child, parent/guardian, and family/whānau:
- All contacts should be recorded.
- Acknowledge progress.
- Address problems as they occur.
- Maintain momentum.

Reviews are incorporated into the individual plan:
- Process for review will depend on the relationship between the social worker and the child, parent/guardian, and family/whānau.
- Check that goals have been met within specified time frames.
- Should address the needs and goals in the plan in order to ascertain whether a new plan is required or the case should be closed.
- Modify or set new goals for a new plan.
- Should address the question of whether the level of service delivery is appropriate.
- Should contain information from other stakeholders, especially the school/kura.
- All reviews should be recorded and held with child/family information.

During the monitoring, review, and assessment period, several situations may result:
a) service continued and/or additional plan required
b) plan breakdown/ consent withdrawn
c) service delivery reductions
d) planning ahead

a. Service continued and/or additional plan required

Monitoring and review may show that the plan is working well and progress is being made towards the goals. It may also show that an additional plan is necessary in order to meet particular goals. Once the goals have been identified, you will have to go through the process of developing and recording the additional plan.

b. Plan breakdown

Breakdown does not mean failure – it means that you have to assess the situation and try again.

Sometimes the plan doesn't meet its goals, so you have to be prepared for this possibility. Breakdown can become apparent during the course of service delivery or during a specific review.

It is not useful to assign blame, but it is important to clarify the factors that led to the breakdown. These may include:

- Changed circumstances of the child and/or their parent/guardian and family/whānau.
- Inappropriate goal-setting in the plan.
- Incorrect identification of strengths and/or needs during the Strengths and Needs Assessment.
- Significant factors or events affecting the plan.

Once you have clarified what happened, you can begin work on a new planning process. This may mean that you have to review the Strengths and Needs Assessment or, if the first assessment is no longer relevant, review it and add more information (or do another one).

c. Service delivery reduction

As the child and their parent/guardian and family/whānau achieve their goals and objectives, the intensity of the service should be reduced. The relationship is coming to an end and a planned withdrawal should begin.

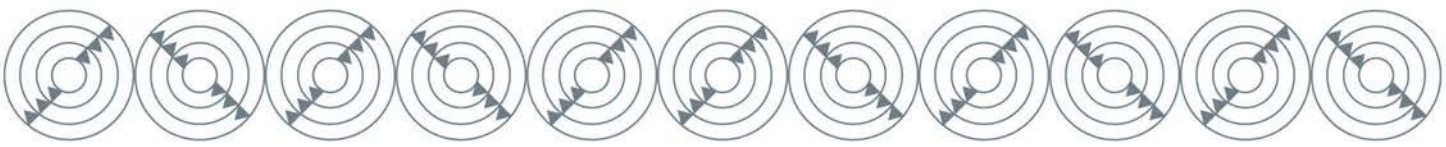
Closure can be difficult for all parties. It is, in effect, the reversal of the relationship- building process that enabled the service to be delivered. In some cases the parent/guardian and family/whānau may be reluctant to end their contact with the service, and you will have to develop strategies in response to this.

Discuss a plan for the closure of the case with your professional supervisor. It is important to acknowledge and celebrate outcomes as part of the closure process.

d. planning ahead

It may be helpful to draw up a plan for what will happen after the case is closed. This is useful where parent/guardian and family/whānau have on-going needs that are outside the scope of the SWiS service.

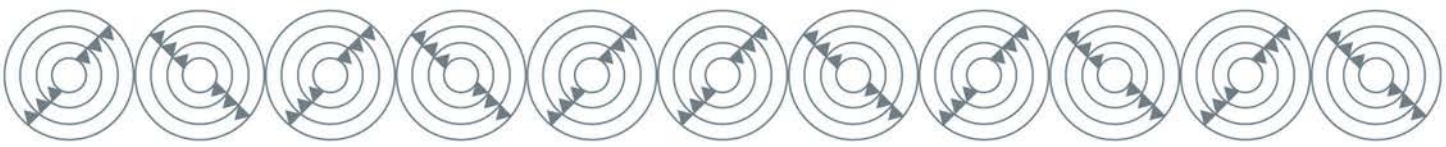
The concept is the same as the original plan, except that all tasks in relation to goals are carried out by the parent/guardian and family/whānau or external service providers. In such cases, this plan serves the purpose of:



- Identifying services that the parent/guardian and family/whānau may access for on-going needs.
- Identifying services that the parent/guardian and family/whānau may access in the event that a previous problem or need recurs.
- Identifying those people who make up the extended family and support network that is available to give assistance.
- Increasing confidence of the parent/guardian and family/whānau that they can manage if problems occur in the future.

You may wish to record this in the case notes and monitor and review progress.

Note: when monitoring, reviewing, and assessing plans do not delete the original information. If there is significant new information, or you feel you viewed something wrongly, then record the new information in addition to the original.



APPENDIX 1

This table shows the key players and their responsibilities for this step of the process.

KEY PLAYERS	RESPONSIBILITIES
Social worker	• Work with the child and family/whānau to develop plan(s) to achieve intervention goals. • Ensure implementation of plans. • Engage therapeutically with the child and family/whānau and be available to offer advice and guidance. • Write referrals agreed to in the plan(s). • Monitor and review progress.
Parent/guardian and family/whānau	• Work towards meeting objectives and goals in plan(s). • Engage with other agencies as agreed in the plan(s).
Child	• Work towards meeting objectives and goals in plan(s).
Service provider	• Ensure the implementation action of plan(s).
Professional supervisor	• Provide guidance to the social worker in regards to best practice, maintaining boundaries, and child/worker safety.

APPENDIX 2

This table shows the key documents for this step of the process.

DOCUMENT	WHAT IS IT FOR?	WHO CAN VIEW THE DOCUMENT
Strengths and Needs Assessment	A reminder of the specific needs and issues of concern for the child, parent/guardian, and their family/whānau, as well as the strengths they possess in relation to those needs (remember the SDQ forms a part of this process).	• Child • Social worker • Parent/guardian and family/whānau • Provider • SWiS supervisor • Social Services Accreditation Assessor
Plan (there may be several plans, depending on the situation)	A record of the steps that will be taken in order to meet specific intervention goals and objectives (used to review and monitor progress).	• Child • Social worker • Parent/guardian and family/whānau • Provider • Professional supervisor • Social Services Accreditation Assessor
Child's file/records	A record of actions taken in the case.	• Child • Social worker • Parent/guardian • Provider • Professional supervisor • Social Services Accreditation Assessor