REVIEW OF

REGIONAL INTEGRATED CASE MANAGEMENT SERVICES

For The

THE MINISTRY FOR CHILDREN AND FAMILIES

June 1998

Contracted with:
University of Victoria
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EXECUTIVE SUMMARY

Integrated Case Management (ICM) is one practice that the Ministry for Children and Families is implementing to promote the integration of services that focuses on children, recognizes diversity and maximizes participation of clients. Regional implementation of integrated case management is a high priority for the Ministry, with early 1999 set as the target date for implementation across the province. A policy for integrated service delivery and integrated case management has been approved and a detailed implementation plan is being developed. This report is intended to contribute to the development of the implementation plan and overall implementation of ICM.

The Ministry for Children and Families is interested in knowing more about the differing integrated case management systems and practice models in use in order to assist regions to implement their own integrated case management process and to inform future provincial standards, evaluation, and training. To this end, a review of four regions was conducted by a multi-disciplinary research team from the University of Victoria’s Child, Family and Community Research Program.

Project Objectives

The objectives of the review were:

- To identify regional service delivery models that effectively combine integrated case management practice, strategies and system administration and which result in benefit to the client being served.

- To identify the potential supports required for regional operating agencies to implement an effective integrated case management system and practice.

- To identify the training needs required by field staff in order to implement integrated case management strategies and practice.

Methodology

The four participating regions volunteered to be involved in this review. The review was conducted using a collaborative approach, involving MCF staff in site selection, participant selection, and the review of draft reports and materials. Once review sites were selected, a qualitative methodology, involving the following data collection methods and processes, was employed:

- Focus groups (and/or individual interviews, where preferred by the participant) with practitioners and supervisors, regarding the process, experience and perceived outcomes associated with integrated case management;

- Review of a sample of client files (i.e., files of clients who have received services from practitioners engaging in integrated case management), in order to determine how information regarding the processes and outcomes associated with integrated case management is documented;

- Individual interviews with service users (parents and/or youth) regarding the processes, experience and perceived outcomes associated with receiving services that are provided through an integrated case management approach to service delivery.

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When requested by participants, researchers returned to the sites with drafts of the findings for their site. Participating sites were interested in examining their ICM practice and were very interested in the results as a way of learning and improving their practice. For them, the process of the review provided an opportunity to reflect on their practice, and thus was of great value.

**HIGHLIGHTS OF FINDINGS**

**Definition and Key Elements of Integrated Case Management**

"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."

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.

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 wholistic 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:**
- Multi-disciplinary case conferences
- Proactive assessment, planning, review and implementation of case plans
- Follow-through/follow-up
- Assignment of a case coordinator

A relationship exists between the depth of understanding of the key elements and degree of experience practicing ICM. For those with little experience, these key elements constituted their vision; for others with more experience, these elements were enacted in their day to day work. Those who were practicing ICM were clear that the movement from the elements as vision to practice was based on continual reflection, discussion, and modification of practice.
While this review highlighted case conferencing as an aspect of ICM, it is clear that ICM is more than collaboration, case conferencing and co-location. It is the aggregate of all of these aspects as well as the key elements.

**Process/Practice of ICM**

There is not a single model of integrated case management, nor is there one approach that should or has been employed in the development of ICM practice. The most evident difference in approach is whether the starting place is relationship and trust building supported by adding structure (documentation, formalized process for meetings, criteria for initiating ICM) or whether the starting place is creating a structure including development of protocols, that is followed by relationship and trust building as the structure is implemented. The different starting places appear to be a result of the differing characteristics of the regions/communities. Some of the differing characteristics include history, size, location (urban/rural), organizational structures, leadership and contract restructuring processes. Regardless of the approach, in order to fully implement ICM it is clear from the experiences of the review regions that relationships, trust building and structure all need to be in place.

The successful implementation of ICM is a developmental process that requires time, effective support and a long term commitment at both the provincial and regional levels. It represents a shift in approach to practice that will take time to integrate and consolidate. The shift to ICM requires the presence of “champions” whose vision of ICM is clear and whose commitment is untiring. ICM is dependent on reflective practice that builds on experience and requires an ongoing investment in facilitated practice and learning opportunities that build on the practical experience of doing ICM.

Overall, there is agreement that ICM is appropriate and often necessary in all instances in which there are more than two services or professionals involved with a family. This guideline for ICM allows for proactive initiation of ICM that may reduce the length of time a client requires service. Similarly there needs to be agreement that practitioners enquire on intake, who is involved with the client and initiate ICM if more than two professionals are involved.

The definition of the role of case manager requires clarification. There is incongruence between the Ministry’s principles that stand behind collaboration and teamwork, and assigning one member of the team as a single point of authority, which the name “case manager” implies. Many see the role as responsibility for setting up the meetings, notifying participants, being recorders of case conferences; distributing information; etc. They were clear however that the case manager did not have decision-making authority outside the team or legislated mandate.

Shared responsibility within the context of how ICM is being practiced, means that practitioners are accountable to each other and to clients for maintaining their part of the integrated case plan. This is a different type of accountability than is implied when there is a single point of authority, and is in keeping with the collaborative approach being fostered at all sites. Indeed, this way of practice strengthens accountability because the ICM plans are developed and agreed to by a team and therefore each person’s accountability is openly scrutinized.

Discipline specific supervision was not raised as an issue in discussions about ICM. Supervision within integrated service teams may be an issue and is being addressed in different ways. However, these concerns were not identified in discussions regarding ICM as participants received supervision from their own team or agency supervisor. Clinical supervision in contracted agencies was raised as an issue as it is rarely provided for in contracts.

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Documentation is a necessary part of ICM for focus, follow-through and review. However, the use of forms and documentation of meetings does not guarantee adequate ICM practice. Practitioners warned of the tyranny of forms and the ease with which forms could become an illusion of good practice without meeting the needs of clients.

The differing types of planning and assessment documentation currently required, and whether there is support for one assessment and planning document are issues that need attention by the central operating agency. While at the field level people are working in integrated service teams, the expectations for documentation centrally continue to be on a program by program basis.

Outcomes of ICM

Practitioners and clients readily identified outcomes of ICM. Of interest is the similarity between the outcomes that were expressed by clients and those expressed by practitioners.

For clients, some outcomes were concrete, such as enabling clients to get (faster) access to needed services and information, or enabling/ensuring that a child remained in school. Other outcomes were more psychological or feelings-based, such as enhancing clients' sense of self-worth, or engendering clients' sense that they were supported and that other people cared.

Clients’ discussion of outcomes of ICM are discussed in their own words below:

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

“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.”

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.”

ICM results in clients feeling respected

“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.”

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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."

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."

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. Others expressed frustration that ICM was problem-focused and crisis initiated for the most part. Still 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!"

For practitioners, integrated case management has affected the ways in which professionals do, think about, and feel about their practice; the ways in which professionals relate to other service providers; and the ways in which professionals think about, and relate to their clients. Not surprisingly, the more experience practitioners have had with ICM, the more positive their discussion of outcomes is. This has implications for implementation of ICM in that it is through the experience of doing ICM that practitioners gain an understanding of the benefits to their practice and workload. 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 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."

ICM reduces practitioners' sense of isolation

"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
"The disciplines talk a different language (e.g., school vs. mental health ... s. 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.”
“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.”

ICM decreases practitioners' workload
Practitioners who are not experienced with ICM often anticipate it will be time consuming and an increase to their workload. Indeed, as with anything new, shifting to an ICM practice approach initially may be more time consuming. However, as identified above, practitioners experienced with ICM have found that the proactive, rather than reactive nature of ICM, reduces workload.

ICM has provided a mentoring experience for both practitioners and clients. It sometimes provides opportunities to develop creative solutions for client issues in a climate of decreasing resources. At the same time there is concern that decreasing resources is a constraint to ICM that will impact the implementation of effective action plans.

Enablers and Barriers
The enablers and barriers to ICM identified are often complementary. In many cases the enablers identified what could be done to reduce the barriers. Some of the major barriers identified were issues of staffing, workload and change within the Ministry. Staff’s experience of “grieving” and of feeling unsettled as a result of the reorganization of the Ministry and of their work environments needs to be taken into consideration and acknowledged as much as possible as the implementation of ICM proceeds.

Practice Support and Learning
Practitioners identified a number of important learning and support needs in relation to ICM. They stated clearly that mandatory, traditional curriculum-based "training" on integrated case management was not what they desired or needed. They also identified a number of ways their support and learning needs could be met. There is no one model of support but a variety of means, including the establishment of ongoing, facilitated discussions on multi-disciplinary and ICM practice, peer mentoring/consulting relationship with practitioners experienced in ICM, and developing protocols regarding the process and practice of ICM. Community partners are an important ally in ICM and need to be incorporated into training and support planning.

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RECOMMENDATIONS

Based on the information presented in the discussions of regional ICM implementation, outcomes, and identification of enablers, barriers and practice supports for ICM, the following recommendations are made:

Central Policy and Standards

1. That MCF allocate the resources necessary to support the implementation and practice of ICM.

2. That policy development recognize and reflect regional differences and practices to allow for approaches to ICM that meet the unique needs of each region.

3. That practice standards for individual program areas should clearly link assessment and planning standards to ICM policy.

4. That the various risk assessments be reviewed in the context of multi-disciplinary and integrated service delivery to ensure linkages within the multi-disciplinary approach.

5. That managers at the regional and central level work with their counterparts in the other health and social policy ministries and community organizations to:
   - promote the understanding and use of ICM within those organizations; and
   - identify “champions” of ICM and multi-disciplinary practice in those organizations.

6. That ICM policy and practice be introduced immediately into all mandatory MCF training for new workers.

7. That MCF develop an information pamphlet and video on ICM for communication with clients and the general public.

Practice

1. That the minimum guideline for initiating an ICM process be when:
   - Two or more services are involved, and/or
   - A professional or the family believes that the client issues are sufficiently complex to warrant further services and professional involvement.

2. That within the context of provincial guidelines and standards, community protocols be developed to reflect the emerging ICM practice in that community. These protocols could address such things as assignment of case coordinator, a conflict resolution process, common intake responses, referral for specialized assessment or treatment, and so on. Practitioners and managers need to be involved in developing these protocols and a process to regularly reflect on and refine the protocols to bring them into line with practice experience should be established in each community or region.

3. That the title of case manager be changed to case coordinator.
4. That the roles and responsibilities of the ICM case conference chair and/or case coordinator include:
   ✓ Organizing of the first meeting with all participants;
   ✓ Chairing and facilitating shared decision making at the ICM case conferences, including preparation of an agenda;
   ✓ Ensuring that case assessment, plans, and outcomes are developed and responsibilities assigned;
   ✓ Ensuring that reviews of client progress and the ICM plan occur at each meeting and that revised plans and responsibilities are assigned;
   ✓ Updating and distributing ICM case conference documents to all participants after each ICM case conference;
   ✓ Ensuring that progress, achievement of goals and outcomes is tracked and documented;
   ✓ Establishing a schedule for ICM case conferences;
   ✓ Ensuring that absent participants are notified of next meeting.

5. That the role of child protection workers and probation officers, as case coordinators, be reviewed and clarified within the context of their mandated responsibilities.

6. That the practice relationship between all discipline-specific risk assessments and ICM be clarified for workers in the field.

7. That ICM be used as an approach for early intervention in order to assess the need for and deliver the appropriate level of service as early as possible.

Documentation

1. That documentation requirements regarding assessment and care plans by program areas be integrated in order to support integrated teams at the field level.

2. That guidelines for documentation should be established provincially to guide regional or local development of document formats. This should be viewed as a developmental piece to allow for emergence of “best practices” in recording formats for ICM. For those regions that do not wish to develop their own documentation formats, sample formats should be provided centrally.

3. That documentation for ICM be comprehensive and reflect all dimensions of a person’s life and include:
   - an assessment format;
   - a planning format that establishes client and ICM outcomes, time frames and responsibility for actions;
   - a monitoring format that documents progress, changes, contingency plans, and assigns new tasks and responsibilities;
   - case transfer or closure formats that document progress to date, reason for transfer/closure and recommended next steps as appropriate, as well as presenting an evaluation of the effectiveness of the ICM process.

4. That all regions have the capacity to implement computerized ICM recording and electronic transfer of documents to all members of the ICM teams.

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5. That MCF review and rationalize the filing requirements in light of ICM policy and practice.

Practice Support and Learning

That a facilitated self-assessment process be developed for MCF integrated teams to identify what supports they need in order to implement or refine their ICM practice. The self-assessment should be based on the key elements of ICM. The facilitation should assist in the process of reflection on practice and relationship building. The outcome of this self-assessment would be a training plan for ICM implementation or refinement in their region or community. A sample self-assessment framework is provided in Appendix F.

2. That once the self-assessment is complete, MCF support facilitation of the regional/community training plan. Such strategies as team building, facilitated workshops, regional conferences, knowledge and skill development training are some examples of facilitated supports that may be necessary. Specific topics may include professional roles and responsibilities, language, philosophy, practice modalities, etc.; client involvement; information sharing; documentation; conflict resolution; resources available locally, regionally, and provincially and how to access them; and so on. Administrative support staff need to be involved in this process as well.

3. That MCF organize regional mentoring opportunities for regions who have some experience with ICM to work with other regions who are not as experienced. These mentors could also act as consultants to practitioners on an ongoing basis.

4. That within each region someone is assigned responsibility to oversee and act as a consultant to the implementation and ongoing practice of ICM.

5. That MCF ensure administrative supports such as inclusion of ICM in job descriptions for MCF and community agency practitioners, writing expectations for ICM in contracts and protocol agreements with other agencies, organizations and individuals, and ensuring adequate facilities to conduct ICM case conferences are in place to support ICM.

6. That MCF routinely collect and distribute examples of regional approaches to ICM for information and use by other regions.

ICM Outcome Evaluation

That MCF develops a framework for ongoing evaluation of ICM implementation and practice. This evaluation framework should include outcomes for clients, practitioners, the process, and identify organizational impacts.
I INTRODUCTION AND OVERVIEW

The Ministry for Children and Families (MCF) was created in 1996 to address the need for a coordinated approach to the wide range of service needs of children, youth, families and other adults. This has brought together professionals, programs and services from five ministries to streamline services to clients, within the context of their communities, through a regional delivery system.

With the formation of the Ministry, the provincial government seeks to shape the way services are delivered so that they are not aligned with professional disciplines or programs, but rather client centred and integrated in order to meet the wholistic needs of clients. As well, parents, children, youth and communities told government they wanted greater opportunities to be heard, greater involvement in decision making and to have more flexibility in creating solutions to address their issues. It is expected that an inclusive, coordinated approach will result in positive outcomes for children, youth, families and other adults.

Integrated case management (ICM) is one practice that the Ministry is implementing to promote the integration of services that focuses on children, recognizes diversity and maximizes participation of clients. Regional implementation of integrated case management is a high priority for the Ministry, with early 1999 set as the target date for implementation across the province. A policy for integrated service delivery and integrated case management has been approved and a detailed implementation plan is being developed. This report is intended to contribute to the development of the implementation plan and overall implementation of ICM.

The Ministry policy on integrated service delivery and integrated case management is guided by five principles. They are:

- client centred services
- mutual respect
- advocacy
- multi-disciplinary collaboration and teamwork, and
- accountability.

Further, the policy distinguishes between integrated service delivery and integrated case management. Integrated case management is defined as follows:

This term is to be used when the child, youth, family or other adult has complex and often longer term needs that would require a formal and structured approach among service providers. This necessitates joint decision-making, development, implementation and monitoring of a single service plan and the clarification of their multiple roles and responsibilities. Each member of the integrated case management team must be clear about his/her part in the plan (MCF, 1998).
There exist a variety of integrated case management systems and practice models, some of which are discussed in reports or options papers such as:

- **Common Intake Response/Screening, and Integrated Case Management Model** (Capital Region, 1997).
- **When the Bough Breaks: Coordinating the Planning for Services to Children, Youth, and Families in Vancouver** (United Way, 1993)
- **A Handbook for Integrated Case Management** (C&Y Secretariat, 1993) and

In addition, a pilot project is currently underway in the Capital Region that is intended to develop competencies for practitioners engaged in integrated case management.

Some regions were already using an integrated case management approach before the creation of the Ministry and others are actively engaged in developing approaches consistent with the needs of their regions. The Ministry for Children and Families is interested in knowing more about the differing integrated case management systems and practice models in use in order to assist other regions to implement their own integrated case management process and to inform future provincial standards, evaluation, and training. To this end, a review of four regions, who volunteered to participate, was conducted by a multi-disciplinary research team from the University of Victoria’s Child, Family and Community Research Program.

**Project Objectives**

The objectives of the review were:

To identify regional service delivery models that effectively combine integrated case management practice, strategies and system administration and which result in benefit to the client being served.

To identify the potential supports required for regional operating agencies to implement an effective integrated case management system and practice.

To identify the training needs required by field staff in order to implement integrated case management strategies and practice.

**Timelines for Project**

The initial proposal stated that the review was to be initiated in December 1997 and completed by the end of March 1998. However, a variety of factors identified by the research team, including regional staff workloads, contract restructuring, a commitment to collaborative processes, winter travel and Christmas vacations, suggested a longer time frame to complete the review and write the report. This longer time frame has been important in allowing a positive, collaborative approach, involving Ministry for Children...
and Families regional staff in site selection, participant selection and the review of draft reports and materials. The following table outlines time frames and project activities.

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<tr>
<th>DATE</th>
<th>PROJECT ACTIVITIES</th>
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| Dec 1-Jan, 31, 1998           | Confirmation of participating pilot sites  
Collection and review of descriptions of integrated case management in place in the pilot sites  
Arrange on-site data collection  
Develop interview guide and protocol |
| Feb 1-April 30, 1998          | On site data collection  
Data Analysis  
Follow-up interviews with MCF staff  
Draft outline of Final Report |
| May 1-June 15, 1998           | Draft Final Report  
Review of drafts with participating regions  
Submit Final Report |

During the introductory stages of the project, in consultations with the four regions, participants questioned whether the project was an evaluation. It was suggested that an evaluation was not the most useful approach at this time. Integrated case management practice and structures are at a formative stage in most regions making it difficult to conduct an evaluation. Through discussions with regional and central staff it was agreed that a “review” that describes integrated case management initiatives in the participating regions and identifies supports and training needs associated with the development of integrated case management practice, met the stated objectives of the project and would be more appropriate and useful.

Section Two of the report outlines the methodology. Findings are presented in Section Three, followed by conclusions in Section Four and recommendations in Section Five.
II METHODOLOGY

The review was conducted using a collaborative approach, involving MCF staff in site selection, participant selection, and the review of draft reports and materials. The first step in the project was meeting with designated contact staff in each volunteer region to familiarize them with the project and to select a review site within each region. In preparation for the initial meeting with sites, a two page overview of the project and a one page summary of descriptions of collaborative practice and integrated case management, drawn from previous studies, was provided. For some review sites, this proved to be useful in stimulating discussion and interest in the project. The one page summary is provided in Appendix A.

Once review sites were selected, a qualitative methodology, involving the following data collection methods and processes, was employed.

- Focus groups (and/or individual interviews, where preferred by the participant) with practitioners and supervisors, regarding the process, experience and perceived outcomes associated with integrated case management;

- Review of a sample of client files (i.e., files of clients who have received services from practitioners engaging in integrated case management), in order to determine how information regarding the processes and outcomes associated with integrated case management is documented;

- Individual interviews with service users (parents and/or youth) regarding the processes, experience and perceived outcomes associated with receiving services that are provided through an integrated case management approach to service delivery;

The data collection tools are in Appendix B.

Participants in the review were:

- front line MCF staff and community-based service providers in each participating site
- MCF supervisors and/or regional managers overseeing integrated case management in each participating site; and;
- users of services in each participating site

Each review site is unique and therefore who participated and the number and composition of focus groups, interviews and file reviews varied slightly from site to site. However, focus groups, file reviews and client interviews were conducted at all sites. Additional information regarding who participated as informants at each site is included in the site by site review in Section Three.
All participants signed a consent form prior to taking part in data collection. They were advised of the voluntary nature of their participation in the project. For service users, receipt of service was in no way contingent on their participation, and for practitioners, employment with, or funding by, the Ministry was in no way related to participation. The consent forms are in Appendix C.

Data from the interviews and focus groups were recorded by note-taking and audio-taping, with participant consent. The data were then examined to reveal themes pertaining to the processes, experience and perceived outcomes associated with collaborative practice and integrated case management.

When requested by participants, researchers returned to the sites with drafts of the findings for their site. Participating sites were interested in examining their ICM practice and were very interested in the results as a way of learning and improving their practice. For them, the process of the review provided an opportunity to reflect on their practice, and thus was of great value. This was responded to by returning with feedback in order to further the implementation of ICM in these review sites.

In addition, the draft report was circulated to all review sites before being finalized.
3.1 Regional Integrated Case Management Approaches

The findings are based on the thematic analysis of the data collected through focus groups, key informant interviews, file reviews and client interviews. They are organized as:

- definition and key elements
- process/practice
- clients’ experience
- outcomes
- barriers and enablers
- practice support and learning

Client and practitioner comments have been woven throughout the sections of the report.

3.1.1 Definition and Key Elements of ICM

"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. Some described their vision in more detail than did others. 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 wholistic 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:
- Multi-disciplinary case conferences
- Proactive assessment, planning, review and implementation of case plans
- Follow-through/follow-up
- Assignment of case coordinator

3.1.2 Process/Practice of ICM

Each of the four sites in this review is unique. Characteristics such as history of collaborative relationships between service providers, stability and continuity of the professional community, size of the area served, location (urban/rural), organizational structures, leadership and contract restructuring processes, all affect the development and implementation of ICM process and practice.

Review Site A

Review site A is a mid-size urban area that is relatively affluent. There is one regional MCF office and seven district teams. They have been co-located since April 1997. Youth services and youth corrections, which includes probation services, are housed separately.

Participants in the review at this site included adult community living services, probation, child protection services and services to families including children’s community living, mental health and addictions services. Other service providers such as public health, mental health for adult community living and foster parents also participated. Key informant interviews were also held with the Quality Assurance manager, Adult Community Living Services coordinator, one Team Leader and one Adult Community Living social worker.

Many team members continue to express strong reservations and sadness about leaving their former colleagues to be part of a new multi-disciplinary team.
Overall staffing appears to be relatively stable and most workers have had a history of working with the community.

In addition there are approximately 115 community-based contractors providing companion services such as group homes, alcohol and drug services, aboriginal services, child care workers and home care. Some of these contracted agencies are specific to the pilot site and some provide services across MCF regional boundaries. The community partners also have a history of providing services in the area and are well established.

This region seized upon the contract restructuring process as an opportunity to work collaboratively with the community to create a set of service principles for both contracted and MCF services. These service principles go beyond policies and procedures and identify expectations for working together and for inclusion of clients. Introduction of the service principles is seen as a mechanism for fostering common understandings between MCF and community service providers, and ultimately as a support to the development and implementation of ICM.

This site is at a beginning stage of implementing ICM. Among the three participating teams there is an emerging awareness of ICM, although for the most part the term itself is not used. Co-location, while it has helped increase the awareness of each other’s role and function, has not yet changed practice significantly. A couple of key individuals noted that from their perspective, ICM represents a way of thinking about how to work with families and community and includes working collaboratively and “letting go the need to control”.

There is evidence of some of the elements of ICM in discrete areas. For example, Adult Community Living (ACL) services has a long history of case management and service coordination as part of the annual Personal Service Plan (PSP) which is drawn up for each ACL client. Multi-disciplinary case conferences may occur in addition to the annual PSP, but they occur on more of an ad hoc basis.

A single point of entry for all MCF services in the region, known as the Access Line has been established within the past few months. The Access worker notes the type of services that are needed and calls the appropriate service provider to have them call the person making the inquiry. Child protection calls go either directly to the investigation team or through the Access Line. Awareness and utilization of the Access Line is increasing in this region. This service has the potential to facilitate ICM by identifying all the services a client is receiving or has received in the past.
One Team Leader has begun a process of introducing the concept and practice of ICM to the team by:

- **file updating and file reviews.**
  Asking that all files be updated and reviewed for who is involved and whether MCF still had a role to be involved.

- **creating relationships.**
  Staff are encouraged to get to know their families and the community through the development of collegial relationships with community partners and regular contact and communication with clients. Two social events were hosted within the office which brought MCF staff, community partners and clients for the first time. "Brown bag" lunches with school personnel are regularly hosted by MCF as another way of beginning to create relationships and partnerships.

- **creating opportunities for collaboration**
  The Team Leader is seeking partnerships with other organizations such as schools and the local First Nations band, through the creation of relationships. These relationships are seen as the first step toward creative problem solving. For example, it was noted that a number of families lived in the same complex and received individual financial support to transport their children to school. The school was approached to help find a more creative and collaborative solution such as the provision of a bus.

- **bringing in speakers for staff meetings**
  Different practitioners from the community, with expertise in relevant practice areas, are invited to provide in-service training and consultation with the team. This has provided an opportunity to share practice-related information across disciplines.

- **inclusion of community partners in team meetings**
  Foster parents, for example, have been invited to team meetings to discuss what they offer, their perspectives on providing care to children, and what they would like to learn about.

Supervision is provided by the Team Leaders and through the Quality Assurance Manager, who looks at situations from an outcome based perspective, that is, what is different for the family. If something does not work out, either for a client or practitioner, the QA manager brings everyone together who had involvement, and seeks to both identify the barriers and find a common goal. Through this approach it has become evident in this region that problems most often arise when
decisions by practitioners are made prior to case conference meetings, rather than using meetings as a time to achieve shared decision-making. The file review confirmed that case conferencing is occurring sporadically. Documentation across all files indicates the involvement of a number of services in the lives of families with some coordination of services, but very little integration. Case conferences are largely documented through OV notes, case notes, or running messages and are housed in numerous files, by discipline or program.

**Summary**

This pilot site is at a beginning stage of developing awareness of ICM and shifting practice to encompass ICM, and as such is experiencing some of the normal developmental concerns such as grieving by staff, uncertainty how to incorporate ICM into practice, trying to understand each others’ role and so forth. There is much strength within the region that can assist the transition. For example, there are champions within the region who understand the benefits of ICM, believe in it as a way of working and are mentoring staff to achieve a shift in practice. There is acknowledgement that as a first step, relationships need to be proactively fostered between MCF staff, community partners and First Nations bands. Team members from one team are starting to have positive experiences with service coordination and collaboration and to report those experiences to others on their team.

**Review Site B**

Review site B is a large, complex, heterogeneous, urban center. The MCF region is divided into six areas, and there are two multi-disciplinary teams within each area. Two of the six areas volunteered to participate in the review. An Area Manager leads each area and a Team Leader leads each team within the area.

Discussions at this site were primarily conducted with Team Leaders/Area Managers and to a lesser extent with front line MCF staff. Contracted agencies were not involved in the review.

In the participating teams, many MCF staff, both at the front line and at the manager level, were either new to MCF, new to the region, and/or new to the province. Moreover, many team members, particularly across disciplines but even within disciplines, did not know each other prior to the formation of their team. In other words, for the most part, workers have only had relationships with one another as colleagues since late 1997 or early 1998, a period of less than six months. In addition, several teams are operating with less than their allocated number of staff, which has had an impact on practitioners workload and feelings of overwork. At the same time, relationship building activities such as brown bag
lunches, finding opportunities for collaboration and so forth, have been a priority for some teams.

Finally, some Team Leaders reported resistance and "mourning" within some disciplines to becoming part of MCF, as this has meant having to alter or expand client populations, having to shift practice priorities and having to modify discipline specific training and orientation. Nevertheless, Team Leaders reported that the stress level amongst staff is going down as they gain comfort with each other and with their discipline-specific roles as part of multi-disciplinary teams.

In one of the participating areas, co-location has occurred. In the other area, physical space constraints prevent co-location from occurring until the fall of 1998 or later. One Team Leader sees co-location as an immediate priority and as a precursor or enabler of ICM. The other Team Leader has focussed more on implementing ICM, through case conferences, and intake and review. Team members have not been involved in developing the model per se, but are involved through implementing and refining certain aspects of it.

Since the fall of 1997, the Team Leaders, Area Managers and Quality Assurance Manager have been meeting to develop their vision and model of ICM within the region. This has resulted in a draft working document articulating the model.

Team Leaders place considerable importance on this model development work. At the same time, there is recognition amongst the Team Leaders that "the model" will evolve and be refined as workers "do it" - and that doing ICM is probably the best way for workers to become more comfortable and positive about ICM. However, some front line team members view ICM as a formalization of how they have always practiced. Several focus group participants noted that they had been practicing collaboratively for a long time and in a variety of settings. Only very recently however, has the Ministry "formalized" the approach, as well as articulated strong expectations at the management level, that this approach would form a major part of their casework.

The region’s draft model states that ICM involves the following key components: screening/intake; assessment; planning/service plan; intervention/implementation of service; monitoring/reviews; and closure/transfer. Integrated case conferences are seen as a mechanism through which these functions of ICM are carried out, and through which quality of service can be monitored. Accordingly, Team Managers have had the opportunity for training in multi-disciplinary team work, facilitative leadership and advanced facilitative skills. The plan is for all staff involved in ICM to eventually receive this type of training.

The following protocols and processes have been articulated in the model and currently are being implemented and modified through practice.
• *Identifying the need for ICM*

The region has introduced a systematic review process whereby each team member reviews ongoing files with their supervisor, for their suitability for ICM. This work has both led to, and been informed by, setting criteria for ICM. The criteria for applying ICM in new cases is in draft stage and at the time of this writing, was being revised by team members. Several of the criteria reflect the focus in the area on substance misuse within families and the presence of multiple service providers.

In addition to doing an inventory of existing cases, in one area, there are now Intake and Review Teams and a systematic process for identifying which new cases should employ an ICM approach. Team members have noted that having regularly scheduled bi-weekly Intake and Review meetings provides opportunities for multi-disciplinary team members to meet together. This is especially important given that the teams in this area aren't co-located yet. Similarly, the other participating area is developing a "Common Intake process" and associated documentation that will be shared between the two areas.

Once it has been determined that ICM is the approach that will be used, an Integrated Case Coordinator is assigned. The Integrated Case Coordinator can come from any discipline and/or can be the client. Generally, the Integrated Case Coordinator is the person who has the most longstanding relationship with the client and is selected largely on this basis. The role of the Integrated Case Coordinator is to: oversee the ICM process; ensure that the integrated service plan is being implemented; and ensure that there is appropriate follow-up, including the scheduling of additional integrated case conferences, as necessary.

The responsibilities of the other members of the ICM team are also articulated by the model. These include: sharing responsibility for the ICM process and integrated services plan; sharing accountability for the implementation of the various components of the plan; and sharing information with one another and with the Integrated Case Coordinator regarding progress and barriers in achieving goals associated with the plan.

• *Case Conferences*

Integrated case conferences are a central component of ICM; however, practitioners agreed that ICM involves more than case conferences. Anyone can call the integrated case conference, including the family, MCF, schools, probation, mental health, or the First Nations Band. Once someone identifies the need for a conference, a list of participants is created. This list may be drawn up by the
family in conjunction with a worker, or by a worker in consultation with the family. The family generally vets the list.

The ICM model indicates that integrated case conferences are to be chaired primarily by Team Leaders. Thus, the work of setting up the conference, that is, inviting the relevant participants, arranging a time and place for the meeting, chairing the conference, and facilitating a conflict resolution process if necessary, is done in most cases by the Team Leader. The rationale is that at least in the first year of implementation, it is important to relieve line workers of these activities. Some staff indicated that they have been involved in organizing case conferences as well. From their perspective, the administrative work associated with organizing an integrated case conference was not being done by Team Leaders alone.

The case conference agenda is set as an initial part of the conference itself. Issues are brought forward collectively by any and all participants, including the client(s). The agenda may include the original issue(s) prompting the conference, and/or any one of a number of associated or emerging issues (i.e., issues/concerns/needs arising for other family members). There may be time within the conference to address the emerging issues, or these issues may be the focus of the next integrated case conference.

The focus of the integrated case conference is on information sharing and the development of an integrated service plan. Embedded within the plan is the designation of each participant's role and responsibilities for action. Each participant is responsible for carrying out his/her piece of the plan and/or reporting back to the Chair or Integrated Case Coordinator if either the client's situation changes or the plan cannot be carried out. The date and focus of the next integrated case conference is set at the end of the meeting, although if the plan or client circumstances changes dramatically, a conference can be called earlier.

Clients are key participants in integrated case conferences. Consistent efforts have been made to involve clients, and young people are often present and encouraged to speak at the meetings (including 13-14 year olds). Clients request integrated case conferences frequently and often receive assistance from a trusted worker (either MCF or community based) in developing the participant list, or ensuring that, from their perspective, all key players are present.

Supervision for MCF staff is provided through the clinical supervisor for the team. The clinical supervisor needs to support decisions made at ICM case conferences and as such typically attends case conferences so as to be kept informed of the process and the decisions. Community partners are supervised by their respective agency supervisors.
The participating teams in this region have each developed a form/framework for recording integrated case conferences. The information captured by this form includes: the list of integrated case conference participants; the agenda or focus for the conference; the integrated service plan; and the date for the next meeting. Generally, these notes are written up by the case conference Chair and are distributed to all conference participants, including the family/client. The notes are seen as a valuable record of the plan and a mechanism for keeping everyone informed.

The file reviews reinforced the interview findings. There was evidence of some ICM notes but they are very new; there was little indication of ICM previous to the current initiative.

Summary

This review site is developmentally at an early stage in both the formation of the MCF integrated teams and in the implementation of ICM and as such is experiencing some of the typical types of transition concerns associated with change. At the same time, there are a number of champions of ICM within the region who have experience with this as a way of practice and who are committed to its implementation. In addition, a number of staff indicated that they have a long history of working collaboratively and are therefore comfortable with the concept and practice of ICM.

There has been an emphasis on the development of a model along with a staged introduction of ICM as a part of practice. Team leaders report that in addition, all teams are working on relationship building and there is an appreciation that the development of collaborative relationships takes time and needs nurturing.

Review Site C

Review site C is a mid-size community that is geographically quite diverse. There are four offices within the region, with integrated multi-disciplinary family service teams at each office. The family service teams are organized on an age-continuum: 0-12 (children’s team) and 13-19 (youth team). In addition there is a child protection/investigation team and a community living services team. There is a treatment services coordinator who is a psychologist and is responsible for supervision of treatment services across the area including addiction services. Discipline specific supervision was not raised as an issue in discussions at this site. Co-location has been achieved: social work, probation and mental health staff for each team are together and the alcohol and drug staff is in the office part time. While recently, there has been an increase in staff turnover and stress leaves, historically staffing has been stable.
Interviews in this site were conducted with clients, and a wide range of practitioners from MCF and community agencies, including the child team, youth team, managers, alternate school, daycare, and community family serving and youth serving organizations. There was considerable interest from all sectors in both participating in and learning from the review.

Professionals in this community have a 5-10 year history of working together. This has given rise to collaborative relationships, good communication and a sense of trust amongst the service providers. Historically, the Child and Youth Committee has taken an active role in promoting collaboration, peer consultation, and training.

In addition, there are strong, well-respected community agencies within this part of the region that have been practicing in a collaborative and integrated way for years. Contract restructuring has been seen as a way of creating teams in the contract sector that mirror MCF teams. The intent is to simplify the relationships, reduce the number of players in families’ lives, and streamline ICM.

This review site’s practice of ICM has developed organically and several models of ICM emerged within the community. Some of the different practice approaches were:

- ICM is occurring within some key community agencies. Some have developed their own process internally for doing ICM. This is proactive, and not in response to directives from MCF. One process involves weekly meetings of a multi-disciplinary, multi-agency team, to do check-ins regarding the entire group of clients involved with the relevant community agencies. The check-ins result in planning and follow-through to provide supports as needed to the client population.

- Another key community agency undertakes a review of all of its clients' progress on a quarterly basis, (presumably as part of its MCF funding requirement). The relevant team of multi-disciplinary professionals attends these case reviews, as does the client, in order to examine families' needs, and to determine whether the agency should continue its current level of involvement with the family.

- Within the MCF teams, practitioners observed that there is a tendency for ICM to be used when "the client's behaviour dictates (the relevant disciplines) getting together": in other words, case conferencing is "problem-focussed" and is employed when a client's problems/crisis involves multiple disciplines. Practitioners also indicated that case conferences were done "whenever the players were together", including as a part of risk assessments.
How and when clients are involved in case conferencing varies. While some workers stated that clients were, or should be, involved whenever possible, others expressed concerns and questions about how to involve clients without causing them to feel overwhelmed or intimidated.

There seems to be some lack of clarity and/or differences of opinion regarding both the role of the case manager, and how that role is assigned. Some workers see the role as logistical with responsibility for setting up the meetings, notifying participants, being recorders of case conferences; and distributing information. Others, particularly child protection social workers, see it as involving added responsibility. These social workers stated that their legal mandate and training requires them to assume the case manager role. This is problematic because it contributes to the feeling of being overworked. Nevertheless, there was overall agreement that with ICM, the case manager should be the person with the best relationship and an ongoing role with the client.

Practitioners also expressed discomfort with the term *case manager*. They found too much discrepancy between the philosophical underpinnings of working collaboratively, which they had established, and having a single point of authority which the term implies. They preferred to use the term *case coordinator*.

The review of client files revealed that there was little systematic recording of the work associated with ICM. Files sometimes did reveal a record of case conferences, going back several years; however, the degree of detail contained in these notes as well as their format seemed to vary greatly depending on the recorder. The distribution list for the notes was not evident. Moreover, case conference notes sometimes seemed to be primarily comprised of each involved discipline's report on the problems - and/or progress - of the client, rather than being focussed on developing a care plan and specifying each discipline's respective activities and responsibilities in relation to that plan.

There definitely was evidence of collaborative relations and practice amongst workers in the files, but the notes did not capture an overall, integrated care plan, nor spell out all the involved disciplines and workers associated with a particular client.

**Summary**

Developmentally, this site has a history of working within an ICM framework that has emerged more as an outgrowth of longstanding trusted relationships and peer consultation and training initiated by the Child and Youth Committee within the community, than on the basis of a structured process. As such, practitioners are experiencing the usual types of challenges associated with this stage such as how to better and more consistently include clients; how to develop more structure,
including a consistent format for documentation, and so forth. For example, while practitioners easily articulated the key elements of ICM, their articulation was based on historical relationships and an “organic” process of doing it rather than a formalized structure or process of development. One of the strengths in this site is the broad base of acceptance for ICM as a way of working that exists throughout the community.

As a result of the way in which ICM has emerged in this site, the process of developing a model of ICM has not occurred. As such, different methods of practicing ICM have evolved throughout the area, depending on which group, agency or practitioner is involved. Practitioners expressed an interest in moving forward with creating some structure to support the strengths that exist in order to provide more consistent documentation and follow-through.

**Review Site D**

Review site D is a small, rural community in an isolated section of the province. The MCF team has recently co-located and shares office space with the Ministry for Human Resources. Generalist child and family service/child protection social workers, mental health counsellors and an itinerant youth probation officer are in one integrated office that serves the community. Several community agencies are contracted to provide a variety of alcohol and drug, family and children's services, child care, supported child care, youth justice and health services for the area. Community health offices are in close proximity to the MCF offices. Co-location has not affected the already supportive relationships amongst MCF staff, although regionalization of some services that were formerly community based, such as alcohol and drug, adoptions, child and adult community living, has removed valued resources from the community and is seen to detract from the ability to include these people in ICM processes.

Clients and practitioners from MCF, including child protection social workers, mental health and probation, as well as those from the school, community agencies, public health, and Child, Youth and Family Committee participated in the review at this site.

The Child and Youth Committee initiated the use of integrated case management approximately five years ago. Committee members researched models, chose the Child and Youth Secretariat Integrated Case Management Model and then brought together staff from all child serving agencies in the region to participate in training. Since the initial training, the community has brought the author of the Child and Youth Secretariat model back to the community twice to facilitate a refresher on ICM, to help refine practice and problem solve with the community practitioners. Each time the training has addressed significant ICM practice issues
such as inclusion of clients, documentation, planning and monitoring plans, and conflict resolution.

The Child, Youth and Family Committee (CYFC), as it is now known, is still involved in monitoring the development and implementation of ICM in the community and its members are all "champions" of ICM within the management ranks of their own organizations. Many of these "champions" have lived and worked in the area for many years, thus lending continuity and stability to a culture of community support for children and families.

Developmentally this site has been working with a model of ICM for a number of years. Members of the CYFC have deliberately set about developing and practicing ICM in a reflective manner. As a community, the health, education and social services staff collectively critique their practice of ICM and seek outside help to facilitate improvements in their practice. ICM is used for difficult cases and the expectation is that the team will be working with these clients over the long term. Community practitioners have learned to ask clients who else is involved in their lives, and anyone can call an ICM meeting.

ICM is employed as a tool for early intervention and proactive planning. Sometimes ICM is initiated before a lot of service providers are involved when a client comes in with a complex set of issues. The client is asked if they would mind if other professionals attend a meeting to assess their situation and plan for intervention. The community has found that very few clients resist ICM, although some do express discomfort with having so many people involved. If clients are hesitant they are encouraged to ask a specific professional or friend to accompany them to act as an advocate.

The professional community is aware that too many players around the table may not be useful. In fact they take the presence of a large number of professionals as an indication that perhaps something is wrong with the system, a symptom of balkanization that needs to be addressed. They view a large meeting as a way of making an assessment and determining who is significant to the client(s) and who does not need to be actively involved.

The case manager’s role is primarily one of organizing the first meeting, completing the forms (assessment, plans and updates) based on decisions at ICM meetings, notifying absent members of the next meeting date and circulating information to all participants. Regular meeting dates are set four to six weeks in advance. Agendas are used inconsistently; they are sometimes developed at the meeting or flow from the routine of meeting regularly over an extended period of time.

Anyone can be the case manager and this is decided on a case by case basis. If a client is old enough and wants to take on the role then he or she will do so.
Although there are differing views about the statutory obligations of child protection social workers and probation officers to be case managers, there is clear agreement about the responsibility and accountability each professional has for their mandate and to carry out their part of the plan. The case manager needs to be someone who can be involved for a long time. Experience with ICM has taught practitioners in this area that when ICM teams start to flounder, it is often because no case manager has been appointed and forms are not being used consistently. They are clear that the case manager does not have decision-making authority outside the team or their own sphere of responsibility and does not monitor or supervise the work of others.

Supervision is provided by the worker’s own supervisors. Discipline specific supervision is not an issue for this group; they believe that it is “the role that is important not the discipline”. Lack of resources to pay for clinical supervision is an issue though, especially for the contracted agency.

Planning decisions are routinely made at ICM meetings. Therefore, participants are expected to know beforehand what some of the issues are, what resources are available, and whose approval is required. If approval from a supervisor is necessary, it is up to the practitioner to ensure that the supervisor attends the meeting. This site has also learned through experience that plans developed at an ICM meeting may not always be feasible and so they have developed a practice of setting out contingency plans or “Plan B” so that work can proceed within a range of agreed upon intervention options.

File reviews indicated inconsistent use of an ICM recording format despite at least five years of commitment to ICM and despite references to ICM meetings in case recordings. The ICM recording formats developed by the Child and Youth Secretariat (1993) are used for assessment, planning and monitoring. Documentation of ICM was not filed in all related client files. For example, the assessment, planning and monitoring forms would be found in the Family Service file but not the Child Protection file or they were found in the community agency files, (alcohol and drug or special services) but not in the MCF files. Where formalized ICM documentation existed, and because several clients have received ICM services for up to five years, it was possible to see the development of changes in practice over the years through changes of recording formats on file.

The documentation also includes identification of alternate plans (i.e. Plan B as well as Plan A), should the original plan not be feasible. Concrete planning and ongoing monitoring are seen as ways of moving the professional community beyond collaboration to integrated action in their work with clients, and the development of contingency plans supports this.

Summary
This review site has a long history of working together within an ICM model. They began many years ago by researching and selecting a model that was appropriate for their community and then identifying and requesting relevant training at certain stages of their development to help with implementation of their ICM practice. The service providers have well established, trusting relationships with each other and there are a number of key individuals within the community who provide leadership on ICM. They are supported by a strong and relatively stable community network, and a well established and respected CYFC. Members have worked through a number of practice issues over time such as the need for a case manager, when to call a case conference, communication, information sharing, disagreements, and client involvement. Their practice has become more “reflective” as they have gained experience with each other.

At the same time, practitioners recognize that there are areas of improvement. For example, they noted that they needed more discussion and agreement on a consistent documentation format, further resolution of mandates, ways of using ICM plans in a variety of other arenas such as the court system, how to terminate an ICM process, and documentation of outcomes.

Appendix D is a compilation of sample ICM documentation forms from the review sites and elsewhere.

3.2 Benefits of ICM

3.2.1 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.”

**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!"

3.2.2 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 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.

3.2.3 Outcomes of ICM 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."

"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."

3.3 Supports to ICM

Practitioners identified several factors that enabled and or supported ICM and a number of barriers to. These are briefly discussed below.
3.3.1 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 who might otherwise resist the implementation of ICM.

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.

### 3.3.2 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 which 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 that 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**
"Information sharing is a very confused issue. We've all heard things about the policy, etc. The question is: what should it be?"

“Information sharing across discipline boundaries has affected my relationship with my clients. They’ve become uncomfortable sharing personal information with me, knowing that it may come out.”

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**

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

"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 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.

3.4 Practice Support and Learning Needs

"I don't feel any need to be sent off to a training event called 'How to do integrated case management!' ...It's going to be trial by fire and that's fine."

“We don’t need more training….we need a chance to talk to one another and plan for how we are going to do ICM.”

In all of the participating sites in this review, regardless of the developmental stage in implementing ICM, practitioners stated clearly that mandatory, traditional curriculum based "training" on integrated case management was not what they desired or needed. They were concerned that a training package based on a single model of ICM for the province would not address their ‘hands on’ practice support needs nor the unique characteristics of ICM within each region. Furthermore, community agencies and service partners are seen as important participants in ICM and training needs to occur in a way and format that includes them.

Practitioners did, however, identify a number of important learning and support needs in relation to ICM. Many of these needs could be addressed by some types of “training” as long as the training was conceptualized as building on the strengths of each area, fully interactive, flexible, hands-on, and geared to the unique characteristics of ICM that had evolved based on the service delivery models of each region or community. Their comments on learning and support needs are presented below.

Setting time aside for relationship building, including opportunities to learn about the roles, responsibilities, philosophies, language, and available resources of the disciplines involved in ICM

"We need time spent in relationship building. Let relationships continue to develop. Integrated case management works out of the belief that it's essential to have time for that."

"Understanding what each of us does would really help in integrated case conferences."

"It would have been useful to have come together and have made a list of all of our resources, what we can access."

Practitioners spoke repeatedly about the importance of relationship building. Relationship building can occur both informally and socially, through, for example,
brown bag lunches, as well as through facilitated discussions and learning/training opportunities.

While allocating time for relationship building activities may appear to be a luxury, practitioners who worked in areas in which such activities occurred were able to speak to their lasting, positive benefits. For practitioners who are just learning about the roles and perspectives of the different disciplines involved in ICM, opportunities for facilitated discussions between multi-disciplinary practitioners are essential in order to identify and work through differences in language, practice orientation, and so forth. Such opportunities need to have a "training" or information exchange component, but perhaps more importantly, they must be open, interactive discussions, with a goal toward mutual understanding, respect and the development of common goals.

**Having opportunities to reflect on ICM practice**

"Having time to reflect on practice would be a good way to do it. I think having time is the biggest thing. Having time for reflection and for debriefing. That would be useful."

"Conferences that include all potential ICM team members need to occur regularly, to explore practice in concrete ways. For example, invite an expert in to some, and then plan how to use this information in specific ways in practice."

Many practitioners spoke of their need to have time to reflect upon and discuss ICM practice within their teams. These discussions would provide opportunities to debrief collectively, to examine what worked well and what did not, and to identify and work on any issues that seemed to present barriers to the implementation or positive outcomes of ICM. These discussions could also be opportunities to hear from clients regarding their experiences with ICM and their perceptions of its outcomes.

Practitioners emphasized that such discussions needed to be completely frank and move beyond "the polite phase". Clearly, this requires that professionals have already established trusting relationships and feel comfortable in sharing their concerns and possible differences of opinion.

Practitioners also suggested that some of these ICM practice discussions could involve an outside facilitator and/or "expert", someone who could share practice knowledge regarding ICM. For example, practitioners spoke of their need for particular skills central to ICM, such as group facilitation and conflict resolution. These types of skills could be the focus of interactive training and/or facilitated discussions, led by either an outside consultant, or someone from within the team with expertise in such areas.
Availability of ICM "Consultant" who provide hands-on guidance to practitioners in the region

“What would be wonderful, I think, would be to have someone who's done a lot of this to be available for consultation. Someone to whom I could say: here's the situation, here's the family; someone who could make suggestions for what I could do in a conference, particularly in volatile situations. That would be valuable.”

Along similar lines to having an "expert" come to some ICM practice discussions, practitioners spoke of their desire to have someone experienced in ICM available to advise them in a hands-on way, on difficult case-specific issues or questions. Several such "consultants" might be available on an on-call basis province wide. As part of the "hands-on" work, the consultant might chair or take notes in a case conference, and then facilitate a debriefing discussion with the participants.

Developing protocols/guidelines around the process/practice of ICM

"There needs to be a protocol in place that outlines such things as: the purpose of meetings and who facilitates meetings; contacts participants; terms of reference..."

"There needs to be clarity about what everyone's role is..."

"We were trying to sort out who the case manager was; it ended up being the person with the most involvement with the family. That's got to be part of the ground rules for the protocol."

“Another thing that's come up: we need an information sharing policy document. We need a clear, simple statement regarding info sharing across disciplines, across government. Especially for psychiatry, mental health workers, who feel that they have a different way of working with clients.”

A number of practitioners spoke of their desire for written protocols that formalized and provided guidelines for various aspects of ICM practice. The desire for protocols seemed to emerge most strongly in areas that were in relatively early stages of ICM implementation. Nevertheless, practitioners indicated that they would appreciate clarity on key elements and processes within ICM, such as information sharing and the role and assignment of the case manager.

Implicit in practitioners' discussion of protocols and policies were three key, related points. First, protocols would need to reflect the emerging model and process of ICM within a given region or area of the province. Second, practitioners at both the front line and manager levels needed to be involved in the development of the protocols. Third, in order to best support ICM practice, the use of protocols must be coupled with ICM reflective practice discussions. Protocols thus would be best viewed as living documents that likely would change and be refined on the basis on practitioners' accumulating experiences with ICM.
IV. CONCLUSION

The practice of integrated case management creates a team of people working together to support the best interests of a child, youth or other adult. ICM is more than a mechanism or means by which services can be accessed; the process becomes a service in itself that leads to better outcomes for practitioners and clients.

The key elements of ICM are:
- Common goals
- Wholistic approach
- Shared responsibility and accountability
- Shared decision making
- Trusting relationships
- Respectful and consistent involvement of clients
- Information sharing and frank communication
- Follow through and follow up
- Clarity of roles
- Proactive assessment, planning, review and implementation of case plans
- Multidisciplinary case conferences
- Mechanism for resolving conflicts
- Assignment of a case coordinator

These elements clearly indicate that both the conceptualization and practice of ICM are congruent with the five principles that guide the Ministry’s policy on integrated case management and integrated service delivery (see page two for a list of these principles.).

A relationship exists between the depth of understanding of the key elements and degree of experience practicing ICM. For those with little experience, these key elements constituted their vision; for others with more experience, these elements were enacted in their day to day work. Those who were practicing ICM were clear that the movement from the elements as vision to practice was based on continual reflection, discussion, and modification of practice.

As well, there is a natural developmental progression to ICM that was experienced by each region. Where ICM is newly emerging, there are numerous “beginning” stages of concern such as the grieving felt by staff, uncertainty about who should be involved and how, fostering of relationships, shared decision-making, sorting out of roles and so forth. With more experience with ICM practice, the focus shifts to working more on documentation, gaining trust with each other, more frank and open communication amongst ICM participants, sorting out how to do follow through, and so on. At some point the structure, practice and relationship challenges recede and the focus shifts to “fine tuning” types of activities.
There is not a single model of integrated case management, nor is there one approach that should or has been employed in the development of ICM practice. The most evident difference in approach is whether the starting place is relationship and trust building supported by adding structure (documentation, formalized process for meetings, criteria for initiating ICM) or whether the starting place is creating a structure including development of protocols, that is followed by relationship and trust building as the structure is implemented. The different starting places appear to be a result of the differing characteristics of the regions/communities. Some of the differing characteristics include history, size, location (urban/rural), organizational structures, leadership and contract restructuring processes. Regardless of the approach, in order to fully implement ICM it is clear from the experiences of the review regions that relationships, trust building and structure all need to be in place.

The successful implementation of ICM is a developmental process that requires time, effective support and a long term commitment at both the provincial and regional levels. It represents a shift in approach to practice that will take time to integrate and consolidate. The shift to ICM requires the presence of “champions” whose vision of ICM is clear and whose commitment is untiring. ICM is dependent on reflective practice that builds on experience and requires an ongoing investment in facilitated practice and learning opportunities that build on the practical experience of doing ICM. While by no means comprehensive, Appendix E provides a compilation of “ICM Practice Tips” that were noted during the process of data collection for this review.

Overall, there is agreement that ICM is appropriate and often necessary in all instances in which there are more than two services or professionals involved with a family. This guideline for ICM allows for proactive initiation of ICM that may reduce the length of time a client requires service. Similarly, there needs to be agreement that practitioners inquire at the time of intake, who is involved with the client and initiate ICM if more than two professionals are involved with the client.

While this review highlighted case conferencing as an aspect of ICM, it is clear that ICM is more than collaboration, case conferencing and co-location. It is the aggregate of all of these aspects as well as the key elements. As important as case conferencing, is follow-through, monitoring of plans, and ensuring that practitioners continually refer to the plan, and basing their practice on the plan.

The definition of the role of case manager requires clarification. There is incongruence between the principles that stand behind collaboration and teamwork, and assigning one member of the team as a single point of authority, which the name “case manager” implies. Many see the role as responsibility for setting up the meetings, notifying participants, being recorders of case conferences; and distributing information. They were clear however that the case manager did not have decision-making authority outside the team or legislated mandate. However, it was emphasized that the role of a case coordinator was a necessary component without which, ICM planning often went adrift.
Shared responsibility within the context of how ICM is being practiced, means that practitioners are accountable to each other and to clients for maintaining their part of the integrated case plan. This is a different type of accountability than is implied when there is a single point of authority, and is in keeping with the collaborative approach being fostered at all sites. Indeed, this way of practice strengthens accountability because ICM plans are developed and agreed to by a team and therefore each person’s accountability is openly scrutinized.

Discipline specific supervision was not raised as an issue in discussions about ICM. Supervision within integrated service teams may be an issue and is being addressed in different ways in the regions. However, these concerns were not part of discussions regarding ICM as participants receive supervision from their various team/agency supervisors. Clinical supervision in contracted agencies was raised as an issue as it is rarely provided for in contracts.

Documentation is a necessary part of ICM for focus, follow-through and review. However, the use of forms and documentation of meetings does not guarantee adequate ICM practice. Practitioners warned of the tyranny of forms and the ease with which forms could become an illusion of good practice without meeting the needs of clients. The use of documentation needs to support the process of ICM rather than become the end in itself.

There are a number of formats for documenting ICM. Missing from all the formats reviewed was evidence of measurement of outcomes or closure to integrated case management.

The current differing types of planning and assessment documentation required, and whether there is support for one assessment and planning document are issues that need attention by the central operating agency. While at the field level people are working in integrated service teams, the expectations for documentation centrally continues to be on a program by program basis.

Practitioners and clients readily identified outcomes of ICM. Of interest is the similarity between the outcomes that were expressed by clients and those expressed by practitioners.

For clients, some outcomes were concrete, such as enabling clients to get (faster) access to needed services and information, or enabling/ensuring that a child remained in school. Other outcomes were more psychological or feelings-based, such as enhancing clients' sense of self-worth, or engendering clients' sense that they were supported and that other people cared. For nearly all outcomes, it is interesting to note clients' frequent observation that ICM, or a case conference, "really helped", "made a difference", and/or "was important" - or, as one person noted, "We wouldn't be where we are today, if there hadn't been a case conference".
For practitioners, integrated case management has affected the ways in which professionals do, think about, and feel about their practice; the ways in which professionals relate to other service providers; and the ways in which professionals think about, and relate to, their clients. Not surprisingly, the more experience that practitioners have had with ICM, the more positive their discussion of outcomes. This has implications for implementation of ICM in that it is through the experience of doing ICM that practitioners gain an understanding of the benefits to their practice and workload. Practitioners who are not experienced with ICM often anticipate it will be time consuming and an increase to their workload. Indeed, as with anything new, shifting to an ICM practice approach initially may be more time consuming. However, as identified above, practitioners experienced with ICM have found that the proactive rather than reactive nature of ICM, reduces workload.

ICM has provided a mentoring experience for both practitioners and clients. It sometimes provides opportunities to develop creative solutions for client issues in a climate of decreasing resources. At the same time there is concern that decreasing resources is a constraint to ICM that will impact the implementation of effective action plans.

The enablers and barriers to ICM identified are often complementary. In many cases the enablers identified what could be done to reduce the barriers. Some of the major barriers identified were issues of staffing, workload and change within the Ministry. Staff’s experience of “grieving” and of feeling unsettled as a result of the reorganization of the Ministry and of their work environments, needs to be taken into consideration and acknowledged as much as possible as the implementation of ICM proceeds.

Practitioners identified a number of important learning and support needs in relation to ICM. They stated clearly that mandatory, traditional curriculum-based "training" on integrated case management was not what they desired or needed. They also identified a number of ways their support and learning needs could be met. There is no one model of support but a variety of means, including the establishment of ongoing, facilitated discussions on multi-disciplinary and ICM practice, peer mentoring/consulting relationship with practitioners experienced in ICM, and developing protocols regarding the process and practice of ICM. Community partners are an essential ally in ICM and need to be incorporated into training and support planning.
V RECOMMENDATIONS

Based on the information presented in the previous discussions of regional ICM implementation, outcomes, and identification of enablers and barriers and practice support needs for ICM, the following recommendations are made:

Central Policy and Standards

1. That policy development recognize and reflect regional differences and practices to allow for approaches to ICM that meet the unique needs of each region.

2. That practice standards for individual program areas should clearly link assessment and planning standards to ICM policy.

3. That the various risk assessments be reviewed in the context of multi-disciplinary and integrated service delivery to ensure linkages within the multi-disciplinary approach.

4. That managers at the regional and central level work with their counterparts in the other health and social policy ministries and community organizations to:
   - promote the understanding and use of ICM within those organizations; and
   - identify “champions” of ICM and multi-disciplinary practice in those organizations.

5. That MCF develop an information pamphlet and video on ICM for communication with clients and the general public.

6. That ICM policy and practice be introduced immediately into all mandatory MCF training for new workers.

Practice

1. That the minimum guideline for initiating an ICM process be when:
   - Two or more services are involved, and/or
   - A professional or the family believes that the client issues are sufficiently complex to warrant further services and professional involvement.

2. That within the context of provincial guidelines and standards, community protocols be developed to reflect the emerging ICM practice in that community. These protocols could address such things as assignment of case coordinator, a conflict resolution process, common intake responses, referral for specialized assessment or treatment, and so on. Practitioners and managers need to be involved in developing these protocols and a process to regularly reflect on and refine the protocols to bring them into line with practice experience should be established in each community or region.
3. That the title of case manager be changed to **case coordinator**.

4. That the roles and responsibilities of the ICM case coordinator (in some models this could be the Case Conference Chair) include:
   - Organizing of the first meeting with all participants;
   - Chairing and facilitating shared decision making at the ICM case conferences, including preparation of an agenda;
   - Ensuring that case assessment, plans, and outcomes are developed and responsibilities assigned;
   - Ensuring that reviews of client progress and the ICM plan occur at each meeting and that revised plans and responsibilities are assigned;
   - Updating and distributing ICM case conference documents to all participants after each ICM case conference;
   - Ensuring that progress, achievement of goals and outcomes is tracked and documented;
   - Establishing a schedule for ICM case conferences;
   - Ensuring that absent participants are notified of next meeting.

5. That the role of child protection workers and probation officers, as case coordinators, be reviewed and clarified within the context of their mandated responsibilities.

6. That the practice relationship between all discipline-specific risk assessments and ICM be clarified for workers in the field.

7. That ICM be used as an approach for early intervention in order to assess the need for and deliver the appropriate level of service as early as possible.

**Documentation**

1. That documentation requirements regarding assessment and care plans by program areas be integrated in order to support integrated teams at the field level.

2. That guidelines for documentation should be established provincially to guide regional or local development of document formats. This should be viewed as a developmental piece to allow for emergence of “best practices” in recording formats for ICM. For those regions that do not wish to develop their own documentation formats, sample formats should be provided centrally.

3. That documentation for ICM be comprehensive and reflect all dimensions of a person’s life and include:
   - an assessment format;
   - a planning format that establishes client and ICM outcomes, time frames and responsibility for actions;
• a monitoring format that documents progress, changes, contingency plans, and assigns new tasks and responsibilities;
• case transfer or closure formats that document progress to date, reason for transfer/closure and recommended next steps as appropriate, as well as presenting an evaluation of the effectiveness of the ICM process.

4. That all regions have the capacity to implement computerized ICM recording and electronic transfer of documents to all members of the ICM teams.

5. That MCF review and rationalize the filing requirements in light of ICM policy and practice.

Practice Support and Learning

1. That a facilitated self-assessment process be developed for MCF integrated teams to identify what supports they need in order to implement or refine their ICM practice. The self-assessment should be based on the key elements of ICM. The facilitation should assist in the process of reflection on practice and relationship building. The outcome of this self-assessment would be a training plan for ICM implementation or refinement in their region or community. A sample framework for an ICM self-assessment is provided in Appendix F.

2. That once the self-assessment is complete, MCF support facilitation of the regional/community training plan. Such strategies as team building, facilitated workshops, regional conferences, knowledge and skill development training are some examples of facilitated supports that may be necessary. Specific topics may include professional roles and responsibilities, language, philosophy, practice modalities, client involvement, information sharing, documentation, conflict resolution, resources available locally, regionally, and provincially and how to access them; and so on. Administrative support staff need to be involved in this process as well.

3. That MCF organize regional mentoring opportunities for regions who have some experience with ICM to work with other regions who are not as experienced. These mentors could also act as consultants to practitioners on an ongoing basis.

4. That within each region someone is assigned responsibility to oversee and act as a consultant to the implementation and ongoing practice of ICM.

5. That MCF ensure administrative supports such as inclusion of ICM in job descriptions for MCF and community agency practitioners, writing expectations for ICM in contracts and protocol agreements with other agencies, organizations and individuals, and ensuring adequate facilities to conduct ICM case conferences are in place to support ICM.
6. That MCF routinely collect and distribute examples of regional approaches to ICM for information and use by other regions.

ICM Outcome Evaluation

1. That MCF develops a framework for ongoing evaluation of ICM implementation and practice. This evaluation framework should include outcomes for clients, practitioners, the process, and identify organizational impacts.

ERRATA

On page 15, an error appears in the last sentence on the page. The sentence currently reads: “While some workers stated that clients were, or should be, involved whenever possible, others” It should state: “While some workers stated that clients were, or should be, involved whenever possible, others expressed concerns or questions about clients’ involvement and thought that clients might feel intimidated by attending integrated case conferences.”

On page 17, the first three lines at the top of the page should be ignored. They are a repeat of the last three lines on page 16.

On page 35, in the first paragraph following the list of key elements, the reader is referred to page two of the report for a list of the five principles that guide the Ministry’s policy on integrated case management. The list of five principles is found on page one of the report.
Appendix A

"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 interdependent
- 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 judgment 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.
Review of MCF Regional Integrated Case Management
Client Interview Questions

1. What types(s) of assessment and/or service(s) did you get from the Ministry?

2. What was your experience in getting, or trying to get, service?

3. How were you involved (e.g. in planning for services? Did you ever come to care planning meetings with mcf worker(s) and/or other service providers?)?

4. Who else was involved?

5. Did you know who the case manager was?

6. Did you know who you could go to, to answer your questions and coordinate what was needed?

7. Was it clear to you that the various service providers were co-ordinating what they did - their working together?

8. Were your needs met by the service?

9. What did you like (about the service)?

10. What could have been done differently?

11. Based on your experience, were there any duplication or overlaps in service?

12. Based on your experience, were there any service(s) that you would have liked to receive, but were not available?
Review of MCF Regional Integrated Case Management

Focus Group Interview Questions
Site Practitioners

1. What do you consider to be the characteristics of integrated case management?

2. Who participates in your integrated case management model?

3. How is your case management model supervised?

4. How is communication ensured within your icm model?

5. How is documentation organized/carried out within your icm model?

6. What difference has integrated case management made to your practice?

7. What needs do you have for training and support in relation to integrated case management?
## Integrated Case Management Project
### Draft File Review Protocol

Review #:______  
Other relevant files:
- 
- 
- 

### File Type:  (i.e. F&CS, Community Living, CP, Mental Health)

### Reason for service:

### Demographics:
- Service recipient:  age_________  F _  M _
- Number of children________  Gender and ages:
- Living situation:

### Integrated case management:
- Professionals involved in the care plan and/or case conference

What are their roles?

Were clients involved in the care plan/case conference?  Y  N
What is their role?
<table>
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<th>Documentation:</th>
<th>Notes</th>
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<tr>
<td>Case manager identified:</td>
<td>_ Yes _ No</td>
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<tr>
<td>Care plan evident:</td>
<td>_ Yes _ No</td>
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<tr>
<td>Reviews done</td>
<td>_ Yes _ No</td>
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<tr>
<td>Case conferences held</td>
<td>_ Yes _ No</td>
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<tr>
<td>Case conferences documented</td>
<td>Yes _ No</td>
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<td>Follow-up documented</td>
<td>_ Yes _ No</td>
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Type of information on file

Location of file:

Similar documentation across files when multiple files open? Y N

Comments:
Outcomes:
Client outcomes

Outcome of integrated case management meetings
Review of Regional Integrated Case Management

PARTICIPATING SITES CONSENT

Our organization _____________________________ has consented to permit the above titled research project to take place at our organization and for Deborah Rutman, Carol Hubberstey, Sharon Hume, Betty Tate and/ or Brian Wharf to participate in and observe the activities, access documents, interview practitioners and service users and discuss findings of our organization during the following time period: January 1998 to June 1998

We fully understand that no interviews or focus groups will occur without the signed, informed consent of the practitioner(s) or service user(s) in question. We have reviewed and approved consent forms developed for the purpose of participation in this research project.

We support the voluntary nature of participation both of our employees and clients and also their right to withdraw their participation at any time during the research. We further approve the precautions the researchers have put in place that are intended to maintain confidentiality of information obtained through the evaluation process.

We further understand that the observations and impressions of the researcher(s) will be shared with our organization and we will have opportunity to confirm these prior to the writing of the final report.

DATE:  __________________________________

ORGANIZATION: __________________________________

REPRESENTATIVE: __________________________________

SIGNATURE: ________________________________

print name: __________________________________

RESEARCHER: ________________________________
THIRD PARTY REFERRAL RELEASE FORM

I give ______________________________ permission
(name) at ____________________________ (organization)

to give my name and contact number to Deborah Rutman, Carol Hubberstey, Sharon Hume or Betty Tate, who are working on an Review of Regional Integrated Case Management. I understand that by agreeing to speak with the researcher(s) I am not committed to provide any further information until I am more fully informed and have actually consented to participate in the project.

Date: __________________________

Signature: __________________________

Person willing to be contacted: __________________________

Contact location/number: __________________________
PRACTITIONER CONSENT FORM  
(for focus groups and individual interviews)

I understand that the Review of Regional Integrated Case Management project is looking at how services are coordinated amongst service providers from varied disciplines and what the experience is of parents, families, youth and individuals who make use of those services. I understand that I will be asked to discuss my experience in providing services.

I understand that my participation is completely voluntary and that I can, without explanation, withdraw from the study at any time. Should I have any questions or concerns, I understand that I can call Deborah Rutman, Carol Hubberstey, Sharon Hume or Betty Tate collect at (250) 721-8202.

I understand that any information collected in the study will remain confidential; interview results and questionnaires will be kept in a locked filing cabinet in a locked room. A secretary may transcribe the interview, however, I understand he/she will not have access to identifying information. Furthermore, I understand that my name will not be attached to any published results, and that my anonymity will be protected by using code numbers to identify the information gathered from individuals. Should I withdraw my participation mid-stream, I understand my data will be destroyed. I understand that the project is not intended to be a performance review, and that my relationship with my employer will not be affected by participation in this study.

I understand that my interview may be audiotaped and that the tape will be erased immediately after it has been transcribed, and that all information collected from this interview will be destroyed within 6 months. I also understand that if I do not wish to have my interview taped, I can refuse to do so and that I can still participate in the study.

I have received a copy of this consent form, and know how to contact the researchers in the future if I have questions or concerns.

DATE: ____________________________
SIGNATURE: ____________________________
RESEARCHER: ____________________________
FOCUS GROUP CONTRACT

Each of us who have signed below understand we have consented to participate in this group discussion for the review of regional integrated case management.

We understand and agree that the information, feedback, and opinions expressed by members of our group will be held in strict confidence by all of us and that we will not talk about each other’s stories without their permission. In addition, we agree not to hold any of the information, feedback, or opinions expressed by any person in the group against that person in any way.

We also understand that all the information contained in our individual consent forms also applies to the group interviews as well.

<table>
<thead>
<tr>
<th>Name of group member</th>
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Review of Regional Integrated Case Management

FILE REVIEW CONSENT FORM

The Ministry for Children and Families has initiated a review of collaborative service planning, and your region is one of the participating communities for the project. The Review of Regional Integrated Case Management project is looking at how services are coordinated amongst service providers from varied disciplines and what the experience is of parents, families, youth and individuals who make use of those services.

As part of this project, I understand that I have been asked to give my permission to allow the researchers to review my service file. **I understand that files will be reviewed only in order to see how the work associated with doing integrated case management is being documented.** I also understand that my personal history and circumstances are **not** the focus of the file review.

I understand that any information collected from my file and in the study will remain confidential; the information will be kept in a locked filing cabinet in a locked room. Furthermore, I understand that my name will not be attached to this information or to any published results, and that my anonymity will be protected by using code numbers. Should I withdraw my participation mid-stream, I understand my data will be destroyed.

**I understand that any services I am using now, or may need in the future, will not be affected by my giving or withholding permission to review my file.**

Should I have any questions or concerns, I understand that I can call Deborah Rutman, Carol Hubberstey, Sharon Hume or Betty Tate collect at (250) 721-8202.

I have received a copy of this consent form, and know how to contact the researchers in the future if I have questions or concerns.

DATE: ____________________________
SIGNATURE: ____________________________
WITNESS: ____________________________
Review of Regional Integrated Case Management

SERVICE USER CONSENT FORM

I understand that the Review of Regional Integrated Case Management project is looking at how services are coordinated amongst service providers from varied disciplines and what the experience is of parents, families, youth and individuals who make use of those services. I understand that I will be asked to discuss my experience and/or those of my family in receiving services.

I understand that my participation is completely voluntary and that I can, without explanation, withdraw from the study at any time. Should I have any questions or concerns, I understand that I can call Deborah Rutman, Carol Hubberstey, Sharon Hume or Betty Tate collect at (250) 721-8202.

I understand that any information collected in the study will remain confidential; interview results and questionnaires will be kept in a locked filing cabinet in a locked room. A secretary may transcribe the interview, however, I understand he/she will not have access to identifying information. Furthermore, I understand that my name or my child’s name will not be attached to any published results, and that our anonymity will be protected by using code numbers to identify the information gathered from individuals. Should I withdraw my participation mid-stream, I understand my data will be destroyed. Any services my child is receiving now, or may need in the future, will not be affected by participation in this study.

Should I decide to participate in the evaluation, I understand that I will be paid an honorarium of $25.00 for my expenses. I understand that my interview may be audiotaped and that the tape will be erased immediately after it has been transcribed, and that all information collected from this interview will be destroyed within 6 months. I also understand that if I do not wish to have my interview taped, I can refuse to do so and that I can still participate in the study.

I have received a copy of this consent form, and know how to contact the researchers in the future if I have questions or concerns.

DATE: ____________________________

SIGNATURE: ____________________________
STATEMENT OF UNDERSTANDING
for
PARENTS OF CONSENTING YOUTH

I understand and acknowledge that my child, ________________ being competent
to consent on his/ her own behalf, has agreed to participate in the Review of
Regional Integrated Case Management project. I understand that he/ she has been
informed of his/ her rights as outlined below:

I understand that the Review of Regional Integrated Case Management project is looking at how
services are coordinated amongst service providers from varied disciplines and what the
experience is for the parents, families, youth and individuals who make use of those services.
I understand that I will be asked to discuss my experience in receiving services.

I understand that my participation is completely voluntary and that I can, without explanation,
withdraw from the study at any time. Should I have any questions or concerns, I understand that
I can call a member of the evaluation team: Carol Hubberstey, Deborah Rutman, Sharon Hume or
Betty Tate collect at (250) 721-8202.

I understand that any information collected in the study will remain confidential; interview
results and questionnaires will be kept in a locked filing cabinet in a locked room. A secretary
may transcribe the interview, however, I understand he/ she will not have access to identifying
information. Furthermore, I understand that my name will not be attached to any published
results, and that my anonymity will be protected by using code numbers to identify the
information gathered from individuals. Should I withdraw my participation mid-stream, I
understand my data will be destroyed. Any services I am using now, or may need in the future,
will not be affected by my speaking with researchers.

Should I decide to participate I understand that I will be paid an honorarium of $25.00 for my
expenses. Should I decide to participate in a focus group, I understand that a contract of
confidentiality will be signed by all group members in an attempt to ensure that the information
shared together will remain within the group. I understand that my interview may be audiotaped
and that the tape will be erased immediately after it has been transcribed, and that all information
collected from this interview will be destroyed within 6 months. I also understand that if I do not
wish to have my interview taped, I can refuse to do so and that I can still participate in the study.

I have received a copy of this consent form, and know how to contact the researchers in the future
if I have questions or concerns.

DATE: ______________________________

SIGNATURE: ______________________________

Review of Regional Integrated Case Management
funded by: Ministry for Children and Families
conducted by: Child, Family and Community Research Program
University of Victoria
CONSENT FORM for
PARENTS OF PARTICIPATING YOUTH AGED 12-15

I understand that my child,_________________, has been invited to participate in the Review of Regional Integrated Case Management project. I understand that he/she has been informed of his/ her rights as outlined below:

I understand that the Review of Regional Integrated Case Management project is looking at how services are coordinated amongst service providers from varied disciplines and what the experience is for the parents, families, youth and individuals who make use of those services. I understand that I will be asked to discuss my experience in receiving services.

I understand that my participation is completely voluntary and that I can, without explanation, withdraw from the study at any time. Should I have any questions or concerns, I understand that I can call a member of the evaluation team: Carol Hubberstey, Deborah Rutman, Sharon Hume or Betty Tate collect at (250) 721-8202.

I understand that any information collected in the study will remain confidential; interview results and questionnaires will be kept in a locked filing cabinet in a locked room. A secretary may transcribe the interview, however, I understand he/ she will not have access to identifying information. Furthermore, I understand that my name will not be attached to any published results, and that my anonymity will be protected by using code numbers to identify the information gathered from individuals. Should I withdraw my participation mid-stream, I understand my data will be destroyed. Any services I am using now, or may need in the future, will not be affected by my speaking with researchers.

Should I decide to participate I understand that I will be paid an honorarium of $25.00 for my expenses. Should I decide to participate in a focus group, I understand that a contract of confidentiality will be signed by all group members in an attempt to ensure that the information shared together will remain within the group. I understand that my interview may be audiotaped and that the tape will be erased immediately after it has been transcribed, and that all information collected from this interview will be destroyed within 6 months. I also understand that if I do not wish to have my interview taped, I can refuse to do so and that I can still participate in the study.

I have received a copy of this consent form, and know how to contact the researchers in the future if I have questions or concerns.

In view of my understanding of the above, and in view of my child’s desire and informed consent to participate in this project, I give my permission for my child's participation in this research.

DATE: ______________________________
SIGNATURE: ______________________________
RESEARCHER: ______________________________
Review of Regional Integrated Case Management

Verbal Introduction of project to potential participants

As you may know, the Ministry for Children and Families has initiated a review of collaborative service planning, and your region is one of the participating communities for the project. The Review of Regional Integrated Case Management project is looking at how services are coordinated amongst service providers from varied disciplines and what the experience is of parents, families, youth and individuals who make use of those services.

The review aims to identify
• ways in which collaborative service planning is occurring
• how clients are involved/ included
• what kinds of supports are needed by staff
• what kind of training is required by staff

We would like to stress that your participation is voluntary and will not affect any relationships you have now or in the future with this organization. Also, you are free to withdraw your participation at any time. The information you provide will be kept confidential. Further, please attempt to consider the protection of privacy of other individuals you may refer to doing the interview(s) by not using their name(s).

Do you have any questions?

Would you be willing to participate in a 1-1 interview?
INTEGRATED CASE MANAGEMENT SERVICE PLAN

Name of Child or Youth ____________________________________________
Date ______________________________________
Present:
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Date of next meeting ____________________________________________

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<th>STRENGTHS</th>
<th>CONCERNS</th>
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<tr>
<th>GOALS</th>
<th>ACTION PLAN</th>
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## BARRIERS TO ACHIEVE ACTION PLAN

<table>
<thead>
<tr>
<th>REVISED ACTION PLAN</th>
<th>PERSON RESPONSIBLE</th>
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INTEGRATED CASE MANAGEMENT SERVICE PLAN

Name of Child or Youth: ________________________________
Date: ________________________________

Present:

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<th>STRENGTHS</th>
<th>CONCERNS</th>
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Date of next meeting: ________________________________

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<tr>
<th>GOAL AREAS</th>
<th>STRATEGIES</th>
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<th>ACTION PLAN</th>
<th>PERSON RESPONSIBLE</th>
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MCF MULTI-DISCIPLINARY CASE MANAGEMENT REFERRAL

Date:_______________________

Referral made by: (name, agency, phone number)

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<tr>
<th>Family:</th>
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<tbody>
<tr>
<td>Adults(s):</td>
<td>Address:</td>
<td>Phone:</td>
<td>DOB:</td>
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<table>
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<tr>
<th>Child(ren)/Youth:</th>
<th>Address:</th>
<th>Phone:</th>
<th>DOB:</th>
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Description of concern/reason for referral to integrated case management:

please turn over
Suggested Professionals/Advocates/Personal Support network to participate in case conference:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Agency:</th>
<th>Phone number:</th>
<th>Currently Involved?</th>
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<td>Yes     No</td>
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 Interpreter Required:______________ Language:______________

The following is a list of some possible participants in an integrated case conference for consideration when making a referral:

- Family/friends
- MCF Family Services
- Youth Probation
- Services to People w/ Mental Handicaps
- Guardianship/Adoption
- Guardian/Adoption
- Advocacy Agencies
- Ethno-cultural Agencies
- Addictions
- Mental Health
- Community Health
- School
- Aboriginal Agencies
- Hospital/Physician
- Neighbourhood Houses
- Psychologist
- Churches
- Psychiatrist
- Family Place
- Income Assis.
- Homemaker
- Comm. C's
Integrated Case Management Information Sheet

Date of Conference:____________________________________________________

Case Coordinator:______________________________________________________

Family:_______________________________________________________________
Adult(s)_______________________________________________________________

Address:________________________________________________________________

Child(ren):_____________________________________________________________

Address:________________________________________________________________

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<tr>
<th>Name</th>
<th>Relationship/Agency</th>
<th>Phone</th>
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<th>Address</th>
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Invited but unable to attend:_______________________________________________
# Integrated Case Management Plan

Name:  
Date:  

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<tr>
<th>ITEM</th>
<th>GOAL</th>
<th>ACTION/SERVICE TO BE PROVIDED BY WHOM</th>
<th>COMPLETION DATE</th>
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Service Gaps: ____________________________________________________________

Future Conference: _______________________________________________________

Chairperson: _________________________

Case Coordinator: ________________________
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.
Sample Framework for ICM Self-Assessment

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?

√ Has everyone, 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 community in order to advance the implementation of ICM in your area?

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 serves as 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?
Wholistic approach to working with clients

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

√ What does having a "wholistic approach" look like in your community (discuss examples based on practice)?

√ How does having a wholistic approach contrast to other ways of working with clients?

Do your answers suggest that issues concerning a wholistic 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, etc.)

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 discipline 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?

**Multi-disciplinary case conferences**

Reflect upon the multi-disciplinary 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 multi-disciplinary 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 multi-disciplinary case conferences occur proactively in your office/community?
- √ Does the multidisciplinary case planning include an assessment phase that identifies strengths and issues to be addressed?
- √ Is multi-disciplinary 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, i.e., is the case plan the centrepiece of the notes on the meeting?

√ Are contingency plans routinely developed and documented as part of the multi-disciplinary case conference?

√ Does a mechanism exist to ensure that, when aspects of the plan cannot be carried out, and/or when a client's circumstances 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 multi-disciplinary 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 strengths in ICM?

Based on the above Self-Assessment, what are your priority needs for ICM training/practice support?

1. 2.

3. 4.

5.
What types of training/practice support do you think would be most useful in addressing these priorities? For example, facilitated discussions, workshops, case-specific consultations, skill-based training.

What are the resources and time frames needed to accomplish the training and practice supports?
VII. References


