DBT Residential Trauma Treatment Centre
Care Coordinator / Social Worker
JOB DESCRIPTION

Responsible to: DBT Service Manager
Days of Work: Days to be negotiated
Hours of Work: 32-40 hrs per week (to be determined)
Broad Objective: Care Coordinators deliver clinical services within a multidisciplinary residential therapy team to clients experiencing and affected by a mental health condition. A key part of the role is coordination of the care during treatment and transition to home life in a residential setting.

Key Accountabilities	Objectives	Task	Outcome
Organisation	TWM is committed to Te Tiriti O Waitangi	• Uphold the organisations Vision and Philosophy towards Te Tiriti o Waitangi. • Liaise with Iwi as appropriate	• Appropriate service delivery to Tangata Whaiora • Improved bi-cultural practice.
	To communicate with other health professionals and community agencies as appropriate.	• Liaison between DBT staff and clients' whanau/clinical teams • Attend meetings • Liaise with Golden Bay Community Resources (e.g. GB Hospital, WINZ, Work Centre) as appropriate. • Liaise with other external Mental Health Professionals and whanau (e.g. DHB referrers, ACC clinicians)	• That relevant information is appropriately shared to support client wellbeing. • Collaborative working relationships are developed within GB commuity and other agencies in clients' communities.
	To adhere to TWM policy and procedures	• Participate in meetings, training, supervision, and performance appraisals. • Utilise TWM Administration systems appropriately. • Electronic and hard copy information is kept current and accurate. Confidentiality is observed. • TWM property and resources are treated with responsibility and care	• Professional standards, boundaries and development, are maintained. • The employee works within TWM Policies and Procedures • Information is accessible, and confidentiality is appropriately maintained. • Administrative tasks are completed in a timely fashion and to a professional standard.

Key Accountabilities	Objectives	Task	Outcome
Health & Safety	To maintain a healthy and safe work environment.	• Report any identified hazards. • Take responsibility (as far as is reasonably possible) for personal and professional safety while at work.	• Hazards are reported and managed • The work environment is safe. • Personal/professional safety is maintained.
Clients	To provide effective and quality care coordination for residential clients.	• Work in partnership with clients to help them achieve treatment goals focused on improving their independence and quality of life while adhering to DBT protocols. • Collaboratively formulate, implement, monitor, and review an individualised client treatment plan together with the client, primary therapist, and treatment team with particular attention to enhancing quality of life (i.e. physical health, financial, vocational, and recreational). • Link clients with available resources, coach and consult to the client on effective self-management strategies, and when necessary, advocate on their behalf. • Consult regularly with other members of the residential treatment team to assure quality care. • Assist and coach clients in effective communication and problem-solving skills to independently manage life responsibilities, and develop and nurture effective relationships, including with family/whanau as appropriate. • Assist with coordination of travel arrangements and cope ahead plans for client home visits. • Network and liaise with other organisations and Mental Health professionals to coordinate and assist in the smooth transition of care. • Provide support and advocacy to minimise barriers to the use of health, education and welfare service. Encourage and facilitate family/Whanau involvement/sessions when appropriate and with client consent. • Coverage of the Health and Medication Coordinator's tasks when required (accompany clients to GP visits, liaise with GP and Psychiatrists) • Create tools for psychoeducation (towards quality of life targets).	• Clients achieve increased independence and experience improved quality of life. • Treatment meets the needs of the individual and is responsive to change. • Clients are aware of and able to access a number of resources. • Clients have effective Cope-ahead plans to manage challenges and stressors • The DBT team are kept well informed and there is clear, accurate communication between and amongst the team. • The clients manage practical, day to day arrangements/appointments. • Family/ whanau is involved and included while the client is in TWM Residential DBT Programme. • Other clinicians (GP's, consultant psychiatrist, case managers) are well informed and have relevant, current information. • Medications are managed safely and within regulatory requirements. • Clients receive support, supervision (as required) and monitoring of medication and medication changes. • All new clients are registered with a GP. • Client's physical health is monitored, and any ongoing treatment requirements are provided.

Programme Structure	• To be an effective member of the DBT clinical day staff team	• Deliver programme elements to residents - Teach one skills class per week, facilitate on skills practice group per week - Skills coaching of clients • Cover colleagues' positions when needed • Establish and maintain relationships with referral clinicians/organizations and input to appropriate databases • Respond to and problem-solve referral-related clinical issues • Clinical tasks related to collaborative care model during residential stay, discharge, transition, working in cooperation with the admin team and clinical team. • Ensure that transition for clients from DBT program towards home life is smooth and adequate. • Coaching as necessary	• Involvement in teaching increases professional DBT knowledge • Role within clinical team integrates liaison duties with other aspects of programme structure • Relationships with referrers, clients, DBT staff are built and maintained
Family/Whanau	To work inclusively with family/whanau* * Where client permission has been given	• Develop a supportive and professional relationship with the family/whanau of Clients. • Be cognisant and understanding of family/whanau concerns and issues. • Discern the difference between the needs of family/whanau and those clients. • Maintain communication with Family/whanau. Identify opportunities for involving family/whanau.	• Family/whanau is included in decision making and involved in supporting their family member in achieving their goals whenever possible. • Increased Family/whanau involvement.

Care Coordinator / Social Worker - Person Specifications

Skills and Abilities Communication	- Has excellent communication skills; written and verbal. Can communicate with people in a way that gains their trust and engagement. Can communicate professionally within the team, with colleagues in other areas of TWM, community agencies, and other health professionals.
Supervision	- Committed to receiving supervision as part of their professional development and best practice.
Team Work	- Understand the value, importance and challenges of (multidisciplinary) teamwork.
Networking/Relationships	- Able to develop and maintain professional relationships within the community at a level appropriate to the role.
Administration	- Have a good level of IT literacy, can complete required administrative tasks in a timely and professional manner.
Aptitudes Professional	- Works in a respectful and professional manner with all clients, members of staff, other professionals and members of the community.
Strengths/Solution Focus	- Ability to problem solve through the use of strengths-based solutions to promote an excellent level of service.
Flexibility	- Able to work on own initiative, flexible approach to changing priorities, environment and work demands.
Organised Motivated/Passionate	- Self-motivated, empathetic and enthusiastic with a passion for mental health work.
Knowledge and Experience Relevant Training and/or experience	- Has clinical experience of working with clients with complex problems and needs - Has an understanding of, or willingness to learn, the implementation of Te Tiriti o Waitangi - Committed to a bi-cultural model of practice