Integrated Case Management

Participants’ Manual

Ministry for Children and Families

October 1999
 Legislation, Policies, and Principles Underlying Curriculum

This curriculum is based on the principles and provisions outlined in the Ministry for Children and Families (MCF) Integrated Case Management policy and the corresponding Integrated Case Management: A User’s Guide.

The legislation and policy underlying this curriculum include:

- The *Child, Family and Community Service Act*, Section 3 (a-e)
- The *Young Offender’s Act*
- The *Freedom of Information and Personal Privacy Act*
- The *Child Youth and Family Advocacy Act*
About the Authors

The authors of the ICM training curriculum frequently work together as a team. Prior to working on this project they completed a *Review of Integrated Case Management Project* for the Ministry for Children and Families in 1998. The authors are:

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Betty has a background in nursing and is currently working as an educator, researcher and consultant. Betty is a sessional instructor in the School of Nursing at the University of Victoria. As a researcher and consultant she has been involved in a wide range of projects including participatory evaluation and interdisciplinary practice with children and families.

**Carol Hubberstey, MA**
Carol has a Masters degree from the Faculty of Education in educational psychology. She has a background in direct services with families, as well as agency and project administration, project facilitation and research. Carol has worked as a team member or co-researcher on numerous research and evaluation projects in the human services field, including best practices in child welfare.

**Sharon Hume, MSW**
Sharon has worked as a consultant, manager and line worker in government and with private agencies for 26 years both in BC and the Yukon. While in the Yukon, Sharon helped negotiate and successfully implement the first permanent agreement between the Yukon Government and an aboriginal band to assume responsibility for child welfare services. She worked for the Ministry for Children and Families as Manager of Special Projects until 1997 after which she began working as a consultant.

**Deborah Rutman, Ph.D.**
Deborah has a Ph.D. in psychology and has been the Director of the Child, Family and Community Research Program at University of Victoria since 1994. Deborah has worked on a variety of projects including one with Aboriginal and non-Aboriginal researchers to identify alternative policies and approaches to working with pregnant women who misuse substances. Another major project is examining the experiences and support needs of individuals affected by FAS and their caregivers.

Acknowledgements

The authors wish to acknowledge the invaluable contribution made by practitioners from around the province. They willingly shared their practice expertise in ICM and gave helpful feedback on the development of the competencies and the training modules. The training modules also benefited enormously from the input and participation of community practitioners in the two regions where 6 modules were piloted. The authors also wish to acknowledge the support of the ICM training steering committee, including Irene Borysowich and Anne Cochran at the Training Branch of the Ministry for Children and Families, Cinder Wood of MCF Mental Health and Youth Policy Division and Chuck Eamer, Community Services Manager, North Island Region. They have provided relevant input and important feedback in the development of the curriculum.
# Table of Contents

## Forward

- Legislation, Policy and Procedures Underlying Curriculum
- About the Authors
- Acknowledgements

## Introduction

- Overview
- Competencies and Performance Criteria
- Curriculum Matrix
- Course Agenda

## Module 1: Overview of ICM for Supervisors and Managers

1-1

- Resource #1-1: “Integrated Case Management” and “Collaborative Practice”:
  Some Definitions and Key Elements
- Resource #1-2: Benefits of ICM for Practitioners and Clients
- Resource #1-3: Small Group Discussion: Beginning an ICMProcess
- Resource #1-4: Small Group Discussion: Preparing for Integrated Case Conferencing
- Resource #1-5: Small Group Discussion: Case Conferencing
- Resource #1-6: Small Group Discussion: Reviewing the Plan and Closure
- Resource #1-7: Community Scenario
- Resource #1-8: Supports and Barriers to ICM in a Community
- Resource #1-9: Evaluation Form

## Module 2: Integrated Case Management: Creating a Common Vision

2-1

- Resource #2-1: Integrated Case Management: Principles
- Resource #2-2: “Integrated Case Management” and “Collaborative Practice”:
  Some Definitions and Key Elements
| Resource #2-3: Rethinking The Role Of 19th Century Casework Models In The Design Of 21st Century Child And Family Services | 2-6 |
| Resource #2-4: Definition and Key Elements of ICM | 2-10 |
| Resource #2-5: Case Scenario: Community Living | 2-12 |
| Resource #2-6: Case Scenario: Youth Services | 2-15 |
| Resource #2-7: Evaluation Form | 2-18 |
| **Module 3: Community ICM Self Assessment** | 3-1 |
| Resource #3-1: Community Self-Assessment for Integrated Case Management | 3-2 |
| Resource #3-2: Evaluation Form | 3-8 |
| **Module 4: Beginning ICM and Preparing for Case Conferencing** | 4-1 |
| Resource #4-1: Case Scenario | 4-2 |
| Resource #4-2: Case Scenario | 4-4 |
| Resource #4-3: Case Scenario | 4-6 |
| Resource #4-4: Case Scenario | 4-8 |
| Resource #4-5: Reflective Questions | 4-10 |
| Resource #4-6: Clients’ Experience of ICM and Outcomes of ICM for Clients | 4-11 |
| Resource #4-7: What is Advocacy? | 4-17 |
| Resource #4-8: The Four Parts of Advocacy | 4-19 |
| Resource #4-9: Reflective Questions | 4-21 |
| Resource #4-10: Small Group Questions | 4-23 |
| Resource #4-11: Consistent ICM Documentation | 4-24 |
| Resource #4-12: Small Group Questions | 4-26 |
| Resource #4-13: Role Play Debriefing Questions | 4-27 |
| Resource #4-14: Check List for Effective Collaboration with Children, Youth and Families | 4-28 |
Module 5: Case Conferencing

Resource #5-1: Case Scenario
Resource #5-2: Case Scenario
Resource #5-3: Case Scenario
Resource #5-4: Team Behaviour Questionnaire
Resource #5-5: Small Group Discussion Questions
Resource #5-6: Chilliwack CareTeam Code of Conduct
Resource #5-7: Check List for Effective Collaboration with Children, Youth and Families
Resource #5-8: Consistent ICM Documentation
Resource #5-9: Case Conferencing Documentation Examples
Resource #5-10: Integrated Case Management Practice Tips
Resource #5-11: Evaluation Form

Module 6: Conflict Resolution in ICM

Resource #6-1: Case Scenarios
Resource #6-2: Evaluation Form

Module 7: Information Sharing and Documentation

Resource #7-1: Confidentiality: Personal Reflection Questions
Resource #7-2: Case Scenario
Resource #7-3: Case Scenario
Resource #7-4: Small Group Discussion Questions
Resource #7-5: Consistent ICM Documentation
Resource #7-6: Case Conferencing Documentation Examples
Resource #7-7: Evaluation Form
Module 8: Ongoing Review and Closure of an ICM Process 8-1

Resource #8-1: Case Scenario 8-2
Resource #8-2: Integrated Case Management Plan (Filled in) 8-7
Resource #8-3: Sample Agenda for Follow up Meetings 8-10
Resource #8-4: Consistent ICM Documentation 8-11
Resource #8-5: Case Conferencing Documentation Examples 8-12
Resource #8-6: Service Tracking Example 8-16
Resource #8-7: Key Definitions 8-17
Resource #8-8: Example of Closure Report 8-18
Resource #8-9: Example of Family Questionnaire 8-19
Resource #8-10: Service Outcomes 8-21
Resource #8-11: Evaluation Form 8-22

Bibliography
Overview

The Integrated Case Management (ICM) training manual is part of a Ministry for Children and Families (MCF) sponsored implementation plan for ICM. MCF is committed to ICM “in an effort to achieve better outcomes for clients, including children, youth and families. Integrated case management puts clients at the centre – and gives them an active voice in shaping services that will support them in directing their own lives, now and in the future”\(^1\). In addition to MCF’s commitment and sponsorship of ICM and this training initiative, it is important to emphasize that ICM practice and training needs to be a community driven initiative that reaches beyond MCF staff and contracted agencies.

In the \textit{Review of Integrated Case Management}, report prepared for MCF in June 1998, participants identified the need for a variety of learning and support strategies to promote community ICM initiatives. They saw value in having opportunities to reflect on their practice, to learn more about each other’s roles and responsibilities, and to develop protocols and guidelines that reflected ICM practices in their community.

The modules in this training manual have been developed to meet the needs of ministry and community practitioners and, in so doing, to improve the outcomes for children and families by enhancing and expanding the practice of ICM throughout the province of British Columbia. The modules are designed to:
\begin{itemize}
  \item be flexible and adaptable to differing community needs
  \item utilize interactive approaches to teaching and learning
  \item build on the existing skills and strengths of practitioners
  \item help practitioners to develop a better understanding of ICM, the issues and challenges and how to succeed
  \item facilitate discussion among practitioners on how ICM can be used in their practice
\end{itemize}

The Underlying Values/Principles of ICM used in the Training

The \textit{ICM User’s Guide} and the \textit{Review of Integrated Case Management} identify the following values/principles of ICM practice. The training is built upon these values and principles.
\begin{itemize}
  \item \textbf{Client–centred Service}: Clients are key players and have an active voice in shaping services that will support them.
  \item \textbf{Building on Strengths}: ICM focuses on strengths as the basis for making changes.
  \item \textbf{Advocacy}: Advocates can assist clients to take an active role in the ICM process.
  \item \textbf{Recognizing Diversity}: ICM relies on multiple perspectives.
  \item \textbf{Collaboration}: ICM is based on a team approach to creating and implementing a service plan.
  \item \textbf{Mutual Respect}: ICM is a shared learning experience for all team members and one in which all participants make unique and valuable contributions.
\end{itemize}

- **Participation**: ICM is based on professionals drawing on the experiences and knowledge of one another.
- **Accountability**: ICM requires critical thinking skills and ongoing reflection on practice.
- **Holistic Approach**: ICM provides a comprehensive approach to a client’s circumstances and needs, including family considerations and the development of a care plan to address them.
- **Continuity**: ICM is based on a team approach to creating and implementing a service plan that provides clients with a sense of continuity.
- **Planning for Transitions**: An ICM planning process works with clients and takes into consideration important transitions such as changing schools, changing family structure and entering a new developmental stage.
- **Least Intrusive and Intensive Intervention**: ICM enables services to be provided before difficulties develop into crises and to minimize the number, intensity, duration and restriction of the interventions.

ICM is also consistent with the Service Delivery Principles of the Child, Family and Community Services Act (Section 3).

### Learning Process

The training is designed to provide opportunities for participants to reflect on practice and build on their existing strengths and knowledge in the area of ICM practice. Course materials have been designed to encourage an experiential learning process. Activities within the modules ask participants to reflect on their own experiences and professional/personal practices and to apply new ideas they have learned. Practice-based scenarios, role plays and other strategies that promote interactive discussions provide the framework for the delivery of content and, at the same time, create an awareness of the interdependence and the value of collaboration amongst service providers.

### Training Modules

- **Module 1: Overview of ICM for Supervisors and Managers**
  This module provides managers and supervisors with an overview of ICM practice and gives them an opportunity to think about how they can support ICM. The material will address the process of implementing ICM (beginning, preparing for integrated case conferencing, integrated case conferencing, reviewing the plan and closure) and the role of the supervisor or manager in supporting ICM practice. Participants will identify the supports and barriers to implementing ICM in their offices and their community. Participants will have an opportunity to develop strategies to further the implementation or enhancement of ICM in the community.
• **Module 2: Integrated Case Management: Creating a Common Vision**
  This module introduces the policy and practice framework for ICM. Participants will discuss the values and functions of ICM and, in doing so, facilitate the development of a common vision of ICM for their community/team. Included in this module will be opportunities to develop an overview of the roles, responsibilities, philosophies, language and available resources of the disciplines involved in ICM.

• **Module 3: Community Self Assessment**
  This module introduces the community self-assessment tool. The community self-assessment is designed to assist communities to identify the supports and/or training they might need to implement or refine their ICM practice. It takes into account the different stages that communities might be in their implementation of ICM and acknowledges the unique characteristics of ICM practice in each community.

  The community self-assessment is a facilitated process that encourages reflection on practice and relationship building amongst practitioners. It is structured to elicit the strengths of ICM practice as it exists and to produce a training plan that supports those strengths. At the same time the community self-assessment process helps guide the implementation and refinement of ICM in each community.

• **Module 4: Beginning ICM and Preparing for Case Conferencing**
  This module provides participants with an opportunity to explore when and why they begin ICM and to initiate consensus building regarding the criteria for beginning an ICM process. Participants will develop strategies to help prepare for case conferences, including building relationships amongst service providers and discussing the role of the client. Opportunities will be provided to discuss involving children, youth and families in a meaningful way and to explore the role of advocacy in an ICM process. Participants will look at how to create a receptive environment for advocacy within their ICM practice. Strategies, guidelines and protocols for involving children, youth and families will be initiated in this module. Through practice-based scenarios participants will be able to explore how to plan for a case conference, what to bring in the way of information, prior approvals, etc.

• **Module 5: Case Conferencing**
  This module gives participants an opportunity to practice their case conference facilitation skills and to develop strategies for including clients in case conferencing in a respectful and meaningful way. It provides an opportunity for participants to experience working collaboratively in a team and to identify the skills necessary to successfully work together and with families. Participants will analyze their individual functioning within a team and the factors that strengthen teams to help them work successfully to reach their goal. In addition, participants will evaluate team process and outcomes. Discussion will be initiated to develop protocols or guidelines related to implementing an efficient and effective case conferencing process, a documentation format for case conferences, and a process for reviewing the plan. Participants will also work through some aspects of case conferencing that may be troublesome (e.g., how responsibility for case conferences can be shared and how to involve families).
• **Module 6: Conflict Resolution in ICM**
  This module identifies techniques for resolving conflicts within the planning and case conferencing process. Identifying and resolving planning conflicts are key elements of ICM practice. Using an ICM case conference format, participants will be given opportunities to practice skills in conflict resolution and team problem solving. In addition, they will formulate guidelines for solving impasses in the planning process.

• **Module 7: Information Sharing and Documentation**
  This module addresses the complexities of information sharing, identifies the documentation that supports ICM, and discusses how to support the ongoing work of ICM. Participants will identify the information that must be shared, the information that should be shared, and the information that must not be shared within the context of ICM planning. Participants will practice documenting a case conference and discuss how the documentation can be used to support the ICM process and effective planning.

• **Module 8: Ongoing Review and Closure of an ICM Process**
  This module explores what to do when the circumstances of children, youth and families change and an ICM plan needs to be altered to suit the family’s progress and challenges. It also explores what to do when members of an ICM team do not follow through on their part of the plan. Participants apply team building and conflict resolution skills and use their ICM documentation as tools for accountability, follow-up and review. Closure of an ICM process will also be explored. In addition, strategies, guidelines and protocols will be developed for addressing issues that arise between ICM case conferences, for ongoing review and bringing closure to an ICM process.

**Competencies and Performance Criteria**

The following competencies and performance criteria inform the training, are addressed in the training modules and are part of a broader set of ICM competencies that also address competencies required for ongoing or more advanced ICM practice. Successful ICM practice involves more than competent individual practitioners. An essential characteristic of ICM practice is how practitioners work together on teams and in communities. ICM will not be successful without competent teams and communities. The training is intended to be delivered to groups of people working together on teams and in their communities in order to develop these competencies. Therefore, some of the competencies and performance criteria are individual while others refer to teams and communities working together.

1. **Understand and endorse the purpose, principles and values base of ICM best practice.**
   The practitioner is able to:
   a) Describe the purpose and functions of ICM
   b) Show appreciation for the client centred focus of ICM and the importance of giving children, youth and families an active voice in the process and service plan
   c) Display appreciation for the need to include and work from multiple perspectives
   d) Endorse an orientation to ICM practice that is holistic and solution focused
e) Explain the roles and responsibilities of those involved with ICM
f) Describes the focus of a team approach and building relationships through mutual respect and trust
g) Describe an approach or approaches to shared responsibility and decision making
h) Describe effective approaches to communication and information sharing
i) Describe and endorses the ICM policy and practice framework (MCF ICM Policy and Best Practice Manual)

2. **Prepare for initiating ICM practice in the community**
The practitioner is able to work with community members to:

a) Determine or define who constitutes the community (geographic, demographic, functional, etc.)
b) Identify all stakeholders involved in the delivery of services for children, youth, single adults and families in the community and welcomes their participation in community self assessment
c) Understand and support the need to establish a community ICM Steering Committee
d) Discuss information sharing in relation to confidentiality, ethics, policies, legislation and specific mandates and discusses information sharing channels accordingly
e) Discuss the challenges and best practices in relation to protection of privacy and the sharing of information that balances service plans needs with legal requirements

3. **Bring the community, including families and service providers, together around a shared interest in creating and supporting ICM**
The practitioner is able to work with community members to:

a) Develop and distribute materials to inform the community about the purpose, benefits and services of ICM
b) Establish a community ICM Steering Committee to initiate and prepare for ICM

4. **Assess the community to determine the needs, readiness and capacity to implement or refine its ICM practice**
The practitioner is able to work with community members to:

a) Identify any community issues that create barriers to successful ICM implementation and makes recommendations on how to address these issues
b) Identify opportunities for developing and/or strengthening relationships among those interested or involved in ICM in the community
c) Use an assessment tool such as the ICM community self-assessment guide

5. **Provide and/or promote access to education, consultation and training resources and learning opportunities**
The practitioner is able to work with community members to:

a) Collaborate with community agencies, MCF and other ministries, service providers and private practitioners to identify training needs, and/or the available and required supports and resources
b) Develop and implement an ICM plan to address community ICM training and implementation needs
6. **Involve Children, youth, single adults and families in ICM**  
*The practitioner is able to:*  
a) Operate from the ICM practice value and principle that the client is central to developing and implementing the ICM plan  
b) Show consideration for the strengths, concerns, interests and needs of the client as the focus of ICM planning  
c) Communicate in language that is honest, respectful, clear and jargon free  
d) Explain to clients the need for and benefits of ICM and describes the process so they can make an informed decision about involvement  
e) Demonstrate an understanding of who the client considers as their supportive community and who is seen as not supportive  
f) Understand the role of advocacy in ICM practice  

*The team is able to:*  
g) Communicate information about the purpose, principles and process of ICM in clear, simple and respectful language  
h) Include clients in defining the ICM team and deciding who should participate  
i) Demonstrate the use of respectful, creative and flexible approaches in advocating for and involving client  
j) Listen to and demonstrates respect for the wishes of clients with regard to goals, outcomes, strengths, problems and desired approaches  
k) Ensure there is a debriefing for the client after the conference  
l) Show respect for and ensures clients’ confidentiality  

7. **Initiate and prepare for ICM with a child and/or family**  
*The practitioner is able to:*  
a) Recognize when it is appropriate to start ICM  
b) Determine who to involve in the initial preparation work  
c) Demonstrate flexibility about who is involved in ICM (e.g., that membership is tied to client needs, people come and go as needed)  
d) Demonstrate an understanding of and respect for other disciplines in relation to values base, philosophies, protocols and processes, roles  
e) Identify the available resources and supports of the disciplines  
f) Explain one’s mandates, limitations and boundaries  
g) Develop an approach or plan on how to begin/initiate ICM  

*The team is able to:*  
h) Reach agreement on when and why it is appropriate to start ICM  
i) Explore how to plan for and contribute to a case conference  

8. **Support and contribute to the team process and work**  
*The practitioner is able to:*  
a) Recognize and shows respect for the different disciplines and the skills, experience and diversity represented on the team  
b) Recognize and facilitates team building opportunities  
c) Support and contribute to the shared group decision-making process  
d) Demonstrate conflict resolution and mediation skills as appropriate
9. **Collaborate in developing and implementing the ICM plan**

   *The practitioner is able to work with an ICM team to:*

   a) Develop an ICM plan that includes the assessment, planning and co-ordination of goals, outcomes and services
   b) Develop an ICM plan with achievable goals and appropriate time frames so that people can experience success
   c) Develop the plan with a focus on the strengths of children, youth and families
   d) Identify the decision-making roles/authority of the service providers for following through on the plan (e.g., budget, resources etc.)
   e) Communicate in a respectful, clear and open manner
   f) Ensure that adequate information is shared, with client permission, so that an effective case plan can be developed
   g) Decide how ICM case co-ordination will occur and assigns responsibilities to team members accordingly
   h) Conduct multi-disciplinary case conferences
   i) Determine a process for conflict resolution or mediation
   j) Demonstrate effective problem solving and decision making skills
   k) Demonstrate creativity and openness in identifying possible alternatives and additional resources

10. **Review of the ICM plan**

   *The practitioner is able to:*

   a) Review outcomes for children, youth, single adults and families to ensure that agreed upon outcome objectives are realized
   b) Provide proper closure/transfer of the ICM activity for children, youth, single adults and families

   *The team is able to:*

   c) Establish a regular process for reviewing and updating the desired goals, process, outcomes and services of the integrated case management plan
   d) Determine when to have a closing session and facilitates effective closure

11. **Establish and/or build upon a quality assurance structure**

   *The practitioner is able to work with community members to:*

   a) Identify processes and approaches for monitoring and improving the quality of the ICM model in the community
   b) Identify the desired outcomes that are tied to the ICM goals
# Curriculum Matrix

## Module 1: Overview of Integrated Case Management for Supervisors and Managers

<table>
<thead>
<tr>
<th>Activity</th>
<th>Performance Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overview of ICM Process.</td>
<td>1a, 1e, 1i</td>
</tr>
<tr>
<td>2. Supporting the Implementation of ICM in Your Community</td>
<td>2a, 2b, 3a, 3b, 4a, 4b</td>
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<tr>
<td>3. Next Steps</td>
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## Module 2: Integrated Case Management: Creating a Common Vision

<table>
<thead>
<tr>
<th>Activity</th>
<th>Performance Criteria</th>
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<tbody>
<tr>
<td>1. Introduction to Integrated Case Management</td>
<td>1a, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i</td>
</tr>
<tr>
<td>2. Role Playing an ICM Planning Meeting</td>
<td>2a, 2b, 2c</td>
</tr>
<tr>
<td>3. Identifying a Common Vision of ICM</td>
<td>1a, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i</td>
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<td>4. Next Steps</td>
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## Module 3: Community Self-Assessment

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<th>Activity</th>
<th>Performance Criteria</th>
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<tbody>
<tr>
<td>1. Introduction to Community Self-Assessment</td>
<td>5a</td>
</tr>
<tr>
<td>2. Community Self-Assessment for Integrated Case Management</td>
<td>4c, 5a</td>
</tr>
<tr>
<td>3. Building on Strengths in Integrated Case Management Practice</td>
<td>4a, 4b, 5b</td>
</tr>
<tr>
<td>4. Next Steps</td>
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## Module 4: Beginning ICM and Preparing for Case Conferencing

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<tr>
<th>Activity</th>
<th>Performance Criteria</th>
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<tbody>
<tr>
<td>1. Involving Children, Youth and Families in Case Management Activities</td>
<td>6a, 6b, 6e</td>
</tr>
<tr>
<td>2. Reflection on Practice and Developing Common Agreement (protocol) for Beginning ICM</td>
<td>6c, 6e, 6f, 6g, 6h, 7a, 7b, 7c, 7d, 7e, 7f, 7g, 7h, 7i</td>
</tr>
<tr>
<td>3. Preparing for a Case Conference</td>
<td>6c, 6d, 6g, 6h, 6i, 7a, 7b, 7c, 7d, 7e, 7f, 7g, 7h, 7i</td>
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<td>4. Next Steps</td>
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Module 5: Case Conferencing

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<tr>
<th>Activity</th>
<th>Performance Criteria</th>
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<tbody>
<tr>
<td>1. Understanding Team Behaviour</td>
<td>6i, 8a, 8b, 9d, 9e</td>
</tr>
<tr>
<td>2. Practising an ICM Conference</td>
<td>6j, 6k, 9a, 9b, 9c, 9f, 9g, 9h</td>
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<td>3. Next Steps</td>
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Module 6: Conflict Resolution in ICM

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<tr>
<th>Activity</th>
<th>Performance Criteria</th>
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<tbody>
<tr>
<td>1. Identifying Conflicts in ICM</td>
<td>9c, 9k</td>
</tr>
<tr>
<td>2. Conflict Resolution Skills</td>
<td>8d, 8c, 9c, 9k</td>
</tr>
<tr>
<td>3. Developing Conflict Resolution Protocols</td>
<td>9i</td>
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<td>4. Next Steps</td>
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Module 7: Information Sharing and Documentation

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<th>Activity</th>
<th>Performance Criteria</th>
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<tbody>
<tr>
<td>1. Information Sharing Discussion</td>
<td>2d, 2e, 9j, 6l</td>
</tr>
<tr>
<td>2. Using Documentation to Facilitate a Case Plan</td>
<td>2d, 2e</td>
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<tr>
<td>3. Next Steps</td>
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Module 8: Ongoing Review and Closure of an ICM Process

<table>
<thead>
<tr>
<th>Activity</th>
<th>Performance Criteria</th>
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<tbody>
<tr>
<td>1. As ICM Plans Change</td>
<td>10a, 11a</td>
</tr>
<tr>
<td>2. Ongoing ICM Case Conferencing</td>
<td>10a, 10b, 10c</td>
</tr>
<tr>
<td>3. Closure: An Opportunity to Review ICM Process and Outcomes</td>
<td>10c, 10d, 11a, 11b</td>
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<tr>
<td>4. Next Steps</td>
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# Course Agenda

**Module 1: Overview of Integrated Case Management for Supervisors and Managers**

| Activity 1: Overview of ICM Process | 75 minutes | • Resource #1-1: “Integrated Case Management” and “Collaborative Practice”: Some Definitions and Key Elements  
• Resource #1-2: Benefits of ICM for Practitioners and Clients  
• Resources #1-3: Small Group Discussion: Beginning an ICM Process  
• Resource #1-4: Small Group Discussion: Preparing for Integrated Case Conferencing  
• Resource #1-5: Small Group Discussion: Case Conferencing  
• Resource #1-6: Small Group Discussion: Reviewing the Plan and Closure |
|-----------------------------------|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Activity 2: Supporting the Implementation of ICM in Your Community | 120 minutes | • Resource #1-7: Community Scenario  
• Resource #1-8: Supports and Barriers to ICM in a Community |
| Activity 3: Next Steps | 40 minutes | • Resource #1-9: Evaluation Form |
### Module 2: Integrated Case Management: Creating a Common Vision

| Activity 1: Introduction to Integrated Case Management | 40 minutes | • Resource #2-1: Integrated Case Management: Principles  
• Resource #2-2: “Integrated Case Management” and “Collaborative Practice”: Some Definitions and Key Elements  
• Resource #2-3: Rethinking The Role Of 19th Century Casework Models In The Design Of 21st Century Child And Family Services  
• Resource #2-4: Definition and Key Elements of ICM |
|---|---|---|
| Activity 2: Role Playing an ICM Planning Meeting | 80 minutes | • Resource #2-5: Case Scenario: Community Living  
• Resource #2-6: Case Scenario: Youth Services |
| Activity 3: Identifying a Common Vision of ICM | 60 minutes | • Resource #2-5: Case Scenario: Community Living  
• Resource #2-6: Case Scenario: Youth Services |
| Activity 4: Next Steps | 40 minutes | • Resource #2-7: Evaluation Form |

### Module 3: Community Self-Assessment

<table>
<thead>
<tr>
<th>Activity 1: Introduction to Community Self-Assessment</th>
<th>40 minutes</th>
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<tbody>
<tr>
<td>Activity 2: Community Self-Assessment for Integrated Case Management</td>
<td>90 minutes</td>
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<tr>
<td>Activity 3: Building on Strengths in Integrated Case Management Practice</td>
<td>30 minutes</td>
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<td>Activity 4: Next Steps</td>
<td>40 minutes</td>
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</table>
### Module 4: Beginning ICM and Preparing for Case Conferencing

| Activity 1: Involving Children, Youth and Families in Case Management Activities | 40 minutes | • Resource #4-1: Case Scenario  
• Resource #4-2: Case Scenario  
• Resource #4-3: Case Scenario  
• Resource #4-4: Case Scenario  
• Resource #4-5: Reflective Questions  
• Resource #4-6: Clients’ Experience of ICM and Outcomes of ICM for Clients  
• Resource #4-7: What is Advocacy?  
• Resource #4-8: The Four Parts of Advocacy |
| --- | --- | --- |
| Activity 2: Reflection on Practice and Developing Common Agreement (Protocol) for Beginning ICM | 120 minutes | • Resource #4-9: Reflective Questions  
• Resource #4-10: Small Group Questions |
| Activity 3: Preparing for a Case Conference | 120 minutes | • Resource #4-11: Consistent ICM Documentation  
• Resource #4-12: Small Group Questions  
• Resource #4-13: Role Play Debriefing Questions  
• Resource #4-14: Check List for Effective Collaboration with Children, Youth and Families |
| Activity 4: Next Steps | 40 minutes | • Resource #4-15: Evaluation Form |
**Module 5: Case Conferencing**

| Activity 1: Understanding Team Behaviour | 90 minutes | - Resource #5-1: Case Scenario  
- Resource #5-2: Case Scenario  
- Resource #5-3: Case Scenario  
- Resource #5-4: Team Behaviour Questionnaire  
- Resource #5-5: Small Group Discussion Questions  
- Resource #5-6: Chilliwack CareTeam Code of Conduct  
- Resource #5-7: Check list for Effective Collaboration with Children, Youth and Families |
| Activity 2: Practising an ICM Case Conference | 140 minutes | - Resource #5-8: Consistent ICM Documentation  
- Resource #5-9: Case Conferencing Documentation Examples  
- Resource #5-10: Integrated Case Management Practice Tips |
| Activity 3: Next Steps | 40 minutes | - Resource #5-11: Evaluation Form |

**Module 6: Conflict Resolution in ICM**

| Activity 1: Identifying Conflicts in ICM | 60 minutes |
| Activity 2: Conflict Resolution Skills | 75 minutes | - Resource #6-1: Case Scenarios |
| Activity 3: Developing Conflict Resolution Protocols | 60 minutes |
| Activity 4: Next Steps | 40 minutes | - Resource #6-2: Evaluation Form |

**Module 7: Information Sharing and Documentation**

| Activity 1: Information Sharing Discussion | 90 minutes | - Resource #7-1: Confidentiality: Personal Reflection Questions  
- Resource #7-2: Case Scenario  
- Resource #7-3: Case Scenario  
- Resource #7-4: Small Group Discussion Questions |
| Activity 2: Using Documentation to Facilitate Case Plan | 90 minutes | - Resource #7-5: Consistent ICM Documentation  
- Resource #7-6: Case Conferencing Documentation Examples |
| Activity 3: Next Steps | 40 minutes | - Resource #7-7: Evaluation Form |
## Module 8: Ongoing Review and Closure of an ICM Process

| Activity 1: As ICM Plans Change | 80 minutes | • Resource #8-1: Case Scenario  
| | | • Resource #8-2: Integrated Case Management Plan (Filled In) |
| Activity 2: Ongoing ICM Case Conferencing | 100 minutes | • Resource #8-2: Integrated Case Management Plan (Filled In)  
| | | • Resource #8-3: Sample Agenda for Follow up Meetings  
| | | • Resource #8-4: Consistent ICM Documentation  
| | | • Resource #8-5: Case Conferencing Documentation Examples  
| | | • Resource #8-6: Service Tracking Example |
| Activity 3: Closure: An Opportunity to Review ICM Process and Outcomes | 60 minutes | • Resource #8-7: Key Definitions  
| | | • Resource #8-8: Example of Closure Report  
| | | • Resource #8-9: Example of Family Questionnaire  
| | | • Resource #8-10: Service Outcomes |
| Activity 4: Next Steps | 40 minutes | • Resource #8-11: Evaluation Form |
Overview of Integrated Case Management for Supervisors and Managers

This module provides managers and supervisors with an overview of ICM practice and gives them an opportunity to think about how they can support ICM. The material will address the process of implementing ICM (beginning, preparing for integrated case conferencing, integrated case conferencing, reviewing the plan and closure) and the role of the supervisor or manager in supporting ICM practice. Participants will identify the supports and barriers to implementing ICM in their offices and their community. Participants will have an opportunity to develop strategies to further the implementation or enhancement of ICM in the community.

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<th>Time</th>
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<tr>
<td>150 minutes</td>
<td>Activity 1: Overview of ICM Process</td>
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<td>*20 minutes</td>
<td>Stretch and Refreshment Break</td>
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<tr>
<td>60 minutes</td>
<td>Lunch Break</td>
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<tr>
<td>120 minutes</td>
<td>Activity 2: Supporting the Implementation of ICM in Your Community</td>
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<tr>
<td>*20 minutes</td>
<td>Stretch and Refreshment Break</td>
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<td>40 minutes</td>
<td>Activity 3: Next Steps</td>
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“Integrated Case Management” and "Collaborative Practice": Some Definitions and Key Elements

To stimulate discussion on integrated case management within MCF, we have provided below several definitions and core characteristics of integrated case management and collaborative practice. These have been excerpted from a recent report submitted to MCF on multi-disciplinary child welfare education and an options paper on common intake response and ICM.

Collaborative practice can be described as an interactive process by which individuals with diverse training meet together to plan, generate and execute solutions to mutually identified problems related to the welfare of children and families (Knapp et al, 1993, as cited in Tate & Hubberstey, 1997). It is increasingly "seen as an approach to maximize the delivery of coordinated, effective and efficient services to health care consumers" (Fulton, 1996, p. 4, as cited in Tate & Hubberstey, 1997).

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

**Integrated case management** refers to a team approach taken to co-ordinate various services for a specific child and/or families through a cohesive and sensible plan. All members of the team work together to provide assessment, planning, monitoring and evaluation. The team should include all service providers who have a role in implementing the plan, and whenever possible, the child or youth's family.

**Co-operation or collaboration**: working or acting together; collaborating or co-operating means that services remain separate, but that separate service providers have contact, share information and approach a client as a common concern.

**Integration**: combine parts into a whole; this suggests more than co-operation or more co-ordination of various disciplines working together. Integrating disparate services means combining services and service providers with the result that something new is created. Full service integration means that an interdisciplinary team of service providers offers service under a single, unifying mandate.

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Benefits of ICM for Practitioners and Clients

Benefits for Practitioners

Overall, practitioners who were experienced with ICM reported that ICM had positive and often powerful impacts on their practice. Moreover, some practitioners commented that knowing that ICM resulted in positive outcomes and better service for clients was, in turn, rewarding and motivating to them in their work.

Some of the outcomes identified by practitioners are:

**ICM promotes a sense of shared responsibility, accountability and decision making**
"I used to go to meetings and everybody pointed at me (child protection worker) and said, "Fix it!" Now I go to ICM meetings and we are all there together to work out a plan. It is really a relief!"

"ICM is positive in that the responsibility becomes shared. Typically, the social worker has always been seen as the case manager, and carries most of the responsibility. (With ICM), all professionals and the parent have to become more accountable in following through with their part of the service delivery plan."

**ICM builds a sense of community - of people working together**
"The best thing about the conferences is that they are bringing people together to work together and to talk together and to feel connected and committed to working together."

"We're working together, dealing with long term issues. You have a group of consistent people who don't give up. We keep chugging along."

**ICM reduces practitioners' sense of isolation**
"As a social worker, I don't feel alone."

"It's early days to say how it's changed practice. But I think it's changing the way people think. They are realizing that they're not alone. I think that's pretty good. The feeling like they're not alone is a big one."

**ICM provides opportunities for reflective practice**
"Hearing different perspectives and philosophies - it's nice to check-in with others and get a different perspective. It's supportive and educational."

"The disciplines talk a different language (e.g., school vs. mental health vs. probation's understanding of "at risk"); and the conferences are a way to facilitate a better understanding of each other's work."

**ICM provides opportunities for mentoring and a collective increase in professionals' knowledge and skills**
"We work well together because we work often enough together. We have developed a skill and knowledge base together and this extends to foster parents."

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"It is an empowering experience for me because I have knowledge the others need because I spend so much time with the clients."

**ICM enhances practitioners' appreciation of clients' strengths and capacities**

"I was amazed at the competence and level of functioning of the client. I hadn't seen her before, but I would have had a wrong impression... Hearing her talk about all she had done, I had tremendous respect for her. And the social worker was seen as her ally and partner."

"I get a bigger, clearer picture of what's going on in the client's life."

**ICM decreases practitioners' workload**

"When the elements of ICM are in place (i.e., good communication; clear understanding of roles; common goals; trust), my workload decreases."

**Benefits of ICM for Clients**

A wide range of clients was interviewed including youth in care, parents whose children were currently in care through voluntary care agreements, parents whose children had been removed by the Director, parents who were caring for children with unique needs, and foster parents.

While many clients were critical of the Ministry overall, they were overwhelmingly positive about their experiences of ICM. Many also articulated how their experiences with ICM were different from their experiences prior to ICM. They appreciated being seen as a whole person. Often, this was a new experience with dramatic consequences. Most notable was the sense of relief of having one's full range of needs and capacities understood. Clients noted that their relationships with professionals, and in particular with social workers, often improved as they learned to work together through the ICM process. Both seemed to come to a better understanding of each other and perhaps a greater appreciation for what could be realistically achieved.

Through ICM, who was to do what became clearer for clients. They could identify who to turn to, what they could expect from the professionals in their lives and what their own role was. While being involved in integrated case conferences was not easy for many clients, no one indicated that they would rather not attend. What was important, was that they had an opportunity to be involved in information sharing and decision-making, to contribute, to be listened to, and to be kept informed.
Clients from across regional sites spoke of important outcomes of ICM and case conferences. For many clients, these outcomes were quite profound; for example, one parent spoke of ICM as contributing to her child's very survival, while for others, ICM was both validating and helped improve their own and their child's self-esteem. Having a say in decision-making helped clients feel supported, respected and in control of their lives.

Several clients described the positive change in relationships and communication that occurred amongst family members through participation in discussion, planning and joint decision making at ICM meetings. As noted above, clients also spoke of forming positive and trusting relationships with practitioners, and having those relationships improve through the ICM process. In many instances, the ability to develop a trusting relationship was in itself a major accomplishment. As well, a number of clients spoke of having a clear sense of people working together toward common goals, of community support that reduces parental anxiety that in turn assists them to have better relationships with their children. Not surprisingly, clients' reports of positive outcomes were more evident in the sites that were further along in their implementation of ICM.

Below, clients' discussion of outcomes of ICM is presented in their own words:

*ICM helps ensure that people work toward a common goal: the well-being of the child*

“And through the meetings, my ex-husband and I began to work together to support L. I could never talk to him before, but because everything was discussed at the meetings, and there was a plan, we could get together and make it work. That was one of the best things about ICM.”

“My needs are certainly met by ICM. It gives me a sense of support – that people in the community care about my family is the message I get. They want to know about the whole picture and how we are doing in life and they support us to be the best family that we can.”

*ICM helps ensure that clients get needed services and information*

“And MCF has been really good about extending the In Home program. We've actually gotten the program for about a year and a half... They've done some fancy footwork to address our situation, which has helped. We wouldn't be where we are today, if there hadn't been the case conferences.”

“And that's why this last conference was really good. I got more information. We got the names of people we can go to in order to put together an individual (computer) program for K. We're also going to be going to the learning centre for six weeks, so that it sets him up for school. But these things all came out at the case conference, and were talked over.”

ICM was able to identify some of these cracks for my son, and we were able to deal with it.
ICM results in children doing better socially and academically
“I don't think my son would be in school now without it. I don't know where we'd be... And R. has some self-esteem, he feels like he's in control. He's in a regular classroom and he has caught up on all his work. He has friends and activities outside of school. He knows he can get good marks and he's doing really well.”

ICM results in clients learning new skills
“We've both quit drinking and we have support. We're learning how to parent. I am more self-confident and outspoken. Before I would just get mad and pop off; now, I rationally think things through before I act.”

“I think ICM is like a mentoring process - I have learned so much by being part of it and solving problems and recognizing our strengths.”

ICM results in clients feeling respected
“They've listened to me when I've said no to services.”

“I like the way I am treated, that I am respected. If something is important to me, it is valid and important to the group. We all have mutual respect for each other.”

ICM helps enhance clients' self-esteem, in that they are full participants in the care planning process
“In another city, they did it mostly by conference call and I always felt like the "number in the corner". I was never part of it like I am here. I really am a participant and if I don't understand, they explain.”

“At first, I felt like a stranger in my son's life. Now I've got two or three people phoning me to make sure I know what's going on. It feels really good. It makes me feel important, to feel included.”

ICM results in clients feeling supported and that people care
“What I saw and heard in that room was the amount of support that was there. I was sweating bullets - partly because of the number of people and because there were people from my own reserve. But it was really incredible - positive.”

“It really helps to know where my supports are and know that I am supported. In a way the ICM team is a part of my family - they all fight for my son, and I know I'm not alone in my frustration.”

ICM helps promote understanding of clients' cultural context and way of doing things
“And there were Native people educating the non-Native people about our ways of doing things.”
ICM leads to parents’ involvement in decision making regarding their children

“The purpose was to figure out what was going to happen and to make a plan. My social worker came into it intending to go for a permanent order but changed her mind as she heard other people talk about me. Things are going a lot better now. I know what I have to do and what to expect, and we have a gradual plan to get my son home. I’m in contact with the group home and his teachers, and we’re all working together.”
Small Group Discussion: Beginning an ICM Process

Using Resource #1-1 and Resource #1-2 along with the *ICM User’s Guide* identify the characteristics and important components of beginning an ICM process. Assign a recorder and be prepared to report your discussion to the rest of the participants. Use the following questions to prompt your discussion.

- When do you think it is reasonable to begin an ICM process with a client?
- What are your criteria for beginning an ICM process?
- What factors influenced your decision (i.e., your personal values and beliefs, practice experience, managerial responsibilities, organizational policies and so on)?
- What implications would your decision have for care planning?
- Who needs to be involved in the decision to initiate ICM?
- What role would the child/youth/family have in the process of deciding whether or not to initiate ICM?
- Can a family initiate ICM?
- What is the role of a supervisor or manager in initiating ICM?
- How can a supervisor or manager support the initiation of ICM?
Small Group Discussion: Preparing for Integrated Case Conferencing

Using Resource #1-1 and Resource #1-2 along with the *ICM User’s Guide* identify the characteristics and important components of preparing for Integrated Case Conferencing. Assign a recorder and be prepared to report your discussion to the rest of the participants. Use the following questions to prompt your discussion.

- What are the steps in preparing for an integrated case conference (such as agreeing on the purpose, deciding who to invite, agreeing on how to document the conference and so forth)?
- What are the roles associated with an integrated case conference (such as case coordinator, conference facilitator, recorder, and so forth)?
- What is the role of a supervisor or manager in this stage?
- How can the supervisor or manager support staff in their preparations for integrated case conferencing?
Small Group Discussion: Case Conferencing

Using Resource #1-1 and Resource #1-2 along with the *ICM User’s Guide* identify the characteristics and important components of case conferencing. Assign a recorder and be prepared to report back your discussion to the rest of the participants. Use the following questions to prompt your discussion.

- What is involved in integrated case conferencing?
- What different roles and levels of responsibility exist within an integrated case conference?
- What is the role of a supervisor or manager in integrated case conferencing?
- How can a supervisor or manager support integrated case conferencing?
- What are some ways that a supervisor can support family involvement in integrated case conferencing?
Small Group Discussion: Reviewing the Plan and Closure

Using Resource #1-1 and Resource #1-2 along with the *ICM User’s Guide* identify the characteristics and important components of tracking and closure. Assign a recorder and be prepared to report back your discussion to the rest of the participants. Use the following questions to prompt your discussion.

- Why is staying in touch and ongoing review of the ICM process important?
- What is involved in ongoing review of ICM?
- What are some strategies for identifying goals and outcomes for families and youth?
- What are the perceived outcomes of ICM?
- What is the role of a supervisor or manager in supporting the ongoing review of ICM?
- How can a supervisor or manager support staff to keep track of progress towards goals and outcomes and to ensure that ICM is an ongoing process?
Community Scenario

You all work or live in the community of Anywhere, B.C. Anywhere is a community of approximately 80,000 people. The primary industry is forestry and as a result of mill closures there is a large segment of the population that is unemployed. There are two aboriginal reserves within the area and a large off-reserve aboriginal population.

There are 3 high schools in the community. One high school has a large number of youth using alcohol and drugs. Crime in the area around the school has been increasing recently and both the police and school authorities are concerned. At one school, youth violence is a major problem and a student was recently arrested with a gun at school.

There are 12 elementary schools in the community. Three of them have recently implemented school lunch programs because increasingly the children are coming to school hungry.

There is an integrated MCF office with child protection, guardianship and resource workers, additions workers, child and youth mental health and youth probation. Although they all work in the same office there is very little interaction between the programs.

There is a Community Health office that is part of the Regional Health Board. Five public health nurses work there as well as a speech therapist, audiologist, nutritionist and dental hygienist. The public health nurses work in the schools and collaborate with the school system but have very little to do with MCF other than if there is a need to make a report of child abuse. The other people do screening and work with children with special needs.

There are two Neighbourhood Houses in Anywhere. They provide a variety of early intervention programs, family support, employment programs and counselling. Most of these services are provided through contracts with MCF, Ministry of Education and Ministry of Health.

There are several other contracted services in Anywhere, such as sexual abuse services, youth programs, additions services including rehabilitation, out-of-school care, family support and parenting programs.

Over and over again each of you is aware of families who “fall between the cracks” because of a lack of coordinated services. You used to have a Child and Youth Committee in Anywhere that did some case planning but it hasn’t met for 18 months. There is a new Executive Director of one of the Neighbourhood Houses who comes from a community where ICM is working well. She contacted the manager in the MCF office to discuss how they might promote ICM in the community. Together they have organized this meeting with all the managers and supervisors of child and family serving organizations to discuss getting an ICM process formalized and implemented in Anywhere.

Develop a strategic plan to implement ICM in Anywhere. Assign a recorder and be prepared to report back your plan to the large group.
Supports and Barriers to ICM in a Community

Enablers to ICM

**Having honest, trusting relationships with the other participants of a case conference**

“In case conferences, when it's worked, there's been a level of honesty. People could bring things up (e.g., issues for clients)”. 

“I appreciate how easy it is to talk with the other members of my team. We're in a place of equality. There are good communication skills”.

Professionals emphasized that having honest relationships, both among practitioners and between practitioners and clients, both enabled and supported their practice of ICM. Indeed, some practitioners linked positive results of ICM to the presence of honesty in people's relationships and in case conference discussions. Given solid relationships, people were able to work through the potentially thorny and delicate issues that can arise in case planning and follow through. Practitioners also spoke of the importance of dedicating time for relationship building.

**Having several strong "champions" of ICM**

“He has a clear message: all disciplines are part of this, and are part of case conferencing. That really helps. That's necessary - that everyone knows they're part of the mandate to do this”.

There were several key champions of ICM in each participating area of this review. Many practitioners articulated the value of having such people. In our four participating sites, champions came from a variety of disciplines and positions and from both MCF and community agencies. Regardless of whether they were managers or front line practitioners, champions, by their words and actions, gave the strong message that all disciplines were necessary and valued within ICM, and that ICM had positive outcomes for clients and professionals alike. This message was seen as being particularly important to people whom might otherwise resist the implementation of ICM.

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Co-location

“Even bringing our own staff together is a good thing. For example, probation, alcohol and drugs, family services... No one could see what they were having to integrate. Once we forced the issues: ‘You will do so many cases this month!’ then suddenly people realized that they did have cases in common. There is a reason for us to work together”.

“The over-riding intent of co-locating is to support integrated case management. But we're trying to de-emphasize the office as the issue: Be where you need to be to serve the client”.

In nearly all focus group discussions and interviews with practitioners, co-location was identified as a potential enabler of ICM. For the most part, in offices that had co-located, many staff spoke of it as a support to ICM. Co-location fostered information exchange and communication between practitioners, helped to promote relationships between workers and their efforts to identify common interests and goals, and could be useful to clients who needed to meet with professionals from different disciplines. At the same time, practitioners commented that co-location was neither the same as ICM, nor did it guarantee ICM.

Having the ICM case conference Chair possess strong group facilitation/conflict resolution skills

“What's been supportive for me is (my manager's) style as Chair. She's very focussed and clear. It makes a big difference when someone comes in with facilitation skills. Our model really requires someone with good facilitation skills”.

Several practitioners noted that good facilitation and conflict resolution skills - ideally for all members of an ICM team, but especially for the case conference Chair - made a real difference to ICM practice and outcomes. The ability to incorporate different perspectives, reduce or balance power differentials between participants, and move the agenda along, to achieve an agreed upon plan, was seen as critical to the overall success of ICM case conferencing.

Rationalization of the documentation required on each file

“What if the case plan were to become the service plan”.

Several practitioners suggested that there would be value in rationalizing the documentation required by MCF, for example, ICM case plans might replace certain other program-specific care plans. This could help to address the workload issues for practitioners, reduce the number of times clients have to “tell their story”, and support the implementation and practice of ICM.
Barriers to ICM

The different disciplines involved in ICM have different language, perspectives and philosophies and limited understanding of each other’s roles and responsibilities. “The disciplines talk a different language (e.g., school vs. mental health vs. probation's understanding of "at risk").”

“The major problem that I’ve been having is in understanding everyone's role, (including understanding the MCF disciplines’ roles and the contracted agencies/resources’ roles). I might make some assumptions about what other members of the team are doing, as social workers for example, or in addictions, but I really don't know”.

Practitioners spoke repeatedly about the learning curve associated with understanding each other’s perspectives. Participants in ICM have different backgrounds and hold their own perspective that is reflected in their approach to planning and their practice. Similarly, a lack of understanding of the roles, mandates, legal responsibilities, job functions and resources available to each of the disciplines was seen as problematic. It was noted that in some cases the same language was being used but upon further discussion participants discovered that the interpretation or use of the words was different. Continual discussion and clarification of perspectives is time consuming but necessary if ICM is to be effective.

Key people missing

“There are different disciplines involved (in ICM). That often creates difficulty for the client. The contracted agencies are okay. But probation and education – sometimes there’s a control issue with them - we're at loggerheads over who's in charge. We lose the focus on moving ahead for the client”.

“Another thing is that the people who can make things happen and can sign off on resources are not always there at the table at the conferences, and there are no agreements in place”.

“If we're talking about integration of services, we should really be talking about making sure there's better communication between the FAW’s and the social workers. It's even worse now that they're divided into different ministries - the system is even more split up than it was”.

Some participants reported issues of turf, power and control prevented some key players from being involved in ICM. These power issues about who was in control, who had decision-making authority, or who had the resources meant that the focus on the client and family got lost as did coordinated planning and follow-through. They reported that working through these issues would take time, discussion and relationship building.

Financial Aid Workers and medical practitioners often were not present either even though both hold key decision-making roles. This caused problems for both practitioners and clients and made planning more difficult.

Similarly, another barrier is the decision-making processes and authority within each program area. Many participants reported frustrations when those with the decision-
making authority were not involved in case conferences or planning. This often resulted in poor follow-through and in disappointed clients if the plan developed couldn’t be implemented.

**Differing beliefs and comfort regarding client involvement**

“What I’ve seen is that it seems that not everyone at a conference is that comfortable having youth present. People didn’t know how to talk with clients, especially youth. People aren't used to having them being there”.

Differing values and beliefs about giving voice to children and youth and involving the parent/child in decision-making were noted as possible barriers to effective ICM. In some cases, practitioners worried that case conferences and ICM would be overwhelming to clients. In other instances, practitioners expressed discomfort due to unfamiliarity with having clients involved in case conferences.

**Lack of resolution and agreement on information sharing policy and protocols**

“How information is shared, what information is shared, and what the parameters of confidentiality are, continue to be raised as issues that need further clarification and discussion so that they do not become barriers to effective ICM and coordinated planning. Participants expressed confusion with the current information sharing policy and felt it didn’t clearly address many of the concerns they had in practice. On the other hand, there was also concern expressed that information sharing and confidentiality could and is being used as an excuse not to participate in ICM.

**Amount and rate of change within MCF**

“Integration is still very new. It will take a long time to get things in place, like understanding one another's discipline. Or the idea that social workers don't have to be the case managers”.

“People's roles and services are changing. For example, alcohol and drug workers are not used to working with youth or with a harm reduction model, or with resistant families. That's a huge client group for us, and a new one for them”.

“The problem is: There have been so many new things in this Ministry. Jobs are being redefined. Everything is new; too much is new”!

The recent formation of MCF has forced a “rethinking” and shifting of philosophies, mandates, priorities, client groups and ways of practicing for many practitioners. Some participants said they were not used to or confident enough with this shift to be able to enter into discussions with others regarding their roles and functions. Again, for some, the amount of change and adjustment is overwhelming and the time and emotional energy required to implement ICM seems impossible. While participants expressed appreciation of the benefits of ICM and wanted to work towards better outcomes for clients they also expressed a need for change to slow down. Many
stated that the pressure from central office to implement ICM quickly is itself a barrier to the implementation of ICM.

On the other hand, some participants expressed frustration that delays in contract restructuring pending the outcome of the current provincial review may hold up implementation of ICM. Some areas were in the process of purposefully restructuring contracts to incorporate and support the implementation of ICM. For example, contract restructuring in one area would have reduced the number of community agencies significantly, thereby resulting in less complexity for relationship building and coordinated planning and follow-through.

**Staffing and workload issues**

“There’s also the issue of when the case conference is held, and how much notice you have to attend. Can you get to the case conference? I’m a counsellor - I have clients. They depend on me, and I’m committed to being here to see them. So, I can’t come to a lot of conferences; I would have to cancel my appointments with clients. This is an issue that really has to do with workloads”.

“Workload has a lot to do with doing this right. ICM does create more work. The integrated conferences are useful, but they do create more work. And we have team members dropping like flies. We’re in a crisis management mode”.

Issues of workload and recruitment and retention of front line MCF staff – particularly social workers – were critical factors in all the review sites. Understaffing and instability of staff has major implications for the already charged issues of workload, stress and morale. These issues represent significant barriers to the implementation of ICM. Not only do they increase time constraints and interfere with relationship and trust building, they also have diverted the attention of managers and front-line practitioners alike, drawing energy away from development and implementation of ICM as a focus of the teams’ and managers' activity.

Within this context, informants in the earlier stages of implementation saw ICM as an added time consuming activity that increased their workload and stress. Interestingly, practitioners who were experienced in doing ICM spoke of it as a means of decreasing their workload and thus saving them time. Conversely, for practitioners who are just beginning to do ICM, the logistical work associated with arranging case conferences, and recording and distributing notes of meetings, is or seems to be onerous.

**Existing systems of documentation**

“There are 15,000 different files out there. You don't know where the treatment plan is going to be. It might be with MCF, or MH or forensics, or with the school or the community agencies. The treatment plans might differ”.

“But right now, we're asking workers to be part of (and record) the Plan of Care, the Risk Assessment and the integrated service plan. They're all different documents. You get duplications. For example, if you're going to put in homemakers, recording this on this plan of care should be sufficient”.

Repeatedly, practitioners expressed concern that there were too many files and documents with very similar information in them. Although co-location has occurred
in many areas and integrated teams have been formed, integrated files and documentation has not been achieved. In fact, it is perceived that the opposite is happening as program-specific assessments, plans of care and standards are developed provincially. This leaves practitioners feeling that integration is not being supported centrally. The duplication of documentation is seen as time consuming when practitioners are already feeling overloaded.

**Lack of resources**

“There are not enough resources and there is not enough money for resources in the system. That dictates what individuals and the group as a whole can do in conferences”.

Concern was expressed by some focus group participants that the scarcity of resources in specific areas would eventually undermine the case conferencing and case planning process. It is possible that with more experience, the ICM case conferences will become a mechanism for identifying creative solutions to some of the resourcing issues that exist in many regions.
Integrated Case Management Training (Module 1) Evaluation Form

The purpose of this evaluation is to help us understand the value of the activities in meeting the ICM training goals.

This workshop has been designed to provide you with an opportunity to:
- familiarize supervisors and managers with the integrated case management process
- identify leadership strategies and a plan to support the implementation of integrated case management in your community

Using the following rating scale where 1 equals not effective, 3 equals somewhat effective and 5 equals very effective, rate each of the following activities in terms of meeting the workshop goals.

1. Workshop activities
   a) Small group exercise
      1 2 3 4 5 not effective somewhat very effective
   b) Role play
      1 2 3 4 5 not effective somewhat very effective
   c) Large group discussion
      1 2 3 4 5 not effective somewhat very effective

2. How useful were the handouts/resources?
   1 2 3 4 5 not useful somewhat very useful

3. How applicable has this workshop been to your work or experience?
   1 2 3 4 5 not applicable somewhat very applicable
4. What do you feel was your biggest learning today?

5. What was your biggest surprise?

6. What did you like best about the workshop?

7. What would you change if you could?

8. Please add any additional comments.
Integrated Case Management: Creating A Common Vision

This module introduces the policy and practice framework for ICM. Participants will discuss the values and functions of ICM and, in doing so, facilitate the development of a common vision of ICM for their community/team. Included in this module will be opportunities to develop an overview of the roles, responsibilities, philosophies, language and available resources of the disciplines involved in ICM.

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<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>40 minutes</td>
<td>Activity 1: Introduction to Integrated Case Management</td>
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<tr>
<td>80 minutes</td>
<td>Activity 2: Role Playing an ICM Planning Meeting</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Stretch and/or Refreshment Break</td>
</tr>
<tr>
<td>60 minutes</td>
<td>Activity 3: Identifying a Common Vision of ICM</td>
</tr>
<tr>
<td>40 minutes</td>
<td>Activity 4: Next Steps</td>
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</tbody>
</table>
Integrated Case Management: Principles

The following principles will guide all team members in the process of integrated case management:

**Client-centred Service** – The Ministry for Children and Families is committed to putting clients at the centre of all service planning and practice. That means supporting clients to use their strengths to identify and achieve their goals, and direct their own lives to the greatest extent possible. This approach challenges all integrated case management team members to adapt services to fit client needs, rather than to expect clients to adapt to administrative or service structures.

**Building on Strengths** – Far too frequently, in our efforts to improve the circumstances of our clients, we focus immediately on their problems and work to develop solutions. While well-intended, this approach fails at the outset to identify the strengths and successes of the clients, which may often be the foundations for far more lasting changes in their lives. In addition, a positive approach makes it far easier for the client to stay committed and the team to be collaborative.

**Advocacy** – Integrated case management provides clients with the opportunity to participate in decisions that affect their lives. They may find it difficult, however, to attend meetings on their own and to speak for themselves. In these circumstances, clients should be encouraged to bring a friend, advocate or support person with them.

**Recognizing Diversity** – Our clients have diverse needs, background and abilities. The integrated case management team needs to respect and respond to the social, cultural and economic factors that shape clients’ lives.

**Collaboration** – Integrated case management brings together the varied disciplines, talents, perspectives, knowledge and experience of many team members and challenges them to share their individual skills, knowledge and expertise with each other. This process not only supports the best possible outcomes for clients, but it also offers opportunities for increased growth and understanding for all team members.

**Mutual Respect** – It is essential that all team members show respect for one another’s knowledge, skills, experience and perspective, regardless of age, level of training, position, job classification, particular discipline, or the ministry or agency represented. It is particularly important that team members foster a climate of respect for clients.

**Participation** – Team members must be willing to participate fully in the activities of the team. At the beginning of the process, full participation may involve a significant investment of time – in the long run, this initial investment is likely to save time for all team members and improve outcomes for clients.

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**Accountability** – The Ministry for Children and Families is committed to creating a system that is accountable to the people who use it. Clients must be informed to the greatest extent possible of all activities that might affect them. In addition, integrated case management activities must be recorded. The review of this documentation will allow us to enhance our practice and to better understand what approaches work best with which clients.

**A Holistic Approach** – Integrated case management should provide for a complete understanding of the various aspects of a client’s circumstances and needs, including family considerations, and the development of a case plan broad enough to address them.

**Continuity** – Clients need a sense of continuity in the services they are receiving – not only in how the services relate to each other, but also in how the services develop over time. To preserve a sense of continuity, every effort should be made to ensure that over the course of a client’s involvement with the ministry, at least one member of the integrated case management team is present from the beginning to the end of the process.

**Planning for Transitions** – Integrated case management teams should take special care to plan for transitions in the lives of clients – for example, changing schools, moving from childhood to adolescence, and changes in family structure.

**Least Intrusive and Intensive Intervention** – Integrated case management is an important support to the ministry’s promotion, prevention and early supports strategy, which is aimed at providing support to youth and families as early as possible, before difficulties develop into crises. While it is clear that appropriate supports are necessary when clients encounter difficulties, it is important to minimize the number, intensity, duration and restrictiveness of the interventions in order to acknowledge and build on the strength and independence of the families.
“Integrated Case Management” and "Collaborative Practice": Some Definitions and Key Elements

To stimulate discussion on integrated case management within MCF, we have provided below several definitions and core characteristics of integrated case management and collaborative practice. These have been excerpted from a recent report submitted to MCF on multi-disciplinary child welfare education and an options paper on common intake response and ICM.

Collaborative practice can be described as an interactive process by which individuals with diverse training meet together to plan, generate and execute solutions to mutually identified problems related to the welfare of children and families (Knapp et al, 1993, as cited in Tate & Hubberstey, 1997). It is increasingly "seen as an approach to maximize the delivery of coordinated, effective and efficient services to health care consumers" (Fulton, 1996, p. 4, as cited in Tate & Hubberstey, 1997).

Some specific characteristics of collaborative practice include:
• active participation of the client
• sharing or transferring of information and skills across traditional boundaries
• participants view themselves as part of a team and contribute to a common goal
• relationship between participants is non-hierarchical and power is shared
• leadership is shared and participants are inter-dependent
• participants work together in planning and decision making
• participants offer their expertise, share in the responsibility and are acknowledged by other members of the group for their contribution to the goal
• clear definition and understanding by team members of participants' roles/responsibilities
• respect for autonomous professional judgement and autonomous choice and decision making of the client/family
• effective communication skills and group dynamics
• supported by organizational structures and vision

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More Definitions\(^3\)

**Integrated case management** refers to a team approach taken to coordinate various services for a specific child and/or families through a cohesive and sensible plan. All members of the team work together to provide assessment, planning, monitoring and evaluation. The team should include all service providers who have a role in implementing the plan, and whenever possible, the child or youth’s family.

**Co-operation or collaboration**: working or acting together; collaborating or co-operating means that services remain separate, but that separate service providers have contact, share information and approach a client as a common concern.

**Integration**: combine parts into a whole; this suggests more than co-operation or more co-ordination of various disciplines working together. Integrating disparate services means combining services and service providers with the result that something new is created. Full service integration means that an interdisciplinary team of service providers offers service under a single, unifying mandate.

Rethinking the Role Of 19\textsuperscript{th} Century Casework Models in The Design Of 21\textsuperscript{st} Century Child And Family Services. by Ray Lazerik (1998)

1. Defining Case Management: Service Broker and Integrator

The term “case work” is at least a century old. Both “case work” and its more recent adaptation, “case management” are both used today to refer to “facilitating a comprehensive assessment of client needs, developing an individualized service plan, providing access to the needed services, and monitoring the effectiveness and appropriateness of those services”.

The case manager may act as a “broker” who secures and controls services for clients available through the worker’s own agency.

In the role of “integrator”, an expanded broker role, the worker goes farther afield and collaborates with other agencies and worker to secure a coordinated approach to the client and the service plan for the client. “Integrated Case Management” is an important function in an environment where many agencies and their workers may become involved with a case. The need to sort out who is the lead agencies and their workers may become involved with a case. The need to sort out who is the lead person, primary worker or case manager, what all involved are trying to accomplish collectively, and how and when they will interact with the defined “case” or “client’ is important for efficient use of resources, for effectiveness in relation to a plan and for reducing wear and tear on all concerned. Reduced paper work requirements, clearer communication channels, agreed accountabilities and information sharing protocols as well as efforts to create teamwork characterize efforts to create “integrated case management”.

While both “broker” and “integrator” approaches in recent years seek to involve the client in the process in a meaningful way the client or case, once labelled as such, is easily seen as somehow different from ordinary citizens like you and me. The client is able to assume an incompetent, dependent and passive role in the proceedings central to the client’s health and well-being. Sometimes this is encouraged and rewarded by the responses of the case manager and in the further labelling of the client as either “compliant and exhibiting willingness to change” or “difficult and resistant to change”.

2. Implications of Language: Are we managing “cases” or services for people?

While there is no argument against the need for good, integrated case management approaches, there is a question about what case management does and doesn’t do, when and where it should and shouldn’t be used and where it fits in the system we are trying to create. A case worker, representing real authority in legislation, is a powerful role which can create an immediate imbalance in power between worker and client. It has dominated the fields of corrections, child welfare, mental health and...
others. It has not been as dominant in voluntary, community services were it often takes on a different tone, relative to the different nature of the context and how that translates into worker-client relationships. One approach, in the voluntary context, is to assign a “service coordinator” whose job is to:

“assist families in gaining the knowledge and skills necessary to seek appropriate resources and become effective decision makers in matters relating to their children’s needs and care the role changes from one that allocates resources to one that supports the function of the family as caregiver and is knowledgeable about community resources (and by using) procedures that enhance client abilities to function as independently as possible to assume an active role in the process”.  

In the integrated environment of the emerging new Ministry it is important that we not “export” a form of case work practice, culture and language from the involuntary sector to the voluntary, community sector. Every effort should be made to move the practice, wherever possible, in the other direction and in fact, rethink the impact of language and related approaches we use in the “involuntary” services. Becoming “outcome and client focussed” means questioning our assumptions and traditional ways of working with the people we serve.

3. Roots of Casework and Case Management

The literature generally begins the discussion of casework as the product of nineteenth century individualism and the work done by the Charity Organization Societies in Victorian Britain in the 1860’s. Echoing today’s focus, charity organizations were integrated to reduce competition for funds and reduce unnecessary expenditures.

The philosophy of the C.O.S. movement in the U.K. and later in the U.S. and Canada which derived from it, was individualist and saw casework as the task of distinguishing between the deserving and undeserving of assistance. The rule in keeping with the laissez-faire philosophy of the day held that “he who seeks another’s bounty shall also submit to another’s scrutiny”.

The social casework paradigm which assigns the power of the state to a caseworker, to determine risk to a child, suitability of parents or risk to the community is derived, in large part, from the techniques and ethics of those days.

Alternative approaches which focused on the social and economic environment as causes of individual distress and self, group and community education and empowerment as the method for ameliorating distress, were developing at the same time. Group work and community organization and community development have also been part of the social work profession but with marginal impact along the way, compared to the casework model.

The emergence of a variety of casework based disciplines in child welfare, corrections, mental health and other fields were further reinforced and supported by the emergence of a scientifically legitimized field of psychiatry.

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4 Swan and Morgan, Collaborating for Comprehensive Services for Young Children and their Families. 1993.
Casework models, rooted in powerful state bodies such as welfare and child protection have persistently separated the worker from the community of those being served as well as those being served from each other.

It has, as well, removed the capacity of being one’s own “case manager” from the individual, family and community.

The loss of sense of self, family and community described by many Aboriginal people, through their dealings with state welfare, child welfare and Indian affairs “case workers” and “case managers” is an extreme example of the impact of state reliance on approaches that individualize, isolate and transform people into “cases”.

4. Emphasizing New Paradigms: “If our only tool is a hammer, pretty soon all we see are nails”

The collaborative process, including clients, is about discovering why, where and when various paradigms fit and don’t fit in an integrated, child centred, empowering and capacity building approach. Creating a community service network approach is a part of the reform process that should not be overlooked or underestimated in its impact.

Traditional case management as well as service coordination, group work, self help, adult education, health promotion, early intervention, parent relief and community development and other paradigms all have a place in the reformed child and family services network which the new Ministry is committed to creating. We must use our policy documents to reflect this diversity of approaches.

There is a growing body of successful experience, research and community and group based program models which suggest that the casework approach should be used as the prime relationship model only in cases where the state is clearly acting as a “policing” agent and the client is involuntary. It is viewed by critics as inappropriate and counter-productive where there is a voluntary element or where community and family capacity building is the goal.

What is now a focus on integrated case management among professionals may be more productively framed as negotiated relationships, roles and responsibilities among professionals, clients and extended family and community for a) reporting, b) investigating abuse, c) apprehending children and d) providing or developing other voluntary child and family supports.

Even with the involuntary client, the confusion of the case managerial role with that of the coach, facilitator, counsellor, group worker, friend or community worker role, has led some reform efforts to strive to separate the powerful case manager role out and to the margins as a conscious strategy, not as an unintended consequence of busyness. The overworked child protection worker, juggling and shifting roles of policing and documenting risk with that of counsellor have for many years been seen as difficult. A better division of labour rather than blurring contradictory roles may be more useful where it is possible. Ironically, this may best occur within the process of planning integrated case management and collaborative service delivery networks.
Traditional case management and integrated case management is rooted in dependency creating, and caseload generating models of service delivery and should not be the dominant focus nor mode of service delivery where the full impact of state power is not required.

Making casework more effective and removing the inefficient parts of it, where it is required, is necessary. It is not sufficient to improve outcomes for children and families and should be considered in relation to group and community approaches. Community collaboration and realignment of resources from crisis to earlier intervention focus requires a critical discussion of the appropriate use and alternatives to a costly, time consuming, and documentation driven approach which characterizes much of existing case management practice.

It is important in attempting to reform what hasn’t worked, that we not simply add new programs or approaches to the old. We need to examine the foundation and rebuild it for the 21st century. The balance so heavily weighted to case management models needs to be examined and questioned if we are to finally leave the 19th century models behind.
Definition and Key Elements of ICM\(^5\)

"Children are dependent on caregivers and our interventions are to help others take care of the children, not just the parents. Others in the community, besides parents, have responsibilities for caring for children at different times, for example, day care staff, teachers, foster parents. ICM assists everyone in understanding and caring for children in a consistent way".

“I think ICM made a difference to my kids turning out. I don’t think I would be here today talking to you without the experience of ICM. The process has been empowering to me and has validated me as a person and as a parent. It has allowed my children and me to grow together. It has been a huge part of my sanity and my survival.”

Practitioners at all four sites articulated a vision of Integrated Case Management. Those who had more experience practicing ICM or who had spent considerable time developing a vision provided more depth. However, in general there was agreement that ICM is a means by which practitioners from across disciplines and work settings can work in partnership with each other and with clients, to help achieve better outcomes for children, youth, families and other adults. Many noted as well that ICM is not just a mechanism or means by which services can be accessed; it is a service in itself that provides support, coordination and better outcomes for practitioners and clients.

As part of this broad vision, a number of key elements of ICM were identified. One or two elements alone were not seen to be sufficient to encompass ICM practice, but together they were described as comprising the primary processes and activities of ICM.

**Process components:**

- A holistic approach to working with clients
- Respectful and consistent involvement of clients
- The development of trusting relationships
- Common goals
- Shared decision-making
- Clarity of roles
- Information sharing and frank communication
- Shared responsibility and accountability to other professionals and to clients
- A mechanism for resolving conflicts

Activity components:

- Integrated case conferences
- Proactive assessment, planning, review and implementation of case plans
- Follow-through/follow-up
- Assignment of case coordinator
Case Scenario: Community Living

Family

Louise, mother, age 41
Tara, daughter, age 15
Jack, son, age 12
Toby, son, age 11

Louise is a low income, single parent who works part time and goes to college part time. Toby, her youngest, has autism and has been living in foster care for several years. Louise's eldest child, Tara, is learning challenged, and Jack has cerebral palsy accompanied by a seizure disorder and visual impairment. Jack also is non-verbal and has autistic tendencies. Both Tara and Jack live with Louise.

Louise believes in naturopathic ways of managing Jack's seizures, and has had conflicts with health care practitioners about this. For the past several months, there has been an increase in the number and severity of Jack's seizures, both at home and at school. On the occasions that Jack has had a seizure at school, Louise has not been able to leave her work or college early in order to pick him up; at the same time, Louise cannot afford a taxi to go to Jack's school and transport him home. Louise also has no emergency back-up plan for the care of Jack and Tara. School personnel have stated that they do not feel safe in keeping Jack at school.

People involved in case:

MCF Community Living Worker
Guardianship Worker
Nursing support/consultant
School Representatives (Teacher, Principal)
Teaching Assistant (for Jack)
Teaching Assistant (for Tara)
Child Care Worker from After School Program (Tara and Jack)
Physical Therapist
Behavioural Consultant
Louise
Small Group Discussion Questions

Vision of ICM
• Did you all have the same vision/understanding of what was to happen in the meeting? Of Integrated Case Management? If not, what differences emerged? What is your understanding of where the differences originate?

Client involvement
• How were family members involved in the plan? In information-sharing? In decision-making? Did you consider or discuss providing the family with a copy of the plan or documentation?

Holistic approach to working with families
• What did having “a holistic approach” or “being client centred” look like in your meeting? How does this contrast with other ways of working with clients or does it?

Trusting relationships
• Was there evidence of trust among members of the team? If so, what does trust look like? Give examples. How did this trust develop or how was it facilitated in the meeting? If not, what contributed to this lack of trust?

Clarity of roles
• Did team members know about and respect each other’s discipline value base, mandate, role(s), legislative requirements, organizational constraints etc.? If so, how did you know this? Give examples. If not, how did you know this? Give examples.
• Did you assign a case coordinator? Did one emerge from the group? What was the case coordinator’s role? Does everyone agree that this is the role? Did you discuss it or was it assumed? What difference did having (or not having) a case coordinator have to the planning process?

Shared responsibility, accountability and decision making and conflict resolution mechanisms
• How were decisions made within the team? Did people come to the meeting to collectively make decisions or did some people come to present their decisions?
• Was there evidence of “shared responsibility” or “shared accountability” amongst members of your team? What did it look like? How did you know there was sharing of responsibility or not?
• Did different people assume responsibility for different parts of the plan? How were these decisions made? Was accountability to complete their part of the plan discussed or assumed? What do you think would happen if people didn’t follow up on the plan? How would the group handle it?

Information sharing and frank communication
• Was information shared openly and honestly? Did anyone feel constrained about sharing information? If so, why? To what degree did their discipline, personal preferences or information sharing policy influence people? Did family members feel free to share information?
**Multidisciplinary case conference**
- How was the agenda for the meeting developed? Were the goals for the meeting explicit and agreed to?
- Was there anyone who did not want to attend or who thought that it was unlikely that they would attend such a meeting?
- Were there any guidelines for involvement of the family? For communication with each other during the meeting?

**Proactive assessment, planning, review and follow-up/through**
- What was the focus of the planning? Was it the clients’ problems, or were their strengths acknowledged?
- Was there any discussion of what to do if the plan was not followed through?
- Were any plans made for the next meeting or for a process to follow-up and follow-through on the plan that was developed?
Case Scenario: Youth Services

Family

Jess, mother, age 41
Chris, son, age 16

Jess is a single mother who has had an alcohol addiction for years, and has been hospitalized and in and out of treatment for her problems. Chris has been in and out of government care for the past two years, and was first removed at age 14. Chris expressed a desire to be out of his mother's home; at the same time, Ministry workers have protection concerns. Despite his not living with his mother, Chris cares for Jess very much, and has also demonstrated an ability to take care of Jess and the home.

For the past two years, Chris has lived in one foster home and three group homes. As well, for the past year and a half, Chris has accessed a community-based youth shelter numerous times. Several months ago, Chris experienced severe depression and was assessed for mental health issues. His performance and attendance at school has been declining significantly in the past six months. In addition, workers at Chris' current group home suspect that Chris may be engaged in criminal activities, though Chris has denied having involvement in the criminal justice system.

Recently, Chris expressed interest to group home workers in using the Independent Living program; however, the Ministry denied Chris access to this program.

People involved in case:

Child Protection Worker(s)
Resource Worker(s)
School Representative(s) (Teacher, Counsellor)
Mental Health Consultant/Counsellor
Receiving Home Worker(s)
Youth Shelter Worker(s)
Group Home Worker(s)
Foster Parent(s)
Child and Youth Care Worker
Police Representative
Independent Living Program worker
Chris
Jess
Small Group Discussion Questions

Vision of ICM
• Did you all have the same vision/understanding of what was to happen in the meeting? Of Integrated Case Management? If not, what differences emerged? What is your understanding of where the differences originate?

Client involvement
• How were family members involved in the plan? In information-sharing? In decision-making? Did you consider or discuss providing the family with a copy of the plan or documentation?

Holistic approach to working with families
• What did having “a holistic approach” or “being client centred” look like in your meeting? How does this contrast with other ways of working with clients or does it?

Trusting relationships
• Was there evidence of trust among members of the team? If so, what does trust look like? Give examples. How did this trust develop or how was it facilitated in the meeting? If not, what contributed to this lack of trust?

Clarity of roles
• Did team members know about and respect each other’s discipline value base, mandate, role(s), legislative requirements, organizational constraints etc.? If so, how did you know this? Give examples. If not, how did you know this? Give examples.
• Did you assign a case coordinator? Did one emerge from the group? What was the case coordinator’s role? Does everyone agree that this is the role? Did you discuss it or was it assumed? What difference did having (or not having) a case coordinator have to the planning process?

Shared responsibility, accountability and decision making and conflict resolution mechanisms
• How were decisions made within the team? Did people come to the meeting to collectively make decisions or did some people come to present their decisions?
• Was there evidence of “shared responsibility” or “shared accountability” amongst members of your team? What did it look like? How did you know there was sharing of responsibility or not?
• Did different people assume responsibility for different parts of the plan? How were these decisions made? Was accountability to complete their part of the plan discussed or assumed? What do you think would happen if people didn’t follow up on the plan? How would the group handle it?

Information sharing and frank communication
• Was information shared openly and honestly? Did anyone feel constrained about sharing information? If so, why? To what degree did their discipline, personal preferences or information sharing policy influence people? Did family members feel free to share information?
**Multidisciplinary case conference**
- How was the agenda for the meeting developed? Were the goals for the meeting explicit and agreed to?
- Was there anyone who did not want to attend or who thought that it was unlikely that they would attend such a meeting?
- Were there any guidelines for involvement of the family? For communication with each other during the meeting?

**Proactive assessment, planning, review and follow-up/through**
- What was the focus of the planning? Was it the clients’ problems, or were their strengths acknowledged?
- Was there any discussion of what to do if the plan was not followed through?
- Were any plans made for the next meeting or for a process to follow-up and follow-through on the plan that was developed?
Integrated Case Management Training (Module 2) 
Evaluation Form

The purpose of this evaluation is to help us understand the value of the activities in meeting the ICM training goals.

This workshop has been designed to provide you with an opportunity to:
- discuss the values and characteristics of ICM
- discuss the roles and responsibilities of practitioners involved in ICM
- develop a common vision of ICM

Using the following rating scale where 1 equals not effective, 3 equals somewhat effective and 5 equals very effective, rate each of the following activities in terms of meeting the workshop goals.

1. Workshop activities
   a) Role play
      1 2 3 4 5
      not effective  somewhat  very effective

   b) Small group discussion
      1 2 3 4 5
      not effective  somewhat  very effective

   c) Large group debrief/discussion
      1 2 3 4 5
      not effective  somewhat  very effective

2. How useful were the handouts/resources?
   1 2 3 4 5
   not useful  somewhat  very useful

3. How applicable has this workshop been to your work or experience?
   1 2 3 4 5
   not applicable  somewhat  very applicable
4. What do you feel was your biggest learning today?

5. What was your biggest surprise?

6. What did you like best about the workshop?

7. What would you change if you could?

8. Please add any additional comments.
Community Self-Assessment

This module introduces the community self-assessment tool. The community self-assessment is designed to assist communities to identify the supports and/or training they might need to implement or refine their ICM practice. It takes into account the different stages that communities might be in their implementation of ICM and acknowledges the unique characteristics of ICM practice in each community.

The community self-assessment is a facilitated process that encourages reflection on practice and relationship building amongst practitioners. It is structured to elicit the strengths of ICM practice as it exists and to produce a training plan that supports those strengths. At the same time the community self-assessment process helps guide the implementation and refinement of ICM in each community.

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<tr>
<td>40 minutes</td>
<td>Activity 1: Introduction to Community Self-Assessment</td>
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<tr>
<td>90 minutes</td>
<td>Activity 2: Community Self-Assessment for Integrated Case Management</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Stretch and/or Refreshment Break</td>
</tr>
<tr>
<td>30 minutes</td>
<td>Activity 3: Building on Strengths in Integrated Case Management Practice</td>
</tr>
<tr>
<td>40 minutes</td>
<td>Activity 4: Next Steps</td>
</tr>
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Community Self-Assessment for Integrated Case Management

Introduction:

The purpose of the community self-assessment is to assist communities to identify what supports and/or training they need to implement or refine their ICM/ISD practice. It is designed to recognize that communities are at different stages in their implementation of ICM/ISD and to acknowledge the unique characteristics of ICM/ISD practice in each community.

The community self-assessment is a facilitated process that encourages reflection on practice and relationship building amongst practitioners. It is designed to elicit the strengths of ICM practice as it exists and to produce a training plan that supports those strengths. At the same time the community self-assessment process helps guide the implementation and refinement of ICM/ISD in each community.

Section One: ICM Overview

Vision of ICM

Reflect upon the understanding of ICM in your office, community, and/or region:

√ Has ICM been discussed in your area?

√ Has a vision/understanding/model been articulated in your team/community?

√ Have representatives from all appropriate sectors, including community partners been a part of these discussions?

Do your answers suggest that a discussion about ICM and development of a vision/model are a priority for training/practice support in your team or planning in your community in order to advance the implementation of ICM in your area?

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Section Two: ICM Practice

Client involvement

Reflect upon the involvement of clients in your office/community:

√ How are clients involved in their own case planning?
√ How regularly are clients involved in their case planning?
√ Are multi-disciplinary case conferences scheduled at a time that enables/ensures clients' participation?
√ How are clients involved in information sharing? In decision making?
√ Do clients receive a copy of all planning related documentation (e.g., multi-disciplinary case conference notes)?
√ What are the barriers to clients' participation in case planning?

Do your answers suggest that issues concerning client involvement are a priority for training/practice support in your team or community, in order to advance the implementation of ICM in your area?

Holistic approach to working with clients

Reflect upon the approach to working with clients in your office/community:

√ What does having a "holistic approach" look like in your community (discuss examples based on practice)?
√ How does having a holistic approach contrast to other ways of working with clients?

Do your answers suggest that issues concerning a holistic approach are a priority for training/practice support in your team or community, in order to advance the implementation of ICM in your area?

Trusting Relationships

Reflect upon the history and nature of the working relationships among the professionals in your office/community:

√ What kinds of opportunities exist - or have existed historically - for developing and/or strengthening relationships between team members and with community? (e.g., brown bag lunches, "team" days, social events, collaboration between multi-disciplinary professionals, joint training.)
Do your answers suggest that issues concerning relationship building are a priority for training/practice support in your team or community, in order to advance the implementation of ICM in your area?

Clarity of roles

Reflect upon the roles of the multi-disciplinary professionals in your office/community:

√ In the practice of ICM in your area, do the multi-disciplinary practitioners and team members know about and respect each other's: professional value base, mandate, role(s), and available resources in their work with individuals and families?

√ What kinds of opportunities exist - or have existed historically - for deepening this understanding of discipline-related work/roles? (e.g., brown bag lunches, "team" days, social events, collaboration between multi-disciplinary professionals, joint training, etc.)

√ In the practice of ICM in your area, have the roles of case coordinator and/or case conference chair been formally articulated?

√ Is there common understanding of these roles?

Do your answers suggest that issues concerning the clarity of roles are a priority for training/practice support in your team or community, in order to advance the implementation of ICM in your area?

Shared responsibility, accountability and decision making, and conflict resolution mechanisms

Reflect upon the mechanisms for handling issues of responsibility, accountability, decision making and conflict resolution in your office/community:

√ What does "shared responsibility" and/or "shared accountability" look like in the practice of ICM in your area?

√ Is one person or sector generally responsible for overseeing the case planning, or is there shared responsibility among team members, including the client?

√ How are accountability issues dealt with?

√ How are decisions made within the multi-disciplinary case conferences in your area? (e.g., Do you go to meetings to make decisions or to present decisions?)

√ What happens when there are disagreements within the team regarding the case plan? How are disagreements handled and resolved?

√ Do all participants in multidisciplinary case conferences routinely follow-up on their parts of case plans?
Do your answers suggest that issues concerning shared responsibility, accountability and decision making are a priority for training/practice support in your team or community, in order to advance the implementation of ICM in your area?

Information sharing and frank communication

Reflect upon the mechanisms for information sharing and communication in your office/community:

√ How does information generally get shared amongst the multi-disciplinary professionals in your office/community?

√ How comfortable are practitioners with sharing information, and with communicating across disciplines in the presence of clients? Do professionals and/or clients feel free to discuss their comfort level regarding frank information exchange?

√ What kinds of opportunities exist - or have existed historically - to discuss and address information sharing issues across disciplines and with clients?

Do your answers suggest that issues concerning information sharing and open communication are a priority for training/practice support in your team or community, in order to advance the implementation of ICM in your area?

Integrated case conferences

Reflect upon the integrated case conferences that have been held in your office/community:

√ Are multi-disciplinary case conferences occurring regularly in your area?

√ Are common goals established as part of the agenda building process in case conferences?

√ Have you articulated guidelines/criteria regarding when multi-disciplinary case conferences are to be employed with clients and families?

√ Are your multi-disciplinary case conferences routinely and systematically documented? Does documentation include: a list of the participants of the case conference; a write-up of each component of the agreed upon case plan(s), and each participant's responsibilities in relation to carrying out the plan; a timeframe for action; expected outcomes, and the next case conference date?

√ What, if anything, serve as barriers to routinely having multi-disciplinary case conferences in your office/community?

Do your answers suggest that issues concerning multi-disciplinary case conferences are a priority for training/practice support in your team or community, in order to advance the implementation of ICM in your area?
Proactive assessment, planning, review and follow-up/through

Reflect upon the integrated case management process in your office/community:

√ Are integrated case conferences and integrated case management occurring proactively in your office/community (or are conferences and ICM occurring reactively, in response to problems or crises)?

√ Have you articulated steps to ensure that ICM and integrated case conferences occur proactively in your office/community?

√ Does the integrated case planning include an assessment phase that identifies strengths and issues to be addressed?

√ Is integrated case planning the central focus of multi-disciplinary case conferences (i.e., not just a review of clients’ problems)? Does the documentation of case conferences reflect this focus?

√ Are contingency plans routinely developed and documented as part of the integrated case conference?

√ Does a mechanism exist to ensure that, when aspects of the plan cannot be carried out, and/or when a client’s circumstance change, all team members are notified and the plan is altered accordingly?

√ Does a mechanism exist to ensure that there is follow-up and follow-through on all components of the integrated case plans?

Do your answers suggest that issues concerning proactive assessment, planning, review and follow-up/through are a priority for training/practice support in your team or community, in order to advance the implementation of ICM in your area?
Section Three: ICM Training and Practice Support Plan

| Based on the above Self-Assessment, what are your community strengths in ICM? |
|---|---|
| In what ways could these strengths be built upon? |
| Based on the above Self-Assessment, what are your community’s priority needs for ICM training/practice support? |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| What types of training support do you think would be most useful in addressing these priorities? For example, facilitated discussions, workshops, case-specific consultations, skill-based training. |
| What types of practice support do you think would be useful? For example, case consultation, team debriefing, regularly scheduled days to hold ICM case conferences. |
| What are the resources and time frames needed to accomplish the training and practice supports? |
Integrated Case Management Training (Module 3) Evaluation Form

The purpose of this evaluation is to help us understand the value of the activities in meeting the ICM training goals.

This workshop has been designed to provide you with an opportunity to:
- reflect on integrated case management practice
- identify community strengths in practicing integrated case management
- identify priorities for training and supports to ICM in your community

Using the following rating scale where 1 equals not effective, 3 equals somewhat effective and 5 equals very effective, rate each of the following activities in terms of meeting the workshop goals.

1. Workshop activities
   a.) Community self-assessment
      1 not effective  2 somewhat  3 very effective

   b.) Small group discussion
      1 not effective  2 somewhat  3 very effective

   c) Large group debrief/discussion
      1 not effective  2 somewhat  3 very effective

2. How useful were the handouts/resources?
   1 not useful  2 somewhat  3 very useful

3. How applicable has this workshop been to your work or experience?
   1 not applicable  2 somewhat  3 very applicable
4. What do you feel was your biggest learning today?

5. What was your biggest surprise?

6. What did you like best about the workshop?

7. What would you change if you could?

8. Please add any additional comments.
Beginning ICM and Preparing for Case Conferencing

This module provides participants with an opportunity to explore when and why they begin ICM and to initiate consensus building regarding the criteria for beginning an ICM process. Participants will develop strategies to help prepare for case conferences, including building relationships amongst service providers and discussing the role of the client. Opportunities will be provided to discuss involving children, youth and families in a meaningful way and to explore the role of advocacy in an ICM process. Participants will look at how to create a receptive environment for advocacy within their ICM practice. Strategies, guidelines and protocols for involving children, youth and families will be initiated in this module. Through practice-based scenarios participants will be able to explore how to plan for a case conference, what to bring in the way of information, prior approvals, etc.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>40 minutes</td>
<td>Activity 1: Involving Children, Youth and Families in Case Management</td>
</tr>
<tr>
<td></td>
<td>Activities</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Stretch and/or Refreshment Break</td>
</tr>
<tr>
<td>120 minutes</td>
<td>Activity 2: Reflection on Practice and Developing Common Agreement</td>
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<td></td>
<td>(Protocol) for Beginning ICM</td>
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<tr>
<td>60 minutes</td>
<td>Lunch Break</td>
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<tr>
<td>120 minutes</td>
<td>Activity 3: Preparing for a Case Conference</td>
</tr>
<tr>
<td>40 minutes</td>
<td>Activity 4: Next Steps</td>
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</tbody>
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Case Scenario (All Activities)

This scenario reflects situations you may encounter in the field. While the situation may be similar to one you have encountered, it is fictitious and is not necessarily meant to be indicative of best practices.

The family

Joe, grandfather, age 52
Kim, mother, age 26
Josh, son, age 3

The family lives together in a basement suite close to town. Joe is the primary caregiver of both Kim and Josh. He has recently suffered a severe and incapacitating heart attack. He is attending a rehabilitative program at the local hospital and is recovering well. However he has been under considerable stress and is worried about both Kim and Josh.

Kim has a severe mental illness that is stabilized with medication but she is not able to take complete responsibility for Josh’s care. She sees a mental health worker at the local mental health centre twice a month. She has a home support person who comes to the house to help her with activities of daily living, including helping her to try to take some responsibility with Josh and household chores to assist her father. She would like to live independently and can’t decide if she wants Josh with her or not.

Josh is an active 3 year old who is not yet toilet trained. Josh lived with Kim for the first 18 months of his life and her illness was not well controlled so their life was chaotic. Joe took them both in to live with him 18 months ago. Josh attends a licensed child care facility and is very attached to the child care staff person. He has been at several child care facilities but has been at this one for the past 7 months and his behaviour is much improved from his early days there. The staff have been very supportive during Joe’s illness and the child care facility provides a stable environment for Josh. Josh also has a child and youth care worker who is working with Joe predominately on strategies to discipline and set limits for Josh.

The child protection worker has initiated a multidisciplinary team meeting after a recent visit to the home. The visit was in response to a complaint from a neighbour about the smell in the apartment – “there is a three year old kid living in the apartment – I don’t know how he can survive that stench”. When the child protection worker visited, there was indeed an overpowering smell of stale air and urine. Joe told the child protection worker that he was trying to care for his daughter and grandchild and Josh regularly wets the bed, which accounts for the smell.
Service Providers Involved

Child Protection Worker
Child Care Worker
Mental Health Worker
Child Care Facility staff person
Home Support Worker
(add other roles that might be appropriate depending on who is participating in the training.)
Case Scenario (All activities)

This scenario reflects situations you may encounter in the field. While the situation may be similar to one you have encountered, it is fictitious and is not necessarily meant to be indicative of best practice.

**Family**

*Catherine, mother, age 19*
*Joe, father, age 20*
*Taylor, son, age 2.5*
*Katie, daughter, age 8 months*

**History:**

Joe and Catherine are young parents who met while in the care of the Ministry (same group home/high school). Both Catherine and Joe have had a long history of child abuse, addictions, and violence from their own families of origin. They formed a strong bond with each other and both really hoped they would make their own family different. They first began living together when Catherine was 17 and Joe was 18; they separated approximately 20 months later.

Catherine, at age 16, became pregnant with Taylor when she was AWOL from group home and had been staying at her mother’s house. Her mother is a known addict/prostitute and Catherine describes being put to work on the streets by her mother to pay for drugs, etc. She was still in her boyfriend relationship with Joe and is certain that Taylor is his child as she made her tricks use condoms, but the child’s paternity has been a source of conflict in their relationship.

They separated primarily because their conflicts had become too much. Catherine is afraid of losing her children to the Ministry – she asked Joe to leave because of his criminal charges (theft and drug trafficking) and ongoing drug use. Catherine has been “clean” since early in her pregnancy with Katie (as soon as she knew - she did use drugs during first trimester). Catherine admits to drug and alcohol use during her pregnancy with Taylor – she worked the street until her sixth month of pregnancy and is very concerned that Taylor is FAE or FAS.

Taylor is developmentally delayed and has some medical and health care concerns. Katie suffered failure to thrive and neglect; and has been hospitalized three times since birth because she was not gaining weight; had frequent bronchial infections and feeding difficulties.

Catherine is very concerned about her children and wants to learn how to be a good parent. She does not have a positive support system as both her extended family and Joe are actively involved in the drug, violence, crime and chaotic lifestyle scene. She wants something more.
The Ministry did apprehend both children approximately six months ago when Katie was admitted to hospital with severe dehydration and severe diaper rash. They returned home, with a range of services placed in home, but were removed again two months later following a report of abandonment. Catherine admitted to leaving the children sleeping alone at night while she went to find Joe because she did not know where he was. After a brief stay in foster care, the children returned home. Joe and Catherine decided to separate for a while. Catherine is now primary caregiver but Joe does visit with the children three times per week.

**Service Providers Involved**

- Child Protection Worker
- Healthiest Babies Possible Worker
- Infant Development Program
- Public Health
- Alcohol and Drug Counsellor
- Home Support Worker
- Probation Officer (Joe’s)
- Aboriginal Family Service Worker

(add other roles that might be appropriate depending on who is participating in the training e.g. Child Care Staff member)
Case Scenario (All Activities)

This scenario reflects situations you may encounter in the field. It is not necessarily meant to be indicative of best practice.

**Family**

**Marion, mother, age 48**
**Josie, daughter, age 12**
**Janie, daughter, age 11**

Marion is the mother of 10 children. After a tumultuous marriage, she and her husband split up. They live on a farm though so he is around on a daily basis, working the farm. The older children live in the community. Josie and Janie are the only children still living at home. After the parents split up, Josie disclosed sexual abuse by her father.

The child protection worker and police did an investigation of the report of sexual abuse made by Josie against her father. The family is well known to the Ministry and over the years there have been many reports of incidents involving alcohol and fighting. Several of the older children have been in care. Following the investigation, the girls were removed from the home and placed in a foster home because Marion could not ensure their safety in the home. They were referred for abuse counselling and Marion was referred to alcohol counselling and violence prevention counselling.

The girls were placed with a very experienced foster parent and she is expressing concern because since the girls have been with her they have been largely uncommunicative with her and do not appear to be adjusting well to her home and her rules. Both say they want to go back home, to be with their mother.

Marion has recently contacted the sexual abuse counsellor who is seeing the girls and has asked for her help in approaching the Ministry about seeing more of the girls. The sexual abuse counsellor knows the girls are upset and angry and want to go home.

Marion is not happy about being referred to alcohol counselling but she attends fairly regularly because she wants to get the girls back. She is not sure what else she has to do. Marion does not believe that she can stop her husband from being at the farm; without him working it, they will likely lose the property. During counselling, Marion was at first suspicious of the counsellor but is beginning to open up a little and talk about her own childhood. She wants the counsellor to help her get the girls back home. Marion also is attending the violence prevention group but does not contribute. She has shown up twice smelling of alcohol and has been sent home.

A multi-disciplinary team meeting has been set up by the sexual abuse counsellor because she is trying to respond to Marion’s request for assistance to see more of her girls.
Service providers involved

Child Protection Worker
Foster Parent
Resource Worker
Guardianship Worker
Sexual Abuse Counsellor
Violence Prevention Group Leader
School Counsellor
Police

(add other roles that might be appropriate depending on who is participating in the training)
Case Scenario (All Activities)

This scenario reflects situations you may encounter in the field. It is not necessarily meant to be indicative of best practice.

Family

Celia, mother, age 42
Sam, father, age 45
Stephen, son, age 15
Susan, daughter, age 10

Celia and Sam are both from Hong Kong and immigrated to Canada when Stephen was two. Life has been hard in Canada; work has been difficult to find. Celia has stayed home with the children and Sam has had a series of low paying jobs. The family now lives in a predominantly white, middle class neighbourhood.

Stephen has been a hard working student who has excelled academically. At school he is known to be quiet and to spend most of his time on his own. The school counsellor has become concerned lately because Stephen's marks have declined dramatically this school year and over the past 2 months his attendance at school has been sporadic. He has tried to contact Stephen’s parents to discuss his concerns but has always got Celia on the phone and she speaks very little English. Last week the school counsellor called Stephen into his office to discuss his attendance. Stephen got very angry when he was told that his parents had been called. He walked out and hasn’t been at school since.

Stephen has recently become known to the downtown street outreach worker. He is on the street on the weekend although seems to go home during the week. The worker is concerned that Stephen is becoming involved with drugs and petty crime. He is trying to encourage him to return home but Stephen says he “hates” his Dad.

Last weekend Stephen was involved in a fight in the downtown area involving 3 youth aged 15, 16 and 18. Stephen had a knife. He was taken to the police station and Sam and Celia were called. When they came to the police station Celia spoke very little English and appeared very confused and upset. Sam spoke English and appeared angry and ashamed. The procedures were explained to them and Stephen was charged and placed on bail supervision under the Young Offenders Act. Celia and Sam asked for police help to keep Stephen off the street.

Celia attends a women’s group at a local community centre/neighbourhood house. The facilitator is an immigrant from Hong Kong and speaks Cantonese, so the group has attracted mainly Cantonese speaking women. Celia recently told the facilitator that her son was in trouble with the law and at school. She doesn’t know what to do. She asked the facilitator to talk to the police and school for her.
Service providers involved

Probation Officer
Community Centre Group Facilitator
School Counsellor
Alcohol and Drug Counsellor
Downtown Youth Outreach Worker

(add other roles that might be appropriate depending on who is participating in the training)
Reflective Questions (Activity 1)

Take 15 minutes to read the case scenario and respond to the following questions based on your reflections on your practice. Be prepared to discuss your responses in your small group. Use these questions to guide your small group discussion as well.

- Would you involve the family in an integrated case conference in this case?
- Why or why not? What would you consider in making your decision?
- If yes, whom would you involve and what role(s) would they assume?
- Can you involve the family in integrated case management without their participation in integrated case conferences?
- Is there a role for an advocate in this situation? Who decides?
- What is your definition of advocacy?
- What factors influenced your thinking (i.e. your personal values and beliefs, practice experience, family capacity, child’s age, child’s or family’s willingness to engage in ICM and so on)?
- What implications would your decision have for care planning for the family?
- Overall, given your answers to the above questions, what are your beliefs and values about involving children, youth and families in integrated case management and how would these beliefs and values influence which factors you considered in making your decision?
- Overall, given your answers to the above questions, what are your beliefs and values about advocacy?
Clients’ Experiences of ICM and Outcomes of ICM for Clients

Benefits of ICM

Clients’ Experience of ICM

A wide range of clients was interviewed including youth in care, parents whose children were currently in care through voluntary care agreements, parents whose children had been removed by the Director, parents who were caring for children with unique needs, and foster parents.

While many clients were critical of the Ministry overall, they were overwhelmingly positive about their experiences of ICM. Many also articulated how their experiences with ICM were different from their experiences prior to ICM. They appreciated being seen as a whole person. Often, this was a new experience with dramatic consequences. Most notable was the sense of relief of having ones’ full range of needs and capacities understood. Clients noted that their relationships with professionals, and in particular with social workers, often improved as they learned to work together through the ICM process. Both seemed to come to a better understanding of each other and perhaps a greater appreciation for what could be realistically achieved.

Through ICM, who was to do what became clearer for clients. They could identify who to turn to, what they could expect from the professionals in their lives and what their own role was. While being involved in integrated case conferences was not easy for many clients, no one indicated that they would rather not attend. What was important, was that they had an opportunity to be involved in information sharing and decision-making, to contribute, to be listened to, and to be kept informed.

While not asked directly about the key elements of ICM, clients’ comments on their experiences clearly reflect many of the key elements. Their comments are therefore reported here by key elements of ICM.

Wholistic approach

“They dealt with us a unit rather than (dealing with) just my son. They included my other son because his behaviour was affected by B. as well.”

“We have been having ICM meetings for six years. We meet every four to six weeks and discuss and agree to action on whatever comes up. It is really for the whole family even though it started around my son. I have only missed one meeting. In a way the ICM team is a part of my family; they all fight for my son and I know I’m not alone in my frustration.”

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The development of trusting relationships
“I assumed everyone was against me but then I heard people supporting me. I realized their job was hard and that they had my son’s best interests at heart. They have hard judgements to make.”

“Now they (social workers) talk to me. They listen to me; they talk to me. They are more comfortable with me. I call the social worker and we are normal together. We are not fighting anymore.”

Clarity of roles
“The case conference helps everyone to keep informed about what’s going on and what they're supposed to be doing.”

“We were able to designate who was able to do what. And who was responsible for what, so there's no duplication of services. Everybody knows what everybody else is doing.”

Common goals
“It’s difficult to have so many new people come into your life that you never would have chosen to be part of your life. But it's always for the sake of the kids.”

“Our number one focus is my son. I think we're all child-centred and that helps in working together.”

Shared decision making
“The Ministry has said, "We won't do anything - i.e., put your son into foster care - without your approval." They have to go through me.”

“I am no longer scared for him or the community. I have back-up now. It is a group decision in the case management process.”

Respectful and consistent involvement of clients
“My social worker arranges the meetings, around my schedule - which I appreciate - and I attend them. I'm the primary caregiver.”

“I'm an equal member of the team. No one wears any special hats there.”

“It was really important that my son was there so he knew what the plans were. He got so he could say “I want to do it this way” or “that won’t work for me” and he was listened to.”

“I was asked whom I wanted to bring to the conference so I took my lawyer, my worker from the mental health clubhouse and an affidavit from my psychiatrist. I felt supported. It was very intimidating at first. I was scared. We sat around a large table and other people were making decisions about my life. But it wasn’t that bad; it was informal and everyone got to say what they thought. I was able to say what I wanted and needed.”

“They held the second case conference at YDC so that my son could attend. Without that he could not have been there.”
**Shared responsibility and accountability**

“This shift has started since doing the integrated case conferences. Accountability comes into it more now too. Accountability to the group; everybody has to come back together and report on their piece of it which helps. And now there is one key person to check in with rather than someone checking in with that person and someone else checking in with someone else.”

“As a parent, I see everyone is doing their job. These meetings pull together all the people in J’s life and I can see that they are working together.”

**Information sharing and frank communication**

“A lot of times the school doesn't realize that the child's medications have changed, and the case conference keeps them up to snuff. A lot of times the school doesn't know that the child is sometimes with one parent and sometimes with the other parent, and the case conferences let them know of that situation.”

“Everybody gets to speak and figure out the best way to go. Everybody contributes. The first time I went I had no idea what to expect. And the second time, there were a few times that I could comment on things T had been doing and they put that into the decision on how things could go. It was part of the information that they needed to make a decision.”

**Follow-up and follow through**

“I'm also at the meetings to ask for services, for example, to get assessments from the school. I've been asking for that for years. After one of the meetings, I said to my social worker, "Now it's time, don't you think?"

“The meetings are open and honest and we decide on things by consensus and then what’s decided on at the meeting gets followed through on between meetings.”

**Proactive assessment, planning, review and implementation of case plans**

“I think it would have been better to have ICM happening for him in elementary school so it didn’t get to such a crisis. Parents and teachers need to work together at that level.”

“Formerly case conferences were reactive; they were initiated to address a problem. The Intensive Child Care Resource case management process is structured to help. While my son was involved with ICCR we met every six to eight weeks.”

**Multi-disciplinary case conferences**

“We are having another conference in June. The conference is an opportunity for me to say what I have been doing and for others to say what they see about my progress. It’s a very positive experience.”

“Before having the case conference, I worked one to one with K’s first social worker. Then he left. I got tired of explaining myself to different workers all the time. I didn’t feel terribly well informed. The team meetings are like life and death. I have hope for the first time. It is the first light at the end of the tunnel. I don’t feel so alone and like a leper.”
Not every client had positive experiences with ICM. Criticism usually focused on issues arising when all players in the child's life were not involved in case conferences from the beginning or were not present at ICM meetings. From clients' perspectives, absences or "exclusion" from ICM meetings inevitably lead to difficulties in communication and resentment. For the youths involved, some felt uncomfortable with the attention and focus on their behavior but acknowledged that it did have a positive impact in the end.

Others expressed frustration that ICM was problem-focused and crisis initiated for the most part. In the site that had been practicing ICM for some time, clients identified that ICM had moved to proactive planning initiated by the team before a crisis develops. They recognized this as different from other communities they had been involved in. Others noted the importance of having follow through on decisions, and the frustration they felt when there was a lack of coordination, follow through, and monitoring of case plans:

"Many individual practitioners are great, but there doesn't seem to be consistent connection between the professionals."

"We were listened to in the meetings, and sometimes there was learning that happened, but the action plans haven't happened. We need to do more than talking."

"Sometimes it seemed like no one had the authority to do anything... All the parties need to listen, agree to a plan, and then IMPLEMENT IT!"

Outcomes of ICM for Clients

Clients from across regional sites spoke of important outcomes of ICM and case conferences. For many clients, these outcomes were quite profound; for example, one parent spoke of ICM as contributing to her child's very survival, while for others, ICM was both validating and helped improve their own and their child's self-esteem. Having say in decision-making helped clients feel supported, respected and in control of their lives.

Several clients described the positive change in relationships and communication that occurred amongst family members through participation in discussion, planning and joint decision making at ICM meetings. As noted above, clients also spoke of forming positive and trusting relationships with practitioners, and having those relationships improve through the ICM process. In many instances, the ability to develop a trusting relationship was in itself a major accomplishment. As well, a number of clients spoke of having a clear sense of people working together toward common goals, of community support that reduces parental anxiety that in turn assists them to have better relationships with their children. Not surprisingly, clients' reports of positive outcomes were more evident in the sites that were further along in their implementation of ICM.
Below, clients’ discussion of outcomes of ICM is presented in their own words:

**ICM helps ensure that people work toward a common goal: the well-being of the child**

“And through the meetings, my ex-husband and I began to work together to support L. I could never talk to him before, but because everything was discussed at the meetings, and there was a plan, we could get together and make it work. That was one of the best things about ICM.”

“My needs are certainly met by ICM. It gives me a sense of support – that people in the community care about my family is the message I get. They want to know about the whole picture and how we are doing in life and they support us to be the best family that we can.”

**ICM helps ensure that clients get needed services and information**

“And MCF has been really good about extending the In Home program. We've actually gotten the program for about a year and a half... They've done some fancy footwork to address our situation, which has helped. We wouldn't be where we are today, if there hadn't been the case conferences.”

“And that's why this last conference was really good. I got more information. We got the names of people we can go to in order to put together an individual (computer) program for K. We're also going to be going to the learning centre for six weeks, so that it sets him up for school. But these things all came out at the case conference, and were talked over.”

“ICM was able to identify some of these cracks for my son, and we were able to deal with it.”

**ICM results in children doing better socially and academically**

“I don't think my son would be in school now without it. I don't know where we'd be... And R. has some self-esteem, he feels like he's in control. He's in a regular classroom and he has caught up on all his work. He has friends and activities outside of school. He knows he can get good marks and he's doing really well.”

**ICM results in clients learning new skills**

“We've both quit drinking and we have support. We're learning how to parent. I am more self-confident and outspoken. Before I would just get mad and pop off; now, I rationally think things through before I act.”

“I think ICM is like a mentoring process - I have learned so much by being part of it and solving problems and recognizing our strengths.”

**ICM results in clients feeling respected**

“They've listened to me when I've said no to services.”

“I like the way I am treated, that I am respected. If something is important to me, it is valid and important to the group. We all have mutual respect for each other.”
**ICM helps enhance clients' self-esteem, in that they are full participants in the care planning process**

“In another city, they did it mostly by conference call and I always felt like the "number in the corner". I was never part of it like I am here. I really am a participant and if I don't understand, they explain.”

“At first, I felt like a stranger in my son's life. Now I've got two or three people phoning me to make sure I know what's going on. It feels really good. It makes me feel important, to feel included.”

**ICM results in clients feeling supported and that people care**

“What I saw and heard in that room was the amount of support that was there. I was sweating bullets - partly because of the number of people and because there were people from my own reserve. But it was really incredible - positive.”

“It really helps to know where my supports are and know that I am supported. In a way the ICM team is a part of my family - they all fight for my son, and I know I'm not alone in my frustration.”

**ICM helps promote understanding of clients' cultural context and way of doing things**

“And there were Native people educating the non-Native people about our ways of doing things.”

**ICM leads to parents’ involvement in decision making regarding their children**

“The purpose was to figure out what was going to happen and to make a plan. My social worker came into it intending to go for a permanent order but changed her mind as she heard other people talk about me. Things are going a lot better now. I know what I have to do and what to expect, and we have a gradual plan to get my son home. I’m in contact with the group home and his teachers, and we’re all working together.”
What Is Advocacy?²

Advocacy is about power and how it is shared; it is about rights and how they are respected; it is about information and how it is accessed. Advocacy can address an individual situation or a systemic issue. The work of an advocate creates tension, for it challenges current practice, policy, or legislation that is not meeting people's needs.

An advocate's work is to create a just and equitable context. In the work of the Child, Youth and Family Advocate's Office, this means ensuring that the individual child or youth requiring advocacy remains central in the drama that is all about him or her. I and my staff seek to ensure that young people's lives and problems are not taken over, or taken away, by professional interventions. Young people must have easy access to full information. They and other significant people around them must be included in all aspects of the work. Above all, young people's voices must be heard and considered in the process of making decisions that affect their lives.

Advocacy is a shared responsibility. Individuals, parents and other family members, friends and professionals must all consider their advocacy responsibilities. In my view, advocacy must not be narrowly owned by a few "experts" who become super-intervenors. Rather, as members of society, each of us must bear direct responsibility both for ourselves and for those around us, whether in our personal or professional lives. The work of the professional advocate is to provide the individual in need, or the person close to that individual, with access to the necessary advocacy assistance.

If this vision of advocacy is to be achieved, we need to change many things -- attitudes, professional practice, policy, legislation -- in order to make service systems inclusive and respectful.

This is no easy or small task, but I am committed to working to achieve it. When I took this job, many people assumed that I would create regional advocacy offices, which would provide direct advocacy services. This would result in the creation of a new layer of bureaucracy, which would become another "actor" in the drama. Such a bureaucracy would be relatively easy to create, and would certainly be instantly visible and easy to understand. However, I do not believe that in the long term this would lead to the shared vision and the just context, which we strive to achieve. Rather, it would be the "place" to which we sent problem situations.

Real solutions need to be local. We need to work to change the context in each community, so that advocacy is understood, accepted and embraced, whether the advocate is the young person him or herself, a friend or relative, a child care or youth care worker, a foster parent, or a social worker. Answers lie, not in bringing in people from outside, but in providing support, information and the means of real empowerment to young people and to those who are already part of

their lives and communities.

To be an advocate requires much questioning and clarity. It is a very different role from that of the service provider, who makes decisions, based on what she or he feels is in the best interests of Clients. The advocate must take direction solely from those requesting assistance. The work must be based on respect for all the people involved. An enlightened approach to advocacy must look for problem resolution rather than retribution or blame, and must respect a person's ability to be involved in decision making and to take charge of his or her own life.
The Four Parts of Advocacy

In the past eighteen months, the Advocate’s office has taken a long, hard look at the question of what advocacy really means and at the role of an advocate acting on behalf of a child or youth. We have done this in conjunction with children, youth, service providers, families, foster parents and others in communities throughout the province.

You may have children of your own or work with young people in your profession. But when you take on the role of advocate for a child or youth, you are not acting as a caregiver, service provider or decision maker. Your role is different. An advocate is not an unbiased participant in situations, which have gone off the rails. Rather, an advocate is the person who ensures that the child or youth trying to get services stays at the centre of the events which are all about him or her.

In my 1995 Annual Report, I talked about advocacy as a shared responsibility. We need to provide the means of real empowerment to young people and to those who are already part of their lives and communities. This year, I want to talk about my four-part definition of advocacy. An effective advocacy process builds on the key elements of rights, information, voice and inclusion. Advocacy is the sum of these parts, and an advocate’s job is to ensure that all of them occur.

1. Rights

In 1989, Canada became a signatory to the UN Convention on the Rights of the Child. This broad-ranging document outlines the inherent rights of children – rights that they have, not because they need to earn them, but rather by virtue of their membership in society.

Children’s rights can be broadly grouped into three clusters. – the right to protection from abuse, neglect and exploitation; the right to the provision of basic needs, such as health care, education, services, play and an adequate standard of living; and the right to participate in all matters that affect them.

As well, for the first time in British Columbia, children and youth in government care have legislated rights. These rights are specified in section 70 of the new Child, Family and Community Service Act and are summarized below:

Children in government care have the following rights:
- To be properly fed, clothed and nurtured
- To be informed about and have input into their plans of care, and to be provided with an interpreter for such discussions if necessary
- To have a reasonable degree of privacy and to retain possession of their personal belongings
- To be free from corporal punishment
- To receive medical and dental care
- To participate in social and recreational activities
- To practice their religion and maintain their cultural heritage

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• To be informed about their rights and about how to contact the Child, Youth, and Family Advocate

An essential part of an advocate’s job is to ensure that individuals know what their rights are in any given situation, and that others are aware of and respect these rights. My experience in this past year has led me to conclude there is no consensus in society regarding the rights of individuals, and especially of young people. I will further discuss these concerns in “What Was Most Troubling This Year?”

2. Information
People who call an advocate for assistance usually do so because they do not believe they have the power to resolve or change a situation they see as wrong. Often this is because they lack information about services and about how the system works. The social service bureaucracy is large and complex, and confusing “insider language” is often used. The failure to give people full information in a clear manner takes away their power and leaves them feeling frustrated and somehow dependent on service providers.

In reviewing the requests we have had for assistance over the past eighteen months, we found that over two thirds of them required less than one hour of service from us. The majority were from people who simply needed a respectful listening ear and some information to enable them to take the next step in solving the identified problem.

All service providers have an obligation to ensure that the people they serve are fully informed about what is happening. It is the duty of service providers to make this information understandable and helpful. Only by so doing can they empower those receiving services.

3. Voice

“To really have a voice, I need the opportunity to say it ‘my way’ to someone who really listens and can do something about it”

_Federation of BC Youth in Care Networks._

Having a voice means saying what needs to be said, in one’s own way. It means being listened to respectfully. Above all, having a voice means that what a young person says will be seriously and respectfully considered in decision making.

There is, however, much confusion about the concepts of voice and decision making. Having a voice does not mean that you will necessarily get your own way. Rather, it means that your views will be listened to and considered.

I will talk more about ensuring that the voices of children and youth are included in the decision-making in “What Was Most Troubling This Year”?
4. **Inclusion**

Decisions affecting the lives of children and youth must be based on full information. Everyone who has anything to contribute must be consulted. This is what inclusion means.

Many calls to our office result from people being excluded. Children, youth, community-based care givers, foster parents and extended family members complain about being poorly treated and having their input dismissed. They worry that decisions are being made without full information and therefore may not be in the best interests of the child or youth involved.

All voices must be heard and considered. Decision makers have an obligation to ensure that this occurs.

If these four vital components of the advocacy process – rights, information, voice and inclusion – are always kept in view, they will lead to a just and comprehensive process, which in turn will lead to well-reasoned decisions. The end result will be good services for our children and youth.
Individual Reflective Questions (Activity 2)

Re-read the scenario and decide what you would do next to respond to this family. Consider:

- Who else, if anyone would you involve? What would they contribute?
- How would you proceed?
- What other information would you need?
- What would you say to the child/youth and/or the family about your ideas about how you would like to proceed with them?
- What would you want to know from them?
- Are there any organizational policies or procedures that you need to consider?

Be prepared to discuss your responses with others in your small group.
Small Group Questions (Activity 2)

In your small groups use these questions to guide your discussions of your individual reflections of when and why to initiate ICM:

- Did any of you consider initiating ICM for this child/youth/family?
- If so, what led you to that consideration? Identify some criteria you were using. If not, again, identify criteria you used to make the decision not to initiate ICM.
- Who else would you consult with in making the decision to initiate ICM or not?
- Who needs to be involved in the decision to initiate ICM?
- What would their roles and responsibilities be in the process? How would this be decided?
- Is there a role for an advocate?
- Would you suggest a client and/or family bring someone to support them? Does the service provider need permission from the family before advocating on their behalf?
- What role would the child/youth/family have in the process of deciding whether or not to initiate ICM?
- Can a family initiate ICM?
- Did you identify any sticking points or challenges as you discussed your individual reflections?
- What happens when you have two service providers each of whom believe they are advocating on behalf of their "mutual" client and the client does not realize this?
Consistent ICM Documentation

It is important to document the process of integrated case management, and to use a consistent format to do so. The use of a consistent format will assist us to:

- Remember to focus on strengths
- Consider all aspects of a child or youth’s life
- Allow for portability of plans from one community or region to another
- Allow for plans of care developed for other purposes (e.g. guardianship and children in care) to be amended rather than redone
- Record services and outcomes
- Demonstrate good practice
- Submit reports as required and report to legally responsible parties
- Allow for provincial evaluation of integrated case management to be carried out

The format that has been selected uses the following areas of consideration:

- Health
- Education
- Identity
- Family and Social Relationships
- Social Presentation
- Emotional and Behavioural Development
- Self Care Skills

These areas have been chosen because they are consistent with the categories used in Looking After Children, an assessment and planning approach being used in the Ministry for Children and Families for children and youth who have been in care for six months or more. “The aim of Looking after Children is to raise the standards of corporate parenting by setting outcome objectives for children and linking them to the types of parenting actions most likely to lead to success.”

For each area, the integrated case management team will use a planning process to develop a plan of care. The planning process requires the team to identify both the strengths (sometimes called protective factors) and the concerns (sometimes called risk factors) for each of the areas. This part of the process is important because often we seem to end up focusing on clients’ problems, when in fact it is more effective to focus on their strengths and to assist them to build resilience. (Resilience has been defined as the ability to recover from or adjust easily to misfortune or change.)

Having identified strengths and concerns, the areas that are a high priority will be selected by the team and desired goals, actions to achieve the goals, responsibilities and timelines will be developed. Regular review of the plan of care will keep the activities on track, allow goals and actions to be changed as circumstances change, allow new goals to be added, and allow the team to know when the family no longer needs service.

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4 “Draft” section to be included in Integrated Case Management: A User’s Guide
5 HMSO. Looking After Children: Good Parenting, Good Outcomes. 1996.
The following chart illustrates the planning process that should be used to develop a plan of care.

**Integrated Case Management Plan**

**Client Name:**

**Date:**

*Ensure that clients initial or check each goal to indicate agreement with the plan where applicable.*

<table>
<thead>
<tr>
<th>FOCUS</th>
<th>STRENGTHS *</th>
<th>CONCERNS *</th>
<th>GOALS (at least one for each dimension)</th>
<th>ACTIONS (for each goal)</th>
<th>RESPONSIBILITY AND TIMELINE</th>
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</thead>
<tbody>
<tr>
<td>Health</td>
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<td>Education</td>
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<td>Emotional &amp; Behavioural Development</td>
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<tr>
<td>Self Care Skills</td>
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<tr>
<td>Other</td>
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</tr>
</tbody>
</table>

*The starred columns are essential components of a plan of care

**Service Gaps:**

**Date of Next Conference:**

**Chairperson:**

**Case Co-ordinator:**
Small Group Questions (Activity 3)

Using the same case scenario work together to decide what needs to be done to prepare for a case conference with this family. Use the following questions as a guide:

- Decide what administration tasks need to be done in preparation for a case conference and who/how they will be completed, including decisions about involving the client(s).
- Discuss who else should be at the conference. Are there people missing? Are there people who shouldn’t be there? Why?
- Agree on who will facilitate the first case conference.
- Reach consensus about the purpose of the case conference (e.g., assessment, planning).
- Agree on the process and format documenting the conference (refer to *Integrated Case Management: A User’s Guide*).

Try to reach agreement on the above questions. Make sure you all express your opinions and questions clearly. Do not be afraid to challenge one another from their different perspectives.

Make sure someone in your group is recording and ready to report back to the large group on your discussion.
Role Play Debriefing (Activity 3)

After you have spent 15 minutes in the role play preparing the family for the case conference return to your small group to debrief your experience.

Use these questions to guide your small group discussion:

For practitioners:
- Which family member(s) were you working with and why?
- In what ways did you help the family reach a decision to participate in ICM and prepare for the integrated case conference (i.e., make a list of people to invite, make a list of questions to ask the team, identify a support person/advocate who can attend, explain the role of case coordinator, ask who client would like to have as case coordinator)?
- Did you use plain language, avoiding the jargon of your profession?
- What did you learn is needed to prepare families for involvement in ICM?

For family member(s):
- What was your experience of being asked to participate in an integrated case conference?
- How well prepared do you think you are for an integrated case conference?
- Is there anything else that would help prepare you?
- Were you comfortable with your role in the process? If not what would have helped to increase your comfort level?
- Did you have an opportunity to suggest who you would like to have as a case coordinator?

Make sure someone in your group is recording your discussion and be prepared to report back to the large group.

If time permits, return to your role play groups, switch roles, i.e., those who played practitioners assume the role of client(s) and vice versa, and re-enact the scenario incorporating what you have discussed based on the above questions.
Check List for Effective Collaboration with Children, Youth and Families (adapted from Victoria Association of Community Living)

For Professionals

Beliefs and Values

- Have I put myself in the person’s place and mentally reversed roles to consider how I would feel as the child, youth or family members?
- Do I see the person in more than one dimension, looking beyond his or her problems?
- Am I able to keep in mind that the person is a part of a family that loves their child?
- Do I really believe that youth/families are equal to me as a professional and in fact, are experts on their own situation?
- Do I judge the person in terms of his/her progress?
- Do I consistently value the comments and insights of family members and make use of their reservoir of knowledge about their total needs and activities?

Logistics and communication

- Do I listen to youth/families and communicate in various ways that I respect and value their insights?
- Do I ask questions of the individual, listen to her or his answers and respond?
- Do I work to create an environment in which the person is comfortable enough to speak and interact?
- Do I consistently address the person by the name he or she desires?
- Do I treat each person that I come into contact as a person capable of understanding, learning, growing and achieving?
- Do I speak plainly and avoid jargon?
- Do I schedule integrated case conferences at times and places that are convenient to youth/families?
- Do I provide reimbursement for youth/family members’ time, transportation or child care expenses?
- What formal and informal ways do I encourage youth/family participation during meetings/conferences?
- Do I suggest/encourage that youth/family members bring a support person or advocate to the meetings/case conferences?
- Do I suggest or encourage that the youth/family members develop a list of questions and their own set of goals for the care planning?
For Youth/Families

- Have I been involved in the overall care planning?
- Do I understand what the roles of the various professionals are?
- Do I have an opportunity to say what my needs are and if they are being met?
- Has anyone helped me prepare for participating in an integrated case conference?
- Have I been involved in creating an agenda or list of people I want to participate in an integrated case conference?
- Do I know what kinds of questions I want to ask?
- Am I encouraged to involve a support person or advocate in meetings?
- Are meetings held at times and places that are convenient to my family and me?
- Do I understand what is being said or written about my family or me?
- Do I feel comfortable/supported to contribute my knowledge in meetings or the care planning?
Integrated Case Management Training (Module 4) Evaluation Form

The purpose of this evaluation is to help us understand the value of the activities in meeting the ICM training goals.

This workshop has been designed to provide you with an opportunity to:

- reflect on practice when planning for children, youth and families
- explore when to initiate ICM
- reach common agreement on when to initiate ICM
- explore advocacy and how to prepare for case conferencing

Using the following rating scale where 1 equals not effective, 3 equals somewhat effective and 5 equals very effective, rate each of the following activities in terms of meeting the workshop goals.

1. Workshop activities
   a) Reflective writing and small group discussion
      1 2 3 4 5
      not effective somewhat very effective
   b) Discussion/development of common agreement
      1 2 3 4 5
      not effective somewhat very effective
   c) Role play
      1 2 3 4 5
      not effective somewhat very effective

2. How useful were the handouts/resources?
   1 2 3 4 5
   not useful somewhat very useful

3. How applicable has this workshop been to your work or experience?
   1 2 3 4 5
   not applicable somewhat very applicable
4. What do you feel was your biggest learning today?

5. What was your biggest surprise?

6. What did you like best about the workshop?

7. What would you change if you could?

8. Please add any additional comments.
Case Conferencing

This module gives participants an opportunity to practice their case conference facilitation skills and to develop strategies for including clients in case conferencing in a respectful and meaningful way. It provides an opportunity for participants to experience working collaboratively in a team and to identify the skills necessary to successfully work together and with families. Participants will analyze their individual functioning within a team and the factors that strengthen teams to help them work successfully to reach their goal. In addition, participants will evaluate team process and outcomes.

Discussion will be initiated to develop protocols or guidelines related to implementing an efficient and effective case conferencing process, a documentation format for case conferences, and a process for reviewing the plan. Participants will also work through some aspects of case conferencing that may be troublesome (e.g., how responsibility for case conferences can be shared and how to involve families).

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>90 minutes</td>
<td>Activity 1: Understanding Team Behaviour</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Stretch and Refreshment Break</td>
</tr>
<tr>
<td>140 minutes</td>
<td>Activity 2: Practicing an ICM Conference</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Stretch and Refreshment Break</td>
</tr>
<tr>
<td>40 minutes</td>
<td>Activity 3: Next Steps</td>
</tr>
</tbody>
</table>
#5-1a: Case Scenario

**Family Support Worker (MCF)**

The practice based scenario is an initial meeting with all the professionals who work with Meghan in the eating disorder program. The child and youth care worker works at Meghan’s school and has been invited to the meeting along with Meghan’s teacher/counsellor.

**The family**

Meghan, daughter, age 15  
Ashley, daughter, age 12 (twin)  
Nathan, son, age 12 (twin)  
Maria, mother, age 40  
Dave, father, age 40

**Brief Family History:**

Meghan is the oldest of three children. All three children live with their biological parents. The family history is unremarkable although Meghan reports ongoing and increasing conflict with her mother Maria, over her school work and choice of friends. Meghan is 15 and was diagnosed with anorexia 3 years ago. Since that time she has been in and out of treatment with a variety of programs, including a period of hospitalization when she was medically fragile. Her weight continues to fluctuate and she has been on the verge of hospitalization lately but she is still attending school. She has a child and youth care worker who sees her 2 or 3 times a week. She has also recently started to attend an eating disorder program that offers a range of multi-disciplinary services. Dave and Maria say they have noticed some new erratic behaviour lately and are worried that Meghan is starting to see her friends again whom they say are a bad influence. They want something to be done to prevent Meghan from seeing this group. They also are not sure how she is being dealt with by any of the professionals.

Dave and Maria have asked for a team meeting because they feel they do not have enough information about their daughter’s treatment and progress.

You are concerned that Meghan’s twin siblings are at risk for eating disorder.
#5-1b: Case Scenario

**Mental Health Worker**

The practice based scenario is an initial meeting with all the professionals who work with Meghan in the eating disorder program. The child and youth care worker works at Meghan’s school and has been invited to the meeting along with Meghan’s teacher/counsellor.

**The family**

Meghan, daughter, age 15  
Ashley, daughter, age 12 (twin)  
Nathan, son, age 12 (twin)  
Maria, mother, age 40  
Dave, father, age 40

**Medical Information**

Meghan is 15 and was diagnosed with anorexia 3 years ago. Since that time she has been in and out of treatment with a variety of programs, including a period of hospitalization 8 months ago when she was medically fragile. Her weight continues to fluctuate and she has been on the verge of hospitalization lately. She is not on any medications.

**Behavioural Information**

Meghan describes starting to feel out of control of her body and her life several years ago. The onset of puberty began earlier for her than for her friends and this was a source of embarrassment for her. Dave and Maria describe Meghan as a quiet child who up until age 12 or so was no problem and did well at school. She then began going with a group of girls that the parents did not think were good role models. It was at this time that the conflict between Meghan and her mom began.

Meghan has also recently started to attend an eating disorder program that offers a range of multi-disciplinary services. Her parents have noticed some new erratic behaviour lately and say they don’t know what is going on with her or how she is been dealt with by any of the professionals. Meghan says everything is ok and she just wishes her parents would stop trying to control her life.
#5-1c: Case Scenario

**Child and Youth Care Worker**

The practice based scenario is an initial meeting with all the professionals who work with Meghan in the eating disorder program. You work at Meghan’s school and have been invited to the meeting along with Meghan’s teacher/counsellor.

**The family**

Meghan, daughter, age 15  
Ashley, daughter, age 12 (twin)  
Nathan, son, age 12 (twin)  
Maria, mother, age 40  
Dave, father, age 40

**Family History**

Meghan is the oldest of three children. She has twin siblings who go to a different school. Meghan is 15 and was diagnosed with anorexia 3 years ago. Since that time she has been in and out of treatment with a variety of programs, including a period of hospitalization when she was medically fragile. Her weight continues to fluctuate and she has been on the verge of hospitalization lately but she is still attending school. Meghan reports ongoing and increasing conflict with her mother Maria, over her schoolwork and choice of friends. She says her mother is trying to control her life and her friends are not that bad. You are aware of the group that Meghan sporadically hangs out with and have some concerns about their influence. Several of the girls are known to be using drugs and to be sexually active. You have been working with Meghan for several months. You have grown to really like her and feel that you know her well.

The parents have asked for a team meeting because they feel they do not have enough information about their daughter’s treatment and progress.
#5-1d: Case Scenario

**Nurse**

The practice based scenario is an initial meeting with all the professionals who work with Meghan in the eating disorder program. The child and youth care worker works at Meghan’s school and has been invited to the meeting along with Meghan’s teacher/counsellor.

**The family**

Meghan, daughter, age 15  
Ashley, daughter, age 12 (twin)  
Nathan, son, age 12 (twin)  
Maria, mother, age 40  
Dave, father, age 40

Meghan is 15 and was diagnosed with anorexia 3 years ago. Since that time she has been in and out of treatment with a variety of programs, including a period of hospitalization when she was medically fragile. She was referred a few months ago by her family physician to the eating disorder program that you work at 2 days a week. You have been talking to Meghan about her eating and her relationship with her mother. Meghan’s weight continues to fluctuate and you have been considering notifying the family physician. Hospitalization may be required. Meghan’s parents have also called recently; they are worried about Meghan and say they have noticed some new erratic behaviour lately. You feel that Meghan needs to get into an eating disorder education group where she will learn about eating disorders and be able to use this information to overcome her anorexia.

The parents have asked for a team meeting because they feel they do not have enough information about their daughter’s treatment and progress.
#5-1e: Case Scenario

Teacher/School Counsellor

The practice based scenario is an initial meeting with all the professionals who work with Meghan in the eating disorder program. The child and youth care worker works at Meghan’s school and has been invited to the meeting along with you.

The family

Meghan, daughter, age 15  
Ashley, daughter, age 12 (twin)  
Nathan, son, age 12 (twin)  
Maria, mother, age 40  
Dave, father, age 40

Meghan is 15 and was diagnosed with anorexia 3 years ago. Since that time she has been in and out of treatment with a variety of programs, including a period of hospitalization when she was medically fragile. Her weight continues to fluctuate and she has been on the verge of hospitalization lately but she is still attending school. She has a child and youth care worker who sees her 2 or 3 times a week.

Recently she has started to attend an eating disorder program that offers a range of multi-disciplinary services. Her parents have noticed some new erratic behaviour lately and are feeling they don’t know what is going on with her and how she is being dealt with by any of the professionals.

You don’t really know Meghan all that well because your role in the school is to facilitate problem solving and to acquire resources for students when they are having difficulties. It was you that arranged for Meghan to have a child and youth care worker.

The parents have asked for a team meeting because they feel they do not have enough information about their daughter’s treatment and progress.
#5-1f: Case Scenario

**Maria (Mother)**

The practice based scenario is an initial meeting with all the professionals who work with Meghan in the eating disorder program. The child and youth care worker works at Meghan’s school and has been invited to the meeting along with Meghan’s teacher/counsellor.

**The family**

Meghan, daughter, age 15  
Ashley, daughter, age 12 (twin)  
Nathan, son, age 12 (twin)  
Maria, mother, age 40  
Dave, father, age 40

Your own family came to Canada when you were very young. Your parents worked hard to give you and your siblings a better life. It was a struggle for them but through many years of hard work, they were able to achieve their goal. Family means everything to you. You stayed home with your children to ensure that they too had a good start in life and a good upbringing. Your oldest daughter Meghan has been struggling with anorexia for the past three years. Anorexia is something you don’t really understand and it scares you that Meghan can make herself stop eating. Meghan was a quiet child who did well at school until the anorexia started.

Meghan has had lots of service in the past three years. In addition she has been hospitalized once already. She is attending school and now has a child and youth care worker who only seems to want to talk to Meghan. You have little idea what they are working on and how much progress is being made. Recently Meghan has been behaving in funny ways and hanging around with girls that you think are a bad influence on her. She is not paying much attention to her school work and you worry that she is going to fail her year at school. Meghan has always been private and wanted her ‘space’ but she has become even more secretive lately. This is another worry for you. Her weight seems to be dropping again and you think she needs to be hospitalized again.

Your relationship with Dave is generally OK but neither of you really know what to do about the anorexia. It is not something you can talk about very easily with him. It always makes you upset because there are so few answers and little that either one of you seem to be able to do.
#5-1g: Case Scenario

Dave (Father)

The practice based scenario is an initial meeting with all the professionals who work with Meghan in the eating disorder program. The child and youth care worker works at Meghan’s school and has been invited to the meeting along with Meghan’s teacher/counsellor.

The family

Meghan, daughter, age 15
Ashley, daughter, age 12 (twin)
Nathan, son, age 12 (twin)
Maria, mother, age 40
Dave, father, age 40

You and Maria have been married for 20 years. Most of the time everything has been good between you. For the most part you have been a close family, doing many outdoor and other recreational activities together. Maria stayed home to raise the children because that is what you both believed was the best. It has been financially difficult at times but overall you still think that has worked out best for the children.

Meghan, the oldest child, has always been your favourite although she and Maria have had a more difficult relationship. For the past three years Meghan has been struggling with anorexia. Anorexia is something you don’t really understand. You feel helpless and very worried about Meghan’s health and well-being. Sometimes you wonder if she will die. You don’t know who to talk to about your feelings; when you talk with Maria she gets upset and starts to cry. Your own family is too far away to be helpful and probably would not understand what to do anyway. You have not told anyone at work or amongst your friends either. You would like to believe that Meghan is getting proper treatment but she does not seem to be improving and you are not even sure what is going on in treatment. Because of her age, the professionals all seem to want to just talk to Meghan and you don’t feel that they are giving you and Maria enough information to know what is going on.

Meghan was hospitalized once already and Maria has been saying that she thinks that she may need to be hospitalized again. Her weight seems to be dropping again. You are not sure how long Meghan’s body can tolerate the stress of not eating.

Lately Meghan has been hanging around with some girls that neither you or Maria approve of. You are worried about their influence on Meghan and lately you have started to worry about the influence of Meghan’s behaviour on the twins.
#5-1h: Case Scenario

Meghan (Daughter)

The practice based scenario is an initial meeting with all the professionals who work with Meghan in the eating disorder program. The child and youth care worker works at Meghan’s school and has been invited to the meeting along with Meghan’s teacher/counsellor.

The family

Meghan, daughter, age 15
Ashley, daughter, age 12 (twin)
Nathan, son, age 12 (twin)
Maria, mother, age 40
Dave, father, age 40

You have been struggling with anorexia for the past three years. You live with both parents and twin siblings who are 3 years younger than you. You were hospitalized once about 8 months ago because your weight got too low. Since then your weight has more or less stabilized, although it has dropped a bit lately. Recently your mother started saying that you might need to be hospitalized again. You don’t want that to happen.

You have been seeing a youth care worker 2 or 3 times a week and like the connection that you have with her. With her help and support you have been attending an eating disorder program. You have started hanging out with some new friends lately; your parents have made it obvious that they do not approve of these friends. It is causing tension at home between you.
#5-2a: Case Scenario

Child Protection Worker

The family

Laurie, mother, age 35
Ann, sister, age 15
John, brother, age 8
Ruth, sister, age 4
Sandra, aunt, age 33

Susan, sister, age 17
Tom, brother, age 11
Bobbie, brother, age 6
Mary, grandmother, age 53
Sammy, boyfriend, age 20

Laurie and her six children live together, off-reserve, in a low income area on the outskirts of town. Laurie's second eldest, Ann, is six months pregnant. Ann fights with her mother and siblings nearly all the time, and for the last year or so, her relationship with her mother has become increasingly worse. Ann has had a boyfriend, Sammy, for the past 15 months, although their relationship is rocky. Sammy is unemployed and a school drop-out.

This Aboriginal family came to the attention of the Ministry for Children and Families because of concerns about the lack of supervision for the three younger children. They have been observed by neighbours during the school hours playing on the roadway in front of their house. On investigation it was learned that Susan and Ann were responsible for getting the children off to school. The single parent mother has to leave the house at 6:30 for work.

Laurie has had a history of alcoholism and abusive, short-term relationships. Susan and Ann have the same father, who moved to Ontario when Ann was 1 or 2. Tom and John each have different fathers, who have also left the scene. Bobbie and Ruth's father also was alcoholic, and became physically abusive of Ruth when she was still quite small. Susan supported her mother in getting a restraining order against this man, and convinced her to begin to attend AA meetings.

Ann is six months' pregnant. She fights with her mother and Susan constantly, although she is closer to Susan than to her mother. At best, she ignores the younger children, though she taunts them and calls them names. She takes Susan's clothes and Laurie's jewellery without permission, often stretching, dirtying or losing them without concern or apology.

Ann's relationship with Sammy is unstable. He is unemployed, a school drop-out, and is either completely broke or occasionally flashing large amounts of cash. Laurie reports that he is particularly unkind to the three brothers - trips them and laughs, tickles them until they cry, calls them filthy names and teaches them foul language. Ann and Sammy have terrible fights, especially when he has been drinking, or late at night. He apparently wants her to move in with him. While she wants to leave home, she is afraid to live with him.
#5-2b: Case Scenario

Band Social Worker

The family

<table>
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Laurie and her six children live together, off-reserve, in a low income area on the outskirts of town. Laurie's second eldest, Ann, is six months pregnant. Ann fights with her mother and siblings nearly all the time, and for the last year or so, her relationship with her mother has become increasingly worse. Ann has had a boyfriend, Sammy, for the past 15 months, although their relationship is rocky. Sammy is unemployed and a school drop-out.

Laurie is receiving respite services to help with the three youngest children, Bobbie, Ruth and John. Laurie’s sister, who lives on reserve, provides the respite services for the children on weekends (‘child in home of relative’). There was some hope that this service could be curtailed soon.

The family came to the attention of the Ministry for Children and Families again recently because of concerns about the lack of supervision for the three younger children. They have been observed by neighbours during the school hours playing on the roadway in front of their house. On investigation it was learned that Susan and Ann were responsible for getting the children off to school. Laurie has to leave the house at 6:30am for work.

Laurie has had a history of alcoholism and abusive, short-term relationships. Susan and Ann have the same father (non-Aboriginal), who moved to Ontario when Ann was 1 or 2. Tom and John each have different fathers, who have also left the scene. Bobbie and Ruth's father also was alcoholic, and became physically abusive of Ruth when she was still quite small. Susan supported her mother in getting a restraining order against this man, and convinced her to begin to attend AA meetings. Since that time, Laurie's functioning and ability to take advantage of support systems has steadily improved.

Although Laurie was born and raised primarily on reserve, she left home when she was 15, seeming to reject both her parents (who were themselves alcoholics) and her Aboriginal heritage. Since she joined AA and has begun to gain more control over her life, she has begun to gain more control over her life, she has begun to come back to the reserve for some events and activities. She brings the children to visit her mother and sister. Her father died some years ago, at which time her mother stopped drinking. Her sister, Sandra, stayed on the reserve and provides respite for the three youngest children. Laurie seems hesitant but hopeful that she can regain some of what she has lost. The children are somewhat more reluctant.
Ann is six months’ pregnant. She fights with her mother and Susan constantly, although she is closer to Susan than to her mother. At best, she ignores the younger children, though she taunts them and calls them names. She takes Susan’s clothes and Laurie’s jewellery without permission, often stretching, dirtying or losing them without concern or apology.

Ann's relationship with Sammy, who is non Aboriginal, is unstable. He is unemployed, a school drop-out, and is either completely broke or occasionally flashing large amounts of cash. Laurie reports that he is particularly unkind to the three brothers - trips them and laughs, tickles them until they cry, calls them filthy names and teaches them foul language. Ann and Sammy have terrible fights, especially when he has been drinking, or late at night. He apparently wants her to move in with him.

Laurie has asked the band social worker whether there are some services on the reserve that might be able to reach Ann where she has been unable to do so.
#5-2c: Case Scenario

**Police Representative**

*The family*

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Laurie and her six children live together, off-reserve, in a low income area on the outskirts of town. Laurie's second eldest, Ann, is six months pregnant. Ann fights with her mother and siblings nearly all the time, and for the last year or so, her relationship with her mother has become increasingly worse. Ann has had a boyfriend, Sammy, for the past 15 months, although their relationship is rocky. Sammy is unemployed and has dropped out of school.

On two occasions in the past three years Tom has been brought into the police station for suspected fire setting. Although police suspect that Tom has indeed set these fires, all they are able to do is return him to his home, as he is not chargeable under the YOA. On both occasions that they have returned him to his home, his mother has not been at home, though an older sister was.

Twice within the past three months, police have been called to the home of this family because of reports of a domestic dispute. In each case neighbours reported the late night loud fighting and threats. When police have arrived, Laurie, Ann and Sammy have been up. Ann and Sammy have been fighting, Laurie has attempted to intervene, and circumstances have escalated. It appeared to the police that Sammy was drunk on both occasions. Both he and Ann were initially verbally abusive toward the police, though they finally settled down when the police threatened to arrest Sammy. Police observed on the latter occasion that Ann's lip was cut and bleeding slightly.

Police suspect that Sammy is involved in a low level, relatively unorganized cigarette theft operation, and that he is a drug user. They have been unable to get adequate evidence to charge him up to this point.
School Representative

The family

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Laurie and her six children live together, off-reserve, in a low income area on the outskirts of town. Laurie's second eldest, Ann, is six months pregnant. Ann fights with her mother and siblings nearly all the time, and for the last year or so, her relationship with her mother has become increasingly worse. Ann has had a boyfriend, Sammy, for the past 15 months, although their relationship is rocky. Sammy is unemployed and a school drop-out.

Ann has been an average student with increasingly poor attendance. Her best work was in English and literature. She was often in trouble for reading novels from the school library instead of doing assigned work. Homework assignments were rarely completed. He was quiet, with few friends. A noticeable change in her performance and attendance occurred about a year and a half ago. She barely made her year last year, and is doing even worse this year in Grade 9.

Ann's older sister, Susan, is an excellent student. She is intelligent, quiet, and works hard at her studies. She is quite withdrawn from school activities but will remain behind to ask questions of the teacher. Her attendance too is erratic, and she often seems to have a cold or flu.

John and Bobbie have very poor attendance. It is difficult to know how they might perform if they were at school regularly. At present, they are both behind the other students. John barely reads and Bobbie has not yet learned. They are quiet and tend to stick together at recess and lunchtime. Both of their teachers have reported that they seem tired; sometimes they have only a piece of bread or fruit for their lunch. Sometimes they have money to go to the corner store to buy candy or potato chips at lunch time.
#5-2e: Case Scenario

**Pregnancy Outreach Nurse**

The family

Laurie, mother, age 35  
Ann, sister, age 15  
John, brother, age 8  
Ruth, sister, age 4  
Sandra, aunt, age 33

Susan, sister, age 17  
Tom, brother, age 11  
Bobbie, brother, age 6  
Mary, grandmother, age 53  
Sammy, boyfriend, age 20

Laurie and her six children live together, off-reserve, in a low income area on the outskirts of town. Laurie's second eldest, Ann, is six months pregnant. Ann fights with her mother and siblings nearly all the time, and for the last year or so, her relationship with her mother has become increasingly worse. Ann has had a boyfriend, Sammy, for the past 15 months, although their relationship is rocky. Sammy is unemployed and a school drop-out.
#5-2f: Case Scenario

Resource Worker

The family

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You have been working with Laurie and her family for the past two years. She is raising six children on her own and in the past has had many struggles with alcoholism and violent relationships. She has had many services over the years. For the past two years she has been getting respite services on weekends for the youngest three children. Her sister, Sandra, who lives on reserve, has been providing the service. It is a lot for her to do as she has 4 children of her own to look after. Although Sandra never complains, you are worried about the strain this is placing on her. The grandmother helps Sandra out as much as she can but her health is not good.

It was your observation that Laurie was stronger now and you had hoped that the formal respite services could be cut back. You recently found out however, that there was a complaint on the family, about the three youngest children being out on the road in front of the house during school hours. Laurie has to go to work early in the morning and has left the task of getting the children up and off to school, up to the two oldest daughters, one of whom is now pregnant.
#5-2g: Case Scenario

**Family Member (This scenario to be used for anyone role playing a family member)**

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Laurie receives respite services to help with the three youngest children, Bobbie, Ruth and John. Laurie’s sister Sandra, who lives on reserve, provides the respite for the children on weekends.

The family came to the attention of the Ministry for Children and Families again recently because of concerns about the lack of supervision for the three younger children. Neighbours reported that they were playing on the roadway in front of their house during school hours. Laurie leaves the house at 6:30am for work and leaves the two oldest girls in charge of getting the others off to school.

Laurie has had a history of alcoholism and abusive, short-term relationships. Susan and Ann have the same father, who moved to Ontario when Ann was 1 or 2. Tom and John each have different fathers, who have also left the scene. Bobbie and Ruth's father also was alcoholic, and became physically abusive of Ruth when she was still quite small. Susan supported her mother in getting a restraining order against this man, and convinced her to begin to attend AA meetings.

Ann is six months' pregnant. She fights with her mother and Susan constantly, although she is closer to Susan than to her mother. At best, she ignores the younger children, though she taunts them and calls them names. She takes Susan's clothes and Laurie's jewellery without permission, often stretching, dirtying or losing them without concern or apology.

Ann's relationship with Sammy is unstable. He is unemployed, a school drop-out, and is either completely broke or occasionally flashing large amounts of cash. He is particularly unkind to the three brothers - trips them and laughs, tickles them until they cry, calls them filthy names and teaches them foul language. Ann and Sammy have terrible fights, especially when he has been drinking, or late at night. He apparently wants her to move in with him.
#5-3a: Case Scenario

**Downtown Street Outreach Worker**

*The family*

**Sandi**, girlfriend, age 16  
**Ken**, boyfriend, age 16

Sandi has been living on the street for nearly a year and has developed a relationship with Ken. They panhandle for food and drugs and have no other resources. Up until six months or so ago, Sandi and Ken both had been attending the downtown alternative school, but their attendance has fallen off dramatically recently. About a month ago, Sandi went to the street clinic and learned she was four weeks pregnant; both Sandi and Ken want to keep the baby because they don't believe in abortion.

You've been working on a team with a local police officer with street youth for the past 3 years. You have good relationships with most of the youth and really like working with them. You have known Sandi for the past year. You have known Ken for 3 years - he is well known on the street as a drug user and has been involved in petty crimes. A couple of weeks ago, Sandi told you she was pregnant. You are very concerned and have talked to Sandi about her drug use and the effects on the baby. As far as you're aware, Sandi has not looked into ongoing prenatal care. She is somewhat receptive. You have told her about the Best Babies Program and have phoned the program to make a referral. So far you are quite sure Sandi has not made contact.
#5-3b: Case Scenario

Community Nurse

The family

Sandi, girlfriend, age 16
Ken, boyfriend, age 16

Sandi has been living on the street for nearly a year and has developed a relationship with Ken. They panhandle for food and drugs and have no other resources. Up until six months or so ago, Sandi and Ken both had been attending the downtown alternative school, but their attendance has fallen off dramatically recently. About a month ago, Sandi went to the street clinic and learned she was four weeks' pregnant; both Sandi and Ken want to keep the baby because they don't believe in abortion.

You are the coordinator of the pregnancy outreach program (Best Babies) at the neighbourhood centre closest to downtown. The program provides counselling regarding having a healthy baby and food and vitamin supplements to high risk moms. Last week you received a call from the Street Outreach Worker referring Sandi. You have not yet seen her and are concerned she will not show. You're aware that because the outreach workers in the program do not go out and walk the streets to connect with the moms some "high risk" moms (e.g., those who are homeless) don't get to the program.
#5-3c: Case Scenario

Guardianship Worker

*The family*

Sandi, girlfriend, age 16  
Ken, boyfriend, age 16

Sandi has been in care since she was 4 years old. Both her natural parents were alcoholic and her mother died living on the streets. Sandi has lived in a number of foster homes with less and less success as she got older. She ran away from the last resource and has been on and off the streets since she was 15. She was attending an alternative school but her attendance there has dropped off over the past few months. You recently found out that Sandi is pregnant. The father is not someone you know of but others have indicated that he is well known on the streets as ‘bad news’.

You are doubtful that Sandi has the skills to take care of herself while she is pregnant- she is likely doing drugs- and you are also concerned about her ability to care for a baby. You would like to reconnect with Sandi and get her into a place where she will get the support and attention that she needs so that she will have a better chance of having a healthy baby.

You have just received a call from a Financial Aid Worker expressing concern about Sandi. She was in the Income Assistance office requesting assistance so she can get off the street and find a place to live before having her baby. The FAW wanted you to know about the situation as the Guardianship worker and also to express her concern that Sandi was high on drugs when she was in the office. She wondered if there might be a protection issue for the unborn child.
School Counsellor

The family

Sandi, girlfriend, age 16
Ken, boyfriend, age 16

Sandi has been living on and off the street for nearly a year and has developed a relationship with Ken. They panhandle for food and drugs and have no other resources. Up until six months or so ago, Sandi and Ken both had been attending the downtown alternative school, but their attendance has fallen off dramatically recently. About a month ago, Sandi went to the street clinic and learned she was four weeks’ pregnant; both Sandi and Ken want to keep the baby because they don’t believe in abortion.

You have been the counsellor at the downtown alternate school for the past 10 years. Both Sandi and Ken have attended the program in the past but you haven’t seen them for the past 6 months. Yesterday Sandi came in to see you to tell you that she and Ken are going to have a baby. You have had a good relationship with Sandi in the past and you think she trusts you. You have always encouraged her to keep up with her schooling and have tried to actively engage her in the school. You are very concerned about her and Ken and their unborn baby.
#5-3e: Case Scenario

**Probation Officer**

*The family*

Sandi, girlfriend, age 16
Ken, boyfriend, age 16

Ken has been living on the street for nearly a year and has developed a relationship with Sandi. They panhandle for food and drugs and have no other resources. Up until six months or so, Ken has been attending the downtown alternative school, but his attendance has fallen off dramatically recently.

You have been Ken's Probation Officer since he was released from Youth Custody 6 months ago. He was in custody for petty crimes and a history of B&E's dating back to when he was 12 years old. Initially after his release he was very regular about checking in with you but lately he has missed a few appointments. You suspect he may be back into some criminal activity to support a drug habit. At his last visit he told you he was going to be a father. He said they want to keep the baby.
#5-3f: Case Scenario

Sandi (Youth)

The family

Sandi, girlfriend, age 16
Ken, boyfriend, age 16

You have been in care since you were 4 years old. Both your natural parents were alcoholic and your mother died on the streets. Living in care is the only life you remember. For the past several years you have found the situation to be increasingly difficult to tolerate. You ran away from the last resource and have been living on and off the street for nearly a year. In that time you developed a relationship with Ken who also lives on the street. Together you panhandle for food and drugs. Up until six months or so ago you and Ken had been attending the downtown alternative school. Lately though your attendance has fallen off. About a month ago you learned that you are four weeks pregnant. You think that you want to keep the baby although you are not always sure of this.
#5-3g: Case Scenario

Ken (Youth)

The family

Sandi, girlfriend, age 16
Ken, boyfriend, age 16

You have been living on the street for nearly a year and have developed a relationship with Sandi. Together you panhandle for food and drugs. You have no other resources. Up until six months or so, you and Sandi were attending the downtown alternative school, but lately you haven’t been too interested in attending even though it is a condition of your probation.

You were released from Youth Custody 6 months ago where you were in custody for petty crimes. You have a long history of B&E’s dating back to when you were 12 years old. Initially after your release you were very regular about checking in with the probation office but lately you have been missing quite a few appointments. You know this could mean trouble for you.

Your girlfriend Sandi recently found out she is four weeks pregnant. You think this is pretty neat and want her to have the baby. You don’t believe in abortion and figure that a baby will help hold the two of you together and might even make you eligible for better Income Assistance or other stuff.
Team Behaviour Questionnaire

Complete the following questions about your experience in your group discussion. Answer the questions individually.

1. Did you have an opportunity to express your feelings in the group? If not, why not?

2. Did anyone hear what you had to say? How do you know?

3. Who had the most influence on the discussion? Why?

4. Would the discussion have been different if a facilitator had been assigned?
Small Group Discussion Questions

When you have completed your individual questionnaires discuss your responses with your group. After you have shared your individual responses to the questionnaires discuss the following questions in your small groups.

- What did you learn about each other?
- How might this learning contribute to trust building?
- What different perspectives emerged?
- How do these differing perspectives influence team relationships and functioning?
- How does talking about/not talking about differing perspectives influence team relationships, trust and team functioning?
- What team characteristics or small group behaviours did you notice being played out in your discussions? What impact did those statements have on the group process? (Include comments on both positive and negative impacts).
- Were there any explicit statements about beliefs and attitudes from team members? What impact did that have?
Chilliwack Careteam Code of Conduct

A Careteam is a group of individuals who meet to plan and provide support for a child or their family. In a more limited form, this has been known as integrated case management. There is an effort in the Careteam to coordinate and properly align the available human energy for the support of a child. Most children have their needs supported to adulthood by their family, school and other voluntary associations. Certain segments of young people require the additional support of social agencies. Together these resources, the family, the school, and other natural community supports and social agencies form a Careteam.

The Careteam, as a human group, is not immune to the normal processes of socialization, establishing norms, mores, establishing boundaries and at times producing conflict, etc. As the vehicle for coordinated care for children, it is essential for the optimal operation of Careteams that these processes be considered and maintained. The following Code of Conduct is developed as a suggested, non-exhaustive list of such considerations.

1. Establishing the Careteam manager

It is important to know at the outset who will take responsibility for the process of the meeting. The Chair should insure that a record is kept of the meeting and that the Code of Conduct is followed. The Chair is the channel for dialogue and needs to insure that meetings do not denigrate into “cross talk” and “multiple mini-discussions”.

2. The purpose of the team should be clear and re-iterated at each meeting

It is important that participants in Careteam meetings understand how the current discussion is related to the larger developmental plan for the child. At times it may be necessary to be reminded that the energy put into the process “up front” can save time and trouble later if conflicting, disjointed service delivery is avoided.

This is particularly important as the service sector moves through the transition from “silo” mandate management toward shared community support.

3. Careteams should model effective communication and affirming human relationships

a) The role of affirmation
Some school based Careteams begin with each participant saying what they like about the child being considered. It is important that the family/child be affirmed but that professional Careteam members feel affirmed as well. Affirmation is the starting point for the respect necessary for people to contribute to the process.

b) Basic “good communication is essential
Team members should model speaking for self, for example, using “I” statements to denote ownership. Team members should avoid the word “but” as it is usually indicative of “rebuttal” or an argumentative, rather than exploratory process.

c) The team process can be helped by “reflective listening”
Although often trained in “reflective listening” there is a tendency in professional
dialogue to assume one knows what the other is saying. Professionals may not use
these skills in the Careteam process because they are conscious of time restrictions. It
seems that it takes more time to check out understandings. However, when one
considers the direct and indirect costs and misunderstandings, it can be seen as quite
efficient.

d) Team members should avoid statements that assume a higher moral ground. More
“this is the way I see it” statements will create a more cooperative environment.

e) The Chair should assure that less assertive voices on the team are heard
Either as a function of personality, professional background or case involvement,
some voices seem to play a more dominant role in Careteam discussions. It is
important that all members have the opportunity to address important issues in the
meeting.

4. Careteams should be open groups with processes for inclusion and leave
taking
The primary Careteam for any child is their family. This natural team includes and lets go
of numerous additional members over the life of a child. As a more specialized Careteam,
multi-agency, multi-disciplinary Careteams also require a means for meaningful inclusion
of others and releasing those who are no longer required to support the child as an active
part of their community.

It should be the responsibility of the Chair to enable the Careteam to recognize when the
commitment of a member is not longer required and to acknowledge her contribution in a
meaningful way. A psychometrician may, for example, join a Careteam for a few
meetings to explain his findings and to help the team to work with the findings. In some
longer term Careteams, staff changes will necessitate the joining of a new key player,
such as a probation officer. In this case it is the responsibility of the Chair and the new
member to see that “catching up” processes are in place to assimilate the new member.
The new member would want to understand the history of the team and how it has arrived
at the current plan of care.

5. Careteams need to have a “long view” as opposed to a “crisis management”
view
Anxiety is a natural enemy of the Careteam process. Anxiety fuels crisis situations and
creates a reactive system of care. Evidence of the presence of anxiety is found when
Careteam members act precipitously, unilaterally and/or engage in the “blame game”. Although there are many situations that call for speedy action to protect children, the
major processes for producing a positive social placement for children are developmental
and evolutionary.

In those Careteams where “crises” arise, it is important to have a pre-arranged “crisis
management” plan or protocol. Once this is in place, the real work of the team is to focus
on those activities which will enable the child to mature to adulthood, with the ability to
find a meaningful place in the world, free from conflict with the law and with reasonable regard for themselves and others.

6. **It is helpful if differing mandates are clearly stated. Advanced careteam practice involves the team sharing and supporting each other in mandate fulfillment**

It is important that members are able to describe their sense of mandate and to expect that this will be valued. In some situations, with appropriate approvals, processes may be found for sharing mandates particularly where risks associated with the plan of care may create vulnerabilities for Careteam members.

7. **Divergence of opinion and disputes present opportunities for strengthening the plan of care**

Alternative hypotheses and any idea, no matter how divergent, would be welcomed, as a means of encouraging creative solutions and as a way of testing the assumptions behind the plan of care.

8. **Triangles should be avoided**

If a Careteam member has a concern about another Careteam member, they should address this to them directly. In the past, professional gossip created a destructive gulf between “clients” and “professionals”. However, the same kind of tensions and gaps can exist between professionals and should be resolved directly and quickly.
Check List for Effective Collaboration with Children, Youth and Families (adapted from Victoria Association of Community Living)

For Professionals

Beliefs and Values
- Have I put myself in the person’s place and mentally reversed roles to consider how I would feel as the child, youth or family members?
- Do I see the person in more than one dimension, looking beyond his or her problems?
- Am I able to keep in mind that the person is a part of a family that loves their child?
- Do I really believe that youth/families are equal to me as a professional and in fact, are experts on their own situation?
- Do I judge the person in terms of his/her progress?
- Do I consistently value the comments and insights of family members and make use of their reservoir of knowledge about their total needs and activities?

Logistics and communication
- Do I listen to youth/families and communicate in various ways that I respect and value their insights?
- Do I ask questions of the individual, listen to her or his answers and respond?
- Do I work to create an environment in which the person is comfortable enough to speak and interact?
- Do I consistently address the person by the name he or she desires?
- Do I treat each person that I come into contact as a person capable of understanding, learning, growing and achieving?
- Do I speak plainly and avoid jargon?
- Do I schedule integrated case conferences at times and places that are convenient to youth/families?
- Do I provide reimbursement for youth/family members’ time, transportation or child care expenses?
- What formal and informal ways do I encourage youth/family participation during meetings/conferences?
- Do I suggest/encourage that youth/family members bring a support person or advocate to the meetings/case conferences?
- Do I suggest or encourage that the youth/family members develop a list of questions and their own set of goals for the care planning?
For Youth/Families

- Have I been involved in the overall care planning?
- Do I understand what the roles of the various professionals are?
- Do I have an opportunity to say what my needs are and if they are being met?
- Has anyone helped me prepare for participating in an integrated case conference?
- Have I been involved in creating an agenda or list of people I want to participate in an integrated case conference?
- Do I know what kinds of questions I want to ask?
- Am I encouraged to involve a support person or advocate in meetings?
- Are meetings held at times and places that are convenient to my family and me?
- Do I understand what is being said or written about my family or me?
- Do I feel comfortable/supported to contribute my knowledge in meetings or the care planning?
Consistent ICM Documentation

It is important to document the process of integrated case management, and to use a consistent format to do so. The use of a consistent format will assist us to:

- Remember to focus on strengths
- Consider all aspects of a child or youth’s life
- Allow for portability of plans from one community or region to another
- Allow for plans of care developed for other purposes (e.g. guardianship and children in care) to be amended rather than redone
- Record services and outcomes
- Demonstrate good practice
- Submit reports as required and report to legally responsible parties
- Allow for provincial evaluation of integrated case management to be carried out

The format that has been selected uses the following areas of consideration:

- Health
- Education
- Identity
- Family and Social Relationships
- Social Presentation
- Emotional and Behavioural Development
- Self Care Skills

These areas have been chosen because they are consistent with the categories used in Looking After Children, an assessment and planning approach being used in the Ministry for Children and Families for children and youth who have been in care for six months or more. “The aim of Looking after Children is to raise the standards of corporate parenting by setting outcome objectives for children and linking them to the types of parenting actions most likely to lead to success”.

For each area, the integrated case management team will use a planning process to develop a plan of care. The planning process requires the team to identify both the strengths (sometimes called protective factors) and the concerns (sometimes called risk factors) for each of the areas. This part of the process is important because often we seem to end up focusing on clients’ problems, when in fact it is more effective to focus on their strengths and to assist them to build resilience. (Resilience has been defined as the ability to recover from or adjust easily to misfortune or change.)

Having identified strengths and concerns, the areas that are a high priority will be selected by the team and desired goals, actions to achieve the goals, responsibilities and timelines will be developed. Regular review of the plan of care will keep the activities on track, allow goals and actions to be changed as circumstances change, allow new goals to be added, and allow the team to know when the family no longer needs service.

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2 Draft” section to be included in Integrated Case Management: A User’s Guide
3 HMSO. Looking After Children: Good Parenting, Good Outcomes. 1996.
#5-9a: Case Conferencing Documentation Example

Integrated Case Management Plan

Client Name: ________________________________  
Date: ________________________________

Ensure that clients initial or check each goal to indicate agreement with the plan where applicable.

<table>
<thead>
<tr>
<th>FOCUS</th>
<th>STRENGTHS *</th>
<th>CONCERNS *</th>
<th>GOALS (at least one for each dimension)</th>
<th>ACTIONS (for each goal)</th>
<th>RESPONSIBILITY AND TIMELINE</th>
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<tbody>
<tr>
<td>Health</td>
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<tr>
<td>Education</td>
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<td>Identity</td>
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<td>Family &amp; Social Relationships</td>
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<td>Social Presentation</td>
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<td>Emotional &amp; Behavioural Development</td>
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<tr>
<td>Self Care Skills</td>
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<tr>
<td>Other</td>
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</table>

*The starred columns are essential components of a plan of care

Service Gaps:  ______________________________________________________
Date of Next Conference: ____________________________________________
Chairperson: ______________________________
Case Co-ordinator: ______________________________
#5-9b: Case Conferencing Documentation Example

Integrated Case Management Plan

Name of Child/Youth: ____________________________  School: ____________________________

Case Manager: ____________________________  Recorder: ____________________________

Date: ____________________________

Date of Next Meeting: ____________________________

<table>
<thead>
<tr>
<th>REASON FOR MEETING</th>
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<th>PRESENT</th>
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<tbody>
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<td>NAME</td>
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</table>
PRIMARY CONSIDERATIONS  *Ensure the client’s perspective is recorded*

<table>
<thead>
<tr>
<th>DIMENSIONS OF CLIENTS LIFE</th>
<th>STRENGTHS</th>
<th>CONCERNS</th>
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<tbody>
<tr>
<td>HEALTH</td>
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<td>EDUCATION</td>
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<td>IDENTITY</td>
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<tr>
<td>FAMILY &amp; SOCIAL RELATIONSHIPS</td>
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<tr>
<td>SOCIAL PRESENTATION</td>
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<tr>
<td>EMOTIONAL &amp; BEHAVIOURAL DEVELOPMENT</td>
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<tr>
<td>SELF CARE SKILLS</td>
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</tbody>
</table>
PLANNING – Each goal and strategy should correspond to a strength or concern identified above.

*Have the client initial each goal/strategy to indicate client’s approval of plan, where applicable*

<table>
<thead>
<tr>
<th>GOALS</th>
<th>STRATEGY</th>
<th>RESPONSIBILITY OF</th>
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</table>

**NEXT MEETING**

<table>
<thead>
<tr>
<th>DATE:</th>
<th>TIME:</th>
<th>LOCATION:</th>
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</table>
Integrated Case Management Practice Tips

The following tips are grounded in current ICM practice found at the review sites. These features of practice are presented below, given their reported value in supporting ICM and/or helping to ensure positive outcomes for clients.

- Within MCF offices and in conjunction with community partners, allocate and book off a set, standing block of time (e.g. one day per week) for integrated case conferences and ICM. Having a dedicated ICM time/day will help ensure that all relevant players are able to attend case conferences and will not have scheduled appointments that might interfere with their ability to participate in ICM.

- Practitioners participating in integrated case conferences and case planning need to be able to make decisions regarding resource allocation. If a practitioner does not have the authority to make such decisions him/herself, the relevant decision maker needs to be part of the case conference as well.

- At the first integrated case conference, set regular dates for subsequent case conferences (e.g. decide that there will be regular conferences once a month, every six weeks, etc.). Only participants who are unable to attend a particular meeting, or "new" participants whose involvement has evolved out of the emerging case plan will be contacted regarding the date of the next conference. This will cut down on the time required to contact all participants of ICM conferences.

- Encourage clients to bring an advocate and/or support person to the integrated case conferences.

- Participants’ comfort in openly sharing relevant information should be checked out as an early part of the integrated case conference agenda.

- Ensure that clients receive copies of all integrated case conference documentation, and in particular, the ICM service/action plan.

- When developing an ICM action/service plan in an integrated case conference, ensure that there is an agreed upon contingency plan (i.e., Plan A and Plan B), and that this is recorded in ICM documentation.

- Following from above, identify as part of the ICM service plan, what barriers if any, there are to implementing the plan. This can help participants find creative ways to overcome barriers, and can help keep plans realistic.

- Celebrate and acknowledge clients' positive change and/or periods during which there are no problems, both within the case conference and in ICM documentation.

---

• **REMEMBER** ICM is more than case conferencing! All participants need to take responsibility for follow through on their portion of support or implementation to the plan.

• Actively refer to plans when in contact with clients in between case conferences. This also means that conversations/consultations may occur between professionals in between conferences.
Integrated Case Management Training (Module 5) Evaluation Form

The purpose of this evaluation is to help us understand the value of the activities in meeting the ICM training goals.

This workshop has been designed to provide you with an opportunity to:
• understand team behaviour
• practice case conference skills
• develop strategies for including clients in case conferencing
• develop a common agreement for ICM case conferencing

Using the following rating scale where 1 equals not effective, 3 equals somewhat effective and 5 equals very effective, rate each of the following activities in terms of meeting the workshop goals.

1. Workshop activities
   a) Team discussion and team behaviour questionnaire
      1 2 3 4 5
      not effective somewhat very effective
   b) Role play
      1 2 3 4 5
      not effective somewhat very effective
   c) Large group discussion
      1 2 3 4 5
      not effective somewhat very effective

2. How useful were the handouts/resources?
   1 2 3 4 5
   not useful somewhat very useful

3. How applicable has this workshop been to your work or experience?
   1 2 3 4 5
   not applicable somewhat very applicable
4. What do you feel was your biggest learning today?

5. What was your biggest surprise?

6. What did you like best about the workshop?

7. What would you change if you could?

8. Please add any additional comments.
MODULE 6

Conflict Resolution in ICM

This module identifies techniques for resolving conflicts within the planning and case conferencing process. Identifying and resolving planning conflicts are key elements of ICM practice. Using an ICM case conference format, participants will be given opportunities to practice skills in conflict resolution and team problem solving. In addition, they will formulate guidelines for solving impasses in the planning process.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>60 minutes</td>
<td>Activity 1: Identifying Conflicts in ICM</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Stretch and/or Refreshment Break</td>
</tr>
<tr>
<td>75 minutes</td>
<td>Activity 2: Conflict Resolution Skills</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Stretch and/or Refreshment Break</td>
</tr>
<tr>
<td>60 minutes</td>
<td>Activity 3: Developing Conflict Resolution Protocols</td>
</tr>
<tr>
<td>40 minutes</td>
<td>Activity 4: Next Steps</td>
</tr>
</tbody>
</table>
#6-1a: Case Scenario:

Sarah, mom, age 17
Brandy, daughter, age 6 months

Sarah is a seventeen-year-old teen parent, who has been in care for five years. Her daughter, Brandy, is six months old today. Sarah comes from a physically abusive home, with an alcoholic father and a mother who has experienced and continues to experience periodic bouts of depression.

Sarah has had difficulty in school and with the law. She has been in four different foster homes. In each foster home, her inability to control her anger and her abuse of alcohol has put the foster parents and other children in the setting at risk.

When Sarah found out she was pregnant she stopped drinking and began to see a counsellor to help her deal with some of her outstanding issues. Despite this, Sarah’s MCF child protection worker was extremely concerned about Sarah’s ability to care for Brandy on her own. So, as a condition of Sarah having her baby with her, a special foster home, which supervises Sarah’s care of Brandy, was set up. Sarah was not happy with this arrangement but felt that she had no choice, so agreed to go along with the plan as a step to independent living. Sarah, on her own initiative, enrolled in the local high school’s program for teen parents. Brandy is cared for in the school child care facility. Sarah has a youth worker, Mary, as part of the school program. Part of the school’s approach is to encourage young people to take more responsibility for their actions and their future. Sarah has been increasingly involved in meetings about her progress in the program and is encouraged to share her ideas. She now feels confident that she can complete her Grade 11 this year and hopes to enroll in College after Grade 12.

Sarah has made excellent progress over the last nine months, although there have been the occasional problems (staying out past the times agreed upon, some depression and angry outbursts, etc.). Still, Sarah feels that she is ready and has earned the right to live independently.

In the most recent case planning meeting with Sarah, her child protection worker, Mary, the teacher and the ECE staff, the child protection worker asked what everyone thinks about Sarah’s independent living plan. The staff say that they think Sarah is not yet ready to live independently. Everyone acknowledges that she is making progress, but feels that she needs more time to work on her issues.

Sarah is angry about the ‘mixed messages’. “You are always telling me to take responsibility for myself, but you still want to make decisions for me!”

---

1 Source: Community Advocacy Workshop; Office of the Child, Youth and Family Advocate.
Small Group Discussion Questions

When your group has finished the role play discuss the following questions in your small group:

• How did you feel in this meeting? How did those feelings affect your behaviour?
• What did the family/individual say they wanted out of this meeting? Did they get what they needed?
• What was the family’s/individual’s experience?
• As a team member did you get what you needed? If so, how? If not, what barriers did you encounter?
#6-1b: Case Scenario

**Josh, boy, age 12**

Josh is a twelve year old boy who is living in a foster home.

Over the summer he participated in programming at the local recreation centre. The recreation worker observed that Josh was inappropriately teasing and touching younger boys in the dressing room and was engaging his peers in sexually explicit conversations on a regular basis. Parents also complained about the stories their children were bringing home from the group. The leisure worker reported this information to Josh's child protection worker.

There had been a previous report that his uncle had sexually abused Josh but an investigation found the allegation to be unsubstantiated. Josh was interviewed and did not disclose abuse.

Josh is living with highly experienced foster parents who have extensive training in meeting the needs of children. In the fall, he began attending a new school closer to his foster home and had a one-to-one child care worker. He is also on the wait list for psychological assessment.

All was going well, until Josh met one of the children from the summer recreation program at his new school. The child’s mother had heard rumours about Josh’s behaviour and was upset to find that Josh was living in her neighbourhood. She told the school principal that, while she knew Josh was a child who needed help, the school had a responsibility to protect all of the children from harm. She didn’t want to make trouble but felt that if the school didn’t take action quickly, she would have to take her concerns to the Parent Advisory Council.

The principal knew that Josh had recently transferred into the school, but did not know the case specifics. He was angry with this and called an emergency meeting with the child protection worker and foster parents. At the meeting the principal asked for guarantees that no other child was at risk of harm from Josh. The child protection worker was unable to give guarantees but was confident that the foster parents and childcare worker were providing adequate supervision. There had been no recent incidents of sexually intrusive behaviour. She was waiting for the psychological assessment before developing a full case plan for Josh.

---

2 Source: Community Advocacy Workshop; Office of the Child, Youth and Family Advocate.
The principal stated that it was his job to assure the safety of all children in the school. He had decided that Josh should be suspended from school until the psychological assessment was complete. Although the child protection worker understood the principal’s concern, she felt that this was unnecessary. The foster parents were equally concerned that Josh’s situation might become the subject of community or media attention, but that suspension would have a negative impact on Josh’s stability. They felt strongly that Josh had a right to remain in the school with his privacy protected.

**Small Group Discussion Questions**

When your group has finished the role play discuss the following questions in your small group:

- How did you feel in this meeting? How did those feelings affect your behaviour?
- What did the family/individual say they wanted out of this meeting? Did they get what they needed?
- What was the family’s/individual’s experience?
- As a team member did you get what you needed? If so, how? If not, what barriers did you encounter?
Integrated Case Management Training (Module 6) Evaluation Form

The purpose of this evaluation is to help us understand the value of the activities in meeting the ICM training goals.

This workshop has been designed to provide you with an opportunity to:

• identify sources of conflict in an ICM process
• identify the skills and strategies necessary for conflict resolution
• begin to develop conflict resolution protocols for ICM

Using the following rating scale where 1 equals not effective, 3 equals somewhat effective and 5 equals very effective, rate each of the following activities in terms of meeting the workshop goals.

1. Workshop activities
   a) Large group discussion
      1 not effective  2  3 somewhat  4  5 very effective
   b) Role play
      1 not effective  2  3 somewhat  4  5 very effective
   c) Developing protocol guidelines for handling conflict in ICM
      1 not effective  2  3 somewhat  4  5 very effective

2. How useful were the handouts/resources?
   1 not useful  2  3 somewhat  4  5 very useful

3. How applicable has this workshop been to your work or experience?
   1 not applicable  2  3 somewhat  4  5 very applicable
4. What do you feel was your biggest learning today?

5. What was your biggest surprise?

6. What did you like best about the workshop?

7. What would you change if you could?

8. Please add any additional comments.
Information Sharing and Documentation

This module addresses the complexities of information sharing, identifies the documentation that supports ICM, and discusses how to support the ongoing work of ICM. Participants will identify the information that must be shared, the information that should be shared and the information that must not be shared within the context of ICM planning. Participants will practice documenting a case conference and discuss how the documentation can be used to support the ICM process and effective planning.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>90 minutes</td>
<td>Activity 1: Information Sharing Discussion</td>
</tr>
<tr>
<td>15 minutes</td>
<td>Stretch and Refreshment Break</td>
</tr>
<tr>
<td>90 minutes</td>
<td>Activity 2: Using Documentation to Facilitate a Case Plan</td>
</tr>
<tr>
<td>40 minutes</td>
<td>Activity 3: Next Steps</td>
</tr>
</tbody>
</table>
Confidentiality: Personal Reflection Questions

1. What are my personal beliefs about confidentiality?

2. What does my professional code of ethics say about confidentiality?

3. How would the presence of the family contribute to my perspective on confidentiality?

4. How do I put these beliefs and ethics into practice in my work with children and families?

5. Do these beliefs/codes present challenges or ethical dilemmas with respect to my duty to report and share information? How?

6. When I am engaged in collaborative planning through an ICM process, how do I balance differing informational needs?

7. What is my understanding of the concept of ‘need to know’?

8. How do I apply the ‘need to know’ concept?
#7-2a: Case Scenario

Community Mental Health Counsellor

The family

Jennifer, mother, age 25  
Callie, daughter, age 8  
Alex, son, age 2  
Sophie, daughter, age 7 months

Jennifer brings Callie to the community agency for counselling. Jennifer tells the counsellor that Callie was in a foster home for a short time when she was 3 because “I was hitting her too hard” but that her current reason for asking for assistance is not related to her past history, but rather because of Callie’s behaviour problems at school. Callie has been in several fights with other children.

In passing Jennifer mentions to the counsellor that she was raised in a family where there was a lot of “hitting” and that she was in The Maples at age 14 for a period of time. She is attending a group for women at a local violence prevention agency to deal with past history.

In the first visit, the counsellor explains the limits of confidentiality to Jennifer and her legal duty to report to the Ministry for Children and Families if she receives information that the children’s safety is at risk. Jennifer signs a form acknowledging receipt of this information.

The third time Jennifer and Callie visit the counsellor, Callie tells the counsellor that she had been left at home alone to care for Alex and Sophie. She also mentions that her dad, who was in jail for robbery, will be coming home soon. The counsellor was not aware of this aspect of the family and does not know what to make of this information.

When the counsellor spoke to Jennifer about what Callie had told her regarding looking after the younger children, Jennifer did not deny her behaviour. The counsellor asks Jennifer to self-report to the Ministry for Children and Families and says she will also be making a report. The counsellor also tells Jennifer that she wants to continue to support her and her family and work on the concerns they originally came to the centre with. The counsellor is non-judgemental and assures Jennifer that she will not be responsible for any investigation that might result from a report but she will have to provide information related to the report. She also asks about the father but Jennifer says Callie is just making up stories because she misses him.

The next week Jennifer returns to the counsellor and is extremely angry with her, says she feels betrayed, judged and not supported. “I came for help because I want things to get better and all that happens is everyone makes it worse and tell me they are helping me”. Jennifer discontinues counselling.
#7-2b: Case Scenario

Child Protection Worker

The family

Jennifer, mother, age 25
Callie, daughter, age 8
Alex, son, age 2
Sophie, daughter, age 7 months

Brief Family History
Callie is the oldest of three children. She has a different father than her two youngest siblings; he is in jail for robbery, but is due to be released soon. The mother has had a series of abusive relationships but is currently on her own and wanting to break the pattern of abusive relationships. The father of the two youngest children disappeared when Jennifer was 6 months pregnant; she has been raising the children on her own ever since. The family is known to the Ministry because of several reports of domestic disputes in the past and several years of sporadic service provision. The oldest child, Callie was in care briefly at age 3 because of physical abuse by her mother. Jennifer was referred to take a parenting course and abuse counselling. Callie was returned to her care within a few months when Jennifer was able to demonstrate her ability to parent. Another factor that made a difference was that Callie’s father was arrested and jailed at that time, which reduced some of the potential violence in the home. Since then Jennifer has had some services from the Ministry, mostly in the area of home support and abuse counselling. The home support service was terminated 3 months ago and it is unlikely that there will be any further support for the abuse counselling. Jennifer likes the services but seems to rely on them to do the work for her.

Current Situation
A complaint was made to the Ministry recently by one of Jennifer’s neighbours who said there was a “funny” smell coming from the townhouse and a lot of people coming and going. In addition, the oldest child had been seen on several occasions, with the two youngest children. It appeared as if she was the only one in charge. Several loud arguments were also heard. The neighbour said that Jennifer told her she was tired and ready to give up. Apparently Jennifer has made two suicide attempts in the past, when she was an adolescent.
School Representative

The family

Jennifer, mother, age 25
Callie, daughter, age 8
Alex, son, age 2
Sophie, daughter, age 7 months

School History

Callie is in grade 2. Academically she is an average student but socially she struggles to make friends. She is often involved in fighting and rough play on the playground at lunch time and recess. These episodes seem to have escalated recently. Her mother appears overwhelmed with the three children and is usually unavailable to come in to discuss the situation regarding Callie. Lately Callie has had trouble getting to school on time; her appearance is often dishevelled and her lunches poorly prepared. Upon questioning Callie said that her mother has not been getting up in the morning because she has been up all night with the baby. Callie does not seem bothered by this and says that a neighbour has been helping get her ready in the morning. She says her mother often “sleeps a lot”.

Callie mentions that she is seeing a counsellor who is “helping her get along better”. Callie says she likes the counsellor but her mother doesn’t.
#7-2d: Case Scenario

Abuse Prevention Worker

The family

Jennifer, mother, age 25
Callie, daughter, age 8
Alex, son, age 2
Sophie, daughter, age 7 months

Jennifer has been attending a 3 month abuse prevention group that runs weekly. She attends fairly regularly although lately her attendance has been a little sporadic. Jennifer came to the group saying she was tired of being in “bad” relationships and wanted to change that pattern. Jennifer has talked about her own experiences growing up in an abusive family and how frightening that was at times. She mentioned in one group having been sexually assaulted by one of her uncles’ when she was 13. It was something she never told her family.

The last couple of times Jennifer came she appeared to be high on something, although it was a little hard to tell. At the last group Jennifer mentioned that she thought her oldest daughter’s father was getting out of jail soon. She sounded a bit scared.
#7-2e: Case Scenario

**Resource Worker**

**The family**

Jennifer, mother, age 25  
Callie, daughter, age 8  
Alex, son, age 2  
Sophie, daughter, age 7 months

**Brief Family History**

Callie is the oldest of three children. She has a different father than her two youngest siblings; he is in jail for robbery, but is due to be released soon. The mother has had a series of abusive relationships but is currently on her own and wanting to break the pattern of abusive relationships. The father of the two youngest children disappeared when Jennifer was 6 months pregnant; she has been raising the children on her own ever since. The family is known to the Ministry because of several reports of domestic disputes in the past and several years of sporadic service provision. The oldest child, Callie was in care briefly at age 3 because of physical abuse by her mother. Jennifer was referred to take a parenting course and abuse counselling. Callie was returned to her care within a few months when Jennifer was able to demonstrate her ability to parent. Another factor that made a difference was that Callie’s father was arrested and jailed at that time, which reduced some of the potential violence in the home. Since then Jennifer has had some services from the Ministry, mostly in the area of home support and abuse counselling. The home support service was terminated 3 months ago and it is unlikely that there will be any further support for the abuse counselling. Jennifer likes the services but seems to rely on them to do the work for her.

**Current Situation**

Jennifer called to ask for help, saying that looking after three children overwhelms her. At first she was unclear as to what the problem was, but eventually acknowledged that she had left Callie in charge of the two younger children while she ran down to the corner store for some diapers. Jennifer says she wasn’t gone long; 15 minutes at most, but the weather was horrible and the baby was asleep and she did not want to get everyone bundled up just so they could go get diapers. Jennifer says she knows it was the wrong thing to do, and sees it as an indication that she needs help with the children. She is upset and worried. She does not want to be “investigated”, she just wants help with the children.
#7-3a: Case Scenario

Guardianship Worker

*The Family*

Mary, daughter, age 15  
Sylvia, stepmother, age 40  
Barry, father, age 39

*Brief Family History*

Mary is the only child of her biological parents. They are reported to have been separated on and off since Mary was a toddler and permanently separated when Mary was five. Mary was sexually abused by a baby-sitter when she was four. This was during a time when her father and mother were temporarily separated. When the parents separated for good, father was granted custody. He raised Mary on his own for three years, then Mary’s step-mother moved in. Mary and her step-mother have had some difficulties in forming a positive relationship, and in the past three years Mary has become increasingly physical when arguing with her step-mother.

*Placement History*

Until she was five Mary was in the custody of her biological parents. They separated frequently, and during those periods Mary remained with her mother. At age five, Mary’s parents separated and custody was given to her father. He raised her on his own until she was eight, when her step-mother moved in. Relationships with the step-mother became increasingly negative until Mary was sent back to live with her mother at age 13. Recently the father went to visit Mary where he discovered that mother was not living at home. The apartment was dirty and Mary was unkempt and defiant. She was taken into care and is currently in a receiving home. Father says he will have her back with him and the step-mother, but Mary has to make some changes. Mary insists that she does not want to return home with him so long as the step-mother is there.
#7-3b: Case Scenario

**Mental Health Worker**

**The Family**

Mary, daughter, age 15  
Sylvia, stepmother, age 40  
Barry, father, age 39

**Behavioural Functioning**

Mary and her parents describe her as “going to extremes.” She says she is both quiet and hyper. Her parents say she is sometimes shy and polite, at other times aggressive and acting out. Mary says her anger is her biggest problem.

**Psychiatrists Report**

This report was completed two years ago when Mary was just 13.

Mary appears to have a behavioural disturbance, the main elements of which are oppositional and provocative behaviour towards parents, culminating in temper tantrums. She gets angry enough to destroy property. Mary steals small items and money both inside and outside the home. She sometimes gives these items away in an effort to gain friends. She does not care for her own possessions. She has problems with peers when they disagree with her and gets into fights with them.

Father, with whom Mary lived from age five until age 13, relates the problems to Mary’s relationship with her biological mother. Before he took custody, he reports that Mary and her mother were in constant conflict. Mary says she loves her mother, which creates ambivalence in accepting the step-mother. Her mother currently has a boyfriend who is abusive and this is a concern to Mary.

The diagnostic impression is that of an adjustment disorder with disturbance of conduct. There is not much to suggest underlying specific developmental disorder, nor contributing medical disturbance. Her level of psychosocial stress is certainly moderate to severe.
#7-3c: Case Scenario

School Representative

*The Family*

Mary, daughter, age 15  
Sylvia, stepmother, age 40  
Barry, father, age 39

*School History*

Mary has had some problems in school from school entrance. During her first three years in school, she would often not return from recess but stay out to play on the playground or leave. Parents seemed unable or unwilling to do anything about this. They said it was the school’s responsibility to keep her at school during the day.

During the latter part of elementary school, Mary was seen frequently by a school counsellor and this seemed to increase her attendance and improve her attitudes toward school. Her performance is average to low average, but she certainly has not shown any enthusiasm, nor does she have any special interests.

After moving to secondary school, Mary’s attendance and school performance dropped steadily until she was placed in an alternative program, where she is doing somewhat better.
#7-3d: Case Scenario

Child and Youth Care Worker

The Family

Mary, daughter, age 15
Sylvia, stepmother, age 40
Barry, father, age 39

Brief Family History

Mary is the only child of her biological parents. They are reported to have been separated on and off since Mary was a toddler and permanently separated when Mary was five. Mary was sexually abused by a baby-sitter when she was four. This was during a time when her father and mother were temporarily separated. When the parents separated for good, father was granted custody. He raised Mary on his own for three years, then Mary’s step-mother moved in. Mary and her step-mother have had some difficulties in forming a positive relationship, and in the past three years Mary has become increasingly physical when arguing with her step-mother.

Recent interventions

Mary was referred for services by MCF when she was in Grade seven. A child care worker has been working with her on social skills. Reports indicate that Mary has no friends but some acquaintances. From observation it appears that Mary can manage on a one-to-one basis, but not in a group. She finds it difficult to make friends and will try to gain friends by giving them money, cigarettes or other small items.

When Mary began having more difficulty with her step-mother, the family was involved in family sessions. These seemed to have somewhat helpful but Mary’s continued rebellion increased until she was sent to live with her mother.

Mary has been involved in some anger management activities but they have not helped enough. She does not wish to discuss the sexual abuse incident that occurred with the babysitter. She is not interested in further counselling and has refused to meet with you anymore.

Mary has bragged about having done B and E’s in the past and has hinted at the possibility that there was another more recent incident that no one knows about.
#7-3e: Case Scenario

**Probation Officer**

**The Family**

Mary, daughter, age 15  
Sylvia, stepmother, age 40  
Barry, father, age 39

**Record of Offences**

There is a current record of two theft offences, the first related to theft of junk food from a grocery store, the second related to theft of cigarettes from a convenience store. The first was committed in the company of several other girls of a similar age. She was diverted and assigned 35 hours of community work, none of which has been done. The second offence was committed on her own, though there were young people hanging around outside the store at the time. At this time she was placed on probation and given an additional 50 hours of community work.

**Record of Contacts**

Although her probation order requires her to report each week, Mary has not reported for three weeks. Because of her failure to comply with the completion of her community service hours or her reporting requirements, she has breached her probation and a summons has been issued to her.
Small Group Discussion Questions

Discuss the case scenario in your group and identify what information you each think you must share, should share and cannot share. Use the following questions to guide your discussion. (Note: some of the questions are more specific to certain roles, however they are worthwhile for everyone to consider.) You can use the Privacy Charter as a resource during your discussion. Select a recorder to record your discussion. The recorder will need to pay attention to identifying what information each person thinks they must share, should share and cannot share and how the ‘need to know’ principle applies when they are working collaboratively with other service providers.

- What information do you think is covered by the ‘need to know’ principle?
- How does the ‘need to know’ principle affect or influence you?
- What information do you have that must be shared?
- What information do you have that should be shared?
- What information do you have that would not be shared?
- What is your reference point for making that decision (i.e. organizational policy, legislation, relationship with family or other service providers, etc.)?
- Is the duty to report in conflict with the role of supporting the family?
- Can the goal of safety for the child be better served by maintaining confidentiality or following through on the legal obligation to report?
- When the relationship with the family has been severed, what do you do about any residual concerns about safety for the children?
- How would you involve the family in the decisions about information sharing?
- What would you do if the parents were unwilling to give their consent to sharing information?
Consistent ICM Documentation

It is important to document the process of integrated case management, and to use a consistent format to do so. The use of a consistent format will assist us to:

- Remember to focus on strengths
- Consider all aspects of a child or youth’s life
- Allow for portability of plans from one community or region to another
- Allow for plans of care developed for other purposes (e.g. guardianship and children in care) to be amended rather than redone
- Record services and outcomes
- Demonstrate good practice
- Submit reports as required and report to legally responsible parties
- Allow for provincial evaluation of integrated case management to be carried out

The format that has been selected uses the following areas of consideration:

- Health
- Education
- Identity
- Family and Social Relationships
- Social Presentation
- Emotional and Behavioural Development
- Self Care Skills

These areas have been chosen because they are consistent with the categories used in Looking After Children, an assessment and planning approach being used in the Ministry for Children and Families for children and youth who have been in care for six months or more. “The aim of Looking after Children is to raise the standards of corporate parenting by setting outcome objectives for children and linking them to the types of parenting actions most likely to lead to success”.

For each area, the integrated case management team will use a planning process to develop a plan of care. The planning process requires the team to identify both the strengths (sometimes called protective factors) and the concerns (sometimes called risk factors) for each of the areas. This part of the process is important because often we seem to end up focusing on clients’ problems, when in fact it is more effective to focus on their strengths and to assist them to build resilience. (Resilience has been defined as the ability to recover from or adjust easily to misfortune or change.)

Having identified strengths and concerns, the areas that are a high priority will be selected by the team and desired goals, actions to achieve the goals, responsibilities and timelines will be developed. Regular review of the plan of care will keep the activities on track, allow goals and actions to be changed as circumstances change, allow new goals to be added, and allow the team to know when the family no longer needs service.

---

1 Draft” section to be included in Integrated Case Management: A User’s Guide
2 HMSO. Looking After Children: Good Parenting, Good Outcomes. 1996.
# 7-6a: Case Conferencing Documentation Example

## Integrated Case Management Plan

**Client Name:**

**Date:**

*Ensure that clients initial or check each goal to indicate agreement with the plan where applicable.*

<table>
<thead>
<tr>
<th>FOCUS</th>
<th>STRENGTHS *</th>
<th>CONCERNS *</th>
<th>GOALS (at least one for each dimension)</th>
<th>ACTIONS (for each goal)</th>
<th>RESPONSIBILITY AND TIMELINE</th>
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</thead>
<tbody>
<tr>
<td>Health</td>
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<td>Development</td>
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<td>Self Care Skills</td>
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<td>Other</td>
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*The starred columns are essential components of a plan of care*

**Service Gaps:** ___________________________________________________________

**Date of Next Conference:** ____________________________________________

**Chairperson:** __________________________

**Case Co-ordinator:** __________________________
7-6b: Case Conferencing Documentation Example

Integrated Case Management Plan

Name of Child/Youth: School:

Case Manager: Recorder:

Date:

Date of Next Meeting:

REASON FOR MEETING

<table>
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<tr>
<th>NAME</th>
<th>ROLE/AGENCY</th>
<th>PHONE</th>
<th>FAX</th>
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PRESENT
PRIMARY CONSIDERATIONS *Ensure the client’s perspective is recorded*

<table>
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<tr>
<th>DIMENSIONS OF CLIENTS LIFE</th>
<th>STRENGTHS</th>
<th>CONCERNS</th>
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<tr>
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<td>EDUCATION</td>
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<td>IDENTITY</td>
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<tr>
<td>SELF CARE SKILLS</td>
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</table>
PLANNING – Each goal and strategy should correspond to a strength or concern identified above. *Have the client initial each goal/strategy to indicate client’s approval of plan, where applicable*

<table>
<thead>
<tr>
<th>GOALS</th>
<th>STRATEGY</th>
<th>RESPONSIBILITY OF</th>
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**NEXT MEETING**

DATE: 
TIME: 
LOCATION:
Integrated Case Management Training (Module 7) Evaluation Form

The purpose of this evaluation is to help us understand the value of the activities in meeting the ICM training goals. 

This workshop has been designed to provide you with an opportunity to:
• identify personal and professional beliefs and values about confidentiality and information sharing
• identify what information must be shared, what should be shared and what cannot be shared within the context of integrated care planning
• practice using documentation to facilitate ICM planning

Using the following rating scale where 1 equals not effective, 3 equals somewhat effective and 5 equals very effective, rate each of the following activities in terms of meeting the workshop goals.

1. Workshop activities
   a) Information sharing
      1 2 3 4 5
      not effective somewhat very effective
   b) Documentation and planning
      1 2 3 4 5
      not effective somewhat very effective

2. How useful were the handouts/resources?
   1 2 3 4 5
   not useful somewhat very useful

3. How applicable has this workshop been to your work or experience?
   1 2 3 4 5
   not applicable somewhat very applicable
4. What do you feel was your biggest learning today?

5. What was your biggest surprise?

6. What did you like best about the workshop?

7. What would you change if you could?

8. Please add any additional comments.
Ongoing Review and Closure of an ICM Process

This module explores what to do when the circumstances of children, youth and families change and an ICM plan needs to be altered to suit the family’s progress and challenges. It also explores what to do when members of an ICM team do not follow through on their part of the plan. Participants apply team building and conflict resolution skills and use their ICM documentation as tools for accountability, follow-up and review. Closure of an ICM process will also be explored. In addition, strategies, guidelines and protocols will be developed for addressing issues that arise between ICM case conferences, for ongoing review and bringing closure to an ICM process.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>80 minutes</td>
<td>Activity 1: As ICM Plans Change</td>
</tr>
<tr>
<td>20 minutes</td>
<td>Stretch And Refreshment Break</td>
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<tr>
<td>100 minutes</td>
<td>Activity 2: Ongoing ICM Case Conferencing</td>
</tr>
<tr>
<td>60 minutes</td>
<td>Lunch Break</td>
</tr>
<tr>
<td>60 minutes</td>
<td>Activity 3: Closure: An Opportunity to Review ICM Process and Outcomes</td>
</tr>
<tr>
<td>40 minutes</td>
<td>Activity 4: Next Steps</td>
</tr>
</tbody>
</table>
#8-1a: Case Scenario

Child Protection Worker

The Family

Tommy, son, age 7  
Bob, father, age 31  
Sue, mother, age 32  
Timmy, brother, age 4

Tommy is a seven year old boy who has recently come to live with his father. His mother, who lives in a northern town, is unable to care for him, and has agreed with the Ministry for Children and Families to have him to live permanently with his birth father (Bob), in this community.

Tommy has one sibling who has remained with his mother. Tommy was protective of and fended for his younger brother.

Tommy has a history of police, community, and school problems in his previous community. He has also shoplifted from the corner store. His school attendance has been sporadic; in fact, he rarely attended. He has been diagnosed with ADHD. He does not know his letters and cannot print. He is registered in Grade two.

Tommy’s mother and his father, Bob have not lived together since Tommy was four. Tommy rarely saw his father in the subsequent years.

Bob is currently attending AA. He has elderly parents and an uncle living in this community. He works full time as a labourer and receives minimum wage.

Bob is very concerned about his son and is unsure how to handle him. He has been in contact with a local physician who referred him to Mental Health.

An initial case conference was held one month ago and the attached plan was developed.

Immediately after the conference you organize for Bob and Tommy to have a Family Support Worker 3 days per week to help Bob with parenting and to work with Tommy on his aggressive behaviour. One week before the next scheduled meeting, the Family Support worker calls you to say that he is concerned about Bob and the stress he is under and that he may be drinking again. What do you do?
#8-1b: Case Scenario

School District Counsellor

The Family

Tommy, son, age 7  
Bob, father, age 31  
Sue, mother, age 32  
Timmy, brother, age 4

Tommy is a seven year old boy who has recently come to live with his father. His mother, who lives in a northern town, is unable to care for him, and has agreed with the Ministry for Children and Families to have him to live permanently with his birth father (Bob), in this community.

Tommy has one sibling who has remained with his mother. Tommy was protective of and fended for his younger brother.

Tommy has a history of police, community, and school problems in his previous community. He has also shoplifted from the corner store. His school attendance has been sporadic; in fact, he rarely attended. He has been diagnosed with ADHD. He does not know his letters and cannot print. He is registered in Grade two.

Tommy’s mother and his father, Bob have not lived together since Tommy was four. Tommy rarely saw his father in the subsequent years.

Bob is currently attending AA. He has elderly parents and an uncle living in this community. He works full time as a labourer and receives minimum wage.

Bob is very concerned about his son and is unsure how to handle him. He has been in contact with a local physician, who referred him to Mental Health.

An initial case conference was held one month ago and the attached plan was developed.

Immediately after the conference the child protection worker arranged for Bob and Tommy to have a Family Support Worker 3 days per week to help Bob with parenting and to work with Tommy on his aggressive behaviour. One week before the next scheduled meeting, the Family Support worker calls you to say that he is concerned about Bob and the stress he is under and that he may be drinking again. What do you do?
#8-1c: Case Scenario

Child and Youth Mental Health Worker

The Family

Tommy, son, age 7
Bob, father, age 31
Sue, mother, age 32
Timmy, brother, age 4

Tommy is a seven year old boy who has recently come to live with his father. His mother, who lives in a northern town, is unable to care for him, and has agreed with the Ministry for Children and Families to have him to live permanently with his birth father (Bob), in this community.

Tommy has one sibling who has remained with his mother. Tommy was protective of and fended for his younger brother.

Tommy has a history of police, community, and school problems in his previous community. He has also shoplifted from the corner store. His school attendance has been sporadic; in fact, he rarely attended. He has been diagnosed with ADHD. He does not know his letters and cannot print. He is registered in Grade two.

Tommy’s mother and his father, Bob have not lived together since Tommy was four. Tommy rarely saw his father in the subsequent years.

Bob is currently attending AA. He has elderly parents and an uncle living in this community. He works full time as a labourer and receives minimum wage.

Bob is very concerned about his son and is unsure how to handle him. He has been in contact with a local physician, who referred him to Mental Health.

An initial case conference was held one month ago and the attached plan was developed.

Immediately after the conference the child protection worker arranged for Bob and Tommy to have a Family Support Worker 3 days per week to help Bob with parenting and to work with Tommy on his aggressive behaviour. One week before the next scheduled meeting, the Family Support worker calls you to say that he is concerned about Bob and the stress he is under and that he may be drinking again. What do you do?
#8-1d: Case Scenario

**Public Health Nurse**

*The Family*

**Tommy, son, age 7**  
**Bob, father, age 31**  
**Sue, mother, age 32**  
**Timmy, brother, age 4**

Tommy is a seven year old boy who has recently come to live with his father. His mother, who lives in a northern town, is unable to care for him, and has agreed with the Ministry for Children and Families to have him live permanently with his birth father (Bob), in this community.

Tommy has one sibling who has remained with his mother. Tommy was protective of and fended for his younger brother.

Tommy has a history of police, community, and school problems in his previous community. He has also shoplifted from the corner store. His school attendance has been sporadic; in fact, he rarely attended. He has been diagnosed with ADHD. He does not know his letters and cannot print. He is registered in Grade two.

Tommy’s mother and his father, Bob have not lived together since Tommy was four. Tommy rarely saw his father in the subsequent years.

Bob is currently attending AA. He has elderly parents and an uncle living in this community. He works full time as a labourer and receives minimum wage.

Bob is very concerned about his son and is unsure how to handle him. He has been in contact with a local physician, who referred him to Mental Health.

An initial case conference was held one month ago and the attached plan was developed.

Immediately after the conference the child protection worker arranged for Bob and Tommy to have a Family Support Worker 3 days per week to help Bob with parenting and to work with Tommy on his aggressive behaviour. One week before the next scheduled meeting, the Family Support worker calls you to say that he is concerned about Bob and the stress he is under and that he may be drinking again. What do you do?
#8-1e: Case Scenario

**Father: Bob**

*The Family*

**Tommy, son, age 7**
**Bob, father, age 31**
**Sue, mother, age 32**
**Timmy, brother, age 4**

Tommy is a seven year old boy who has recently come to live with his father. His mother, who lives in a northern town, is unable to care for him, and has agreed with the Ministry for Children and Families to have him to live permanently with his birth father (Bob), in this community.

Tommy has one sibling who has remained with his mother. Tommy was protective of and fended for his younger brother.

Tommy has a history of police, community, and school problems in his previous community. He has also shoplifted from the corner store. His school attendance has been sporadic; in fact, he rarely attended. He has been diagnosed with ADHD. He does not know his letters and cannot print. He is registered in Grade two.

Tommy’s mother and his father, Bob have not lived together since Tommy was four. Tommy rarely saw his father in the subsequent years.

Bob is currently attending AA. He has elderly parents and an uncle living in this community. He works full time as a labourer and receives minimum wage.

Bob is very concerned about his son and is unsure how to handle him. He has been in contact with a local physician, who referred him to Mental Health.

An initial case conference was held one month ago and the attached plan was developed.

Immediately after the conference the child protection worker arranged for Bob and Tommy to have a Family Support Worker 3 days per week to help Bob with parenting and to work with Tommy on his aggressive behaviour. Shortly before the next scheduled meeting, you start to feel that the Family Support worker is not really listening to you anymore and seems preoccupied with questions about you drinking. What do you do?
Integrated Case Management Plan:

Name of Child/Youth: Tommy  
School: Helpful Elementary

Case Manager: Dan Jones  
Recorder: Linda Rogers

Date: June 8, 1999

Date of Next Meeting: July 8, 1999

**REASON FOR MEETING**

- Initial meeting to begin developing “success plan” for Tommy
- Share history and current information

**PRESENT**

<table>
<thead>
<tr>
<th>NAME</th>
<th>ROLE/AGENCY</th>
<th>PHONE</th>
<th>FAX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dan Jones</td>
<td>MCF Protection Worker</td>
<td>744-7854</td>
<td>744-4361</td>
</tr>
<tr>
<td>Linda Rogers</td>
<td>District Counsellor, SD 92</td>
<td>744-2346</td>
<td>744-9076</td>
</tr>
<tr>
<td>Bob</td>
<td>Father</td>
<td>768-5341</td>
<td></td>
</tr>
<tr>
<td>Val Morris</td>
<td>MCF Child and Youth Mental Health</td>
<td>744-7348</td>
<td>744-2904</td>
</tr>
<tr>
<td>Mary Ingram</td>
<td>Public Health Nurse</td>
<td>768-0091</td>
<td>768-8341</td>
</tr>
<tr>
<td>Mary Turner</td>
<td>RCMP</td>
<td>744-2951</td>
<td>744-6074</td>
</tr>
<tr>
<td>Dave</td>
<td>AA Sponsor/Advocate for Bob</td>
<td>768-0067</td>
<td></td>
</tr>
<tr>
<td>Sandra</td>
<td>Bob’s mother, Tommy’s grandmother</td>
<td>768-4602</td>
<td></td>
</tr>
</tbody>
</table>

1 Adapted from example provided by Chilliwack Child and Youth Committee
## PRIMARY CONSIDERATIONS

*Ensure the client’s perspective is recorded*

<table>
<thead>
<tr>
<th>DIMENSIONS OF CLIENTS LIFE</th>
<th>STRENGTHS</th>
<th>CONCERNS</th>
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</thead>
<tbody>
<tr>
<td><strong>HEALTH</strong></td>
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<tr>
<td></td>
<td></td>
<td>Tommy is diagnosed with ADHD</td>
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<tr>
<td></td>
<td></td>
<td>Tommy is having seizures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bob is alcoholic and attending AA</td>
</tr>
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<td></td>
<td></td>
<td>Dan is worried about Bob’s drinking – Could it become a concern? How can we support Bob?</td>
</tr>
<tr>
<td><strong>EDUCATION</strong></td>
<td>• Tommy is responding to structure at school and having positive experience</td>
<td>Registered in Grade 2 (appropriate for age) but doesn’t know letters and can’t print</td>
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<tr>
<td></td>
<td></td>
<td>How can we help him be successful at school?</td>
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<tr>
<td><strong>IDENTITY</strong></td>
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</tr>
<tr>
<td><strong>FAMILY &amp; SOCIAL RELATIONSHIPS</strong></td>
<td>• Bob shared he had moved to community and had recently taken charge of parenting Tommy</td>
<td>Concerns re effects of separation from brother and mother on Tommy</td>
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<tr>
<td></td>
<td>• Has made tremendous change in life</td>
<td>Tommy separated from Mom and in a new community</td>
</tr>
<tr>
<td></td>
<td>• Very caring relationship with Tommy</td>
<td>Dan – protection concerns around supervision; worried Tommy is left alone</td>
</tr>
<tr>
<td></td>
<td>• Stability in life now; has learned lots in past year</td>
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</tr>
<tr>
<td></td>
<td>• Tommy’s Mom still interested in helping with parenting</td>
<td></td>
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<tr>
<td></td>
<td>• Grandparents supportive</td>
<td></td>
</tr>
<tr>
<td><strong>SOCIAL PRESENTATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EMOTIONAL &amp; BEHAVIOURAL DEVELOPMENT</strong></td>
<td>• Tommy sharing and compassionate with others</td>
<td>Also can be aggressive with other children</td>
</tr>
<tr>
<td></td>
<td>• Attached to younger brother</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Responds to structure</td>
<td></td>
</tr>
</tbody>
</table>
PLANNING – Each goal and strategy should correspond to a strength or concern identified above. Have the client initial each goal/strategy to indicate client’s approval of plan, where applicable

<table>
<thead>
<tr>
<th>GOALS</th>
<th>ACTIVITIES/STRATEGY</th>
<th>RESPONSIBILITY OF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help Bob learn how to ‘navigate’ the health and education systems that support Tommy</td>
<td>1. Provide information to Bob and obtain necessary medical information; help Bob navigate the system</td>
<td>Mary Ingram</td>
</tr>
<tr>
<td>Keep Tommy connected with his mother and brother</td>
<td>2. Invite Tommy’s mother to participate in next meeting via conference call</td>
<td>Dan</td>
</tr>
<tr>
<td>Provide Bob practical support and role modelling for parenting</td>
<td>3. Initiate Family Support Worker in Home</td>
<td>Dan</td>
</tr>
<tr>
<td>Ensure everyone involved has necessary information to keep planning for Tommy on track</td>
<td>4. Share copies of School-based Team meetings with ICM team</td>
<td>Linda</td>
</tr>
<tr>
<td>Get a comprehensive assessment of Tommy</td>
<td>5. Refer Tommy for neurological assessment at Children’s Hospital</td>
<td>Val</td>
</tr>
<tr>
<td>Get a comprehensive assessment of Tommy</td>
<td>6. Refer Tommy for psychometric assessment</td>
<td>Linda</td>
</tr>
<tr>
<td>Support Bob in parenting</td>
<td>7. Attend “Parenting With a Purpose”</td>
<td>Bob</td>
</tr>
<tr>
<td>Bob to get support, information and skills in dealing with Tommy’s behaviour</td>
<td>8. Attend ADHD Support Group</td>
<td>Mary to provide phone number to Bob</td>
</tr>
</tbody>
</table>

NEXT MEETING

| DATE:     | July 8, 1999 |
| TIME:     | 10:00 AM – 11:00 AM |
| LOCATION: | Room 111 Helpful Elementary |
Sample Agenda for Follow up Meetings

1. Introductions
2. Decide on chair, recorder and who’s responsible for distributing minutes
3. Purpose of today’s meeting
4. Review minutes of last meeting
5. Status of specific recommendations/strategies from previous meeting
6. Up-dates re: Current Situation (Home, School, Community) and Strengths/concerns
7. Revise goals
8. Revise Action Plan

<table>
<thead>
<tr>
<th>GOALS</th>
<th>ACTIVITY/STRATEGIES</th>
<th>PERSON(S) RESPONSIBLE</th>
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</thead>
<tbody>
<tr>
<td>HEALTH</td>
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<td>EDUCATION</td>
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<td>FAMILY AND SOCIAL RELATIONSHIPS</td>
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<td>SOCIAL PRESENTATION</td>
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<td>EMOTIONAL AND BEHAVIOURAL DEVELOPMENT</td>
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<td>2.</td>
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9. Next Meeting – Date, Time, Location
Consistent ICM Documentation\(^2\)

It is important to document the process of integrated case management, and to use a consistent format to do so. The use of a consistent format will assist us to:

- Remember to focus on strengths
- Consider all aspects of a child or youth’s life
- Allow for portability of plans from one community or region to another
- Allow for plans of care developed for other purposes (e.g. guardianship and children in care) to be amended rather than redone
- Record services and outcomes
- Demonstrate good practice
- Submit reports as required and report to legally responsible parties
- Allow for provincial evaluation of integrated case management to be carried out

The format that has been selected uses the following areas of consideration:

- Health
- Education
- Identity
- Family and Social Relationships
- Social Presentation
- Emotional and Behavioural Development
- Self Care Skills

These areas have been chosen because they are consistent with the categories used in *Looking After Children*, an assessment and planning approach being used in the Ministry for Children and Families for children and youth who have been in care for six months or more. “The aim of *Looking after Children* is to raise the standards of corporate parenting by setting outcome objectives for children and linking them to the types of parenting actions most likely to lead to success”\(^3\).

For each area, the integrated case management team will use a planning process to develop a plan of care. The planning process requires the team to identify both the strengths (sometimes called protective factors) and the concerns (sometimes called risk factors) for each of the areas. This part of the process is important because often we seem to end up focusing on clients’ problems, when in fact it is more effective to focus on their strengths and to assist them to build resilience. (Resilience has been defined as the ability to recover from or adjust easily to misfortune or change.)

Having identified strengths and concerns, the areas that are a high priority will be selected by the team and desired goals, actions to achieve the goals, responsibilities and timelines will be developed. Regular review of the plan of care will keep the activities on track, allow goals and actions to be changed as circumstances change, allow new goals to be added, and allow the team to know when the family no longer needs service.

---

\(^2\) “Draft” section to be included in *Integrated Case Management: A User’s Guide*

\(^3\) HMSO. *Looking After Children: Good Parenting, Good Outcomes*. 1996.
#8-5a: Case Conferencing Documentation Example

Integrated Case Management Plan: Follow Up

Client Name: Tommy  
Date: July 8, 1999

Ensure that clients initial or check each goal to indicate agreement with the plan where applicable.

<table>
<thead>
<tr>
<th>FOCUS</th>
<th>STRENGTHS *</th>
<th>CONCERNS *</th>
<th>GOALS (at least one for each dimension)</th>
<th>ACTIONS (for each goal)</th>
<th>RESPONSIBILITY AND TIMELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
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<tr>
<td>Education</td>
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<td>Identity</td>
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<td>Family &amp; Social Relationships</td>
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<tr>
<td>Social Presentation</td>
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<td>Self Care Skills</td>
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<tr>
<td>Other</td>
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</table>

*The starred columns are essential components of a plan of care

Service Gaps: ________________________________________________________________
Date of Next Conference: ________________________________________________
Chairperson: _________________________
Case Co-ordinator: _________________________
#8-5b: Case Conferencing Documentation Example

Integrated Case Management Plan: Follow Up

Name of Child/Youth: Tommy  School: Helpful Elementary

Case Manager: Dan Jones  Recorder: Linda Rogers

Date: July 8, 1999

Date of Next Meeting:

<table>
<thead>
<tr>
<th>REASON FOR MEETING</th>
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<tr>
<th>PRESENT</th>
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<tbody>
<tr>
<td>NAME</td>
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Adapted from example provided by Chilliwack Child and Youth Committee
**PRIMARY CONSIDERATIONS** *Ensure the client’s perspective is recorded*

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<tr>
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<tr>
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<tr>
<td>SOCIAL PRESENTATION</td>
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<tr>
<td>EMOTIONAL &amp; BEHAVIOURAL DEVELOPMENT</td>
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*Have the client initial each goal/strategy to indicate client’s approval of plan, where applicable*

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<th>STRATEGY</th>
<th>RESPONSIBILITY OF</th>
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</table>

**NEXT MEETING**

<table>
<thead>
<tr>
<th>DATE:</th>
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<tbody>
<tr>
<td>TIME:</td>
</tr>
<tr>
<td>LOCATION:</td>
</tr>
</tbody>
</table>
Service Tracking Example *(Source: Westwood Team, Prince George)*

<table>
<thead>
<tr>
<th>File #</th>
<th>Name</th>
<th>Referral Date</th>
<th>Referral Meeting Date</th>
<th>Family Service Plan Meeting Date</th>
<th>Family Centred Assessment &amp; Service Plan Completion Date</th>
<th>Progress Review Date(s)</th>
<th>Closure Date</th>
<th>Evaluation Completed by Family Member(s)</th>
<th>Evaluation of Service Completed by Team</th>
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</thead>
<tbody>
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</table>

*(Source: Westwood Team, Prince George)*
### Key Definitions

**Goal**
statements about what you hope to achieve during ICM.

**Activity**
the type of services or interventions used to achieve the goals. For example, training, education, counselling, mentoring, assessment.

**Output**
the products of an ICM process. For example, number of counselling sessions attended, assessments completed, hours of school attendance, number of ICM meetings, number of participants in the ICM process.

**Outcome**
benefits to participants during or after participating in ICM, desired results for participants in ICM process. Often outcomes are changes in participants’ knowledge, attitudes and skills, their behaviour or sense of self and ultimately their condition or status.

**Indicators**
observable and measurable, data or information that would indicate progress toward achieving desired results. Used to track the success of ICM outcomes. Some examples of indicators of outcomes might be, improvement in child’s school grades, increase percentage of times when parents initiate calls to school when child is absent.
Example of Closure Report

Closure Report

Family Name: ____________________________ Referral Date: ____________________________

Closure Date: ____________________________

SERVICES UTILIZED:

<table>
<thead>
<tr>
<th>Referral</th>
<th>Individual</th>
<th>Family</th>
<th>Group</th>
<th>Other</th>
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<tbody>
<tr>
<td>Family Service Plan</td>
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<td>Alcohol &amp; Drug - Assessment Counselling</td>
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<td>Therapy – Assessment Counselling</td>
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<tr>
<td>Child Protective Services</td>
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<tr>
<td>Parenting</td>
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<tr>
<td>Child &amp; Youth Care Counsellor</td>
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<tr>
<td>Others:</td>
<td></td>
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</tbody>
</table>

OUTCOME OF SERVICE PROVISION:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Outcome measures as set by goals in service plan and interventions.

N/A Family referred only (Step 2)
1 Goals not achieved
2 Goals minimally achieved
3 Goals partially achieved
4 Goals predominantly achieved
5 Goals achieved

Signature of Chair: ____________________________ Date: __________

5 Source: Westwood Team, Prince George
Example of Family Questionnaire\textsuperscript{6}

Service Questionnaire

We have developed the following questionnaire to assist us in the development of the M.S.T. approach to working with families in Prince George. We value your input. We are interested in your viewpoint whether positive or negative. Thank you for your time in answering these questions.

1. Were the team’s services clearly explained by the person who referred you?
   - Yes
   - Somewhat
   - No

2. Were you given the M.S.T. information brochure?
   - Yes
   - No

3. How was your participation in the first planning meeting for your family?
   - Comfortable
   - Somewhat comfortable
   - Uncomfortable

   Comments: ___________________________

4. To what extent were you able to participate in the development of your plan?
   - Comfortable
   - Somewhat comfortable
   - Uncomfortable

5. Compared to when services began, how is your situation now?
   - Improved
   - Somewhat improved
   - About the same

\textsuperscript{6} Source: Westwood Team, Prince George
6. Has the family service plan of the team helped you develop and maintain solutions in your life?
   Yes ☐  Somewhat ☐  No ☐

7. As a result of my participation with the M.S.T. services for my family, my confidence level in finding solutions to family stresses is:
   Increased ☐  Somewhat increased ☐  The same ☐

Please rate the following services that you received as part of the family service plan:

<table>
<thead>
<tr>
<th>Services Used:</th>
<th>Not Applicable</th>
<th>Helpful</th>
<th>Somewhat Helpful</th>
<th>Not Helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Service Plan Meetings</td>
<td></td>
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<tr>
<td>Alcohol &amp; Drug - Assessment Counselling</td>
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<tr>
<td>Parenting</td>
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<tr>
<td>Child &amp; Youth Care Counselling</td>
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<tr>
<td>Therapy – Assessment Counselling</td>
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<tr>
<td>Child Protective Services</td>
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</tbody>
</table>

8. What I liked best about working with the Multi-Service Team:______________________________
   __________________________________________
   __________________________

9. What changes would you suggest to improve the Multi-Service approach? (e.g. transportation, day care, more input etc.)______________________________
   __________________________________________
   __________________________
Service Outcomes

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
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<tr>
<td>1.</td>
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<td>2.</td>
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<tr>
<td>Education</td>
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<tr>
<td>Identity</td>
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<td>2.</td>
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<tr>
<td>Family and social relationships</td>
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<td>1.</td>
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<td>2.</td>
<td></td>
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<tr>
<td>Social presentation</td>
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<td>1.</td>
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<td>2.</td>
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<tr>
<td>Emotional and behavioural development</td>
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<tr>
<td>2.</td>
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<tr>
<td>Self care skills</td>
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<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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</table>

Take 10 minutes to complete the above outcome form individually. When you have completed it, choose a recorder for your group and discuss your individual reflections, using the following questions as prompts for the discussion:

- What were the goals for this family?
- What were some of the desired short, medium and long range outcomes that you identified for the family?
- Were they linked to the goals?
- What kind of information would indicate the progress you are making towards achieving these desired results? How would you collect this information?
- Were there any outcomes for service providers?
- Did the community gain any benefit from this ICM process? How would you know?
- How could you document the goals and outcomes of an ICM process?
Integrated Case Management Training (Module 8) 
Evaluation Form

The purpose of this evaluation is to help us understand the value of the activities in meeting the ICM training goals.

This workshop has been designed to provide you with an opportunity to:
• explore ICM tracking process
• practice ICM closure
• develop outcomes for children, youth and families

Using the following rating scale where 1 equals not effective, 3 equals somewhat effective and 5 equals very effective, rate each of the following activities in terms of meeting the workshop goals.

1. Workshop activities
   a) Reflective writing and small group discussion
      1  2  3  4  5
      not effective  somewhat  very effective
   b) Discussion/development of common agreement
      1  2  3  4  5
      not effective  somewhat  very effective
   c) Role play
      1  2  3  4  5
      not effective  somewhat  very effective

2. How useful were the handouts/resources?
   1  2  3  4  5
   not useful  somewhat  very useful

3. How applicable has this workshop been to your work or experience?
   1  2  3  4  5
   not applicable  somewhat  very applicable
4. What do you feel was your biggest learning today?

5. What was your biggest surprise?

6. What did you like best about the workshop?

7. What would you change if you could?

8. Please add any additional comments.
Bibliography


Suggested Readings


