Youth Voice in Integrated Case Management: What helps and what Hinders?

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Supervisory Committee

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Abstract

This study explored what helped and hindered youth participation in Integrated Case Management, a form of collaborative practice. Semi-structured interviews were conducted with 10 youth, age 15 to 17, who were receiving mental health services and had an active care team. Data was analyzed using the Critical Incident Technique (CIT) initially developed by Flanagan, (1954) with elaborations proposed by Butterfield, Borgen, Amundson, and Maglio, (2005). 278 incidents were recorded: 138(49%) were helpful incidents, while 140(51%) were hindering incidents. Incidents were organized into 7 categories and 21 subcategories. The categories were: (1) the team was collaborative; (2) the team was solution-focused and strengths-based; (3) the team involved the youth and accepted their input; (4) the team made youth feel connected; (5) the team was authoritarian; (6) the team was disorganized and confused; and (7) the team felt unsafe. Rutman, Hubberstey, Hume, and Tate (1998) found collaborating, communicating, and focusing on strengths when looking for solutions was found to be a fundamental aspect of Integrated Case Management. Similarly, in this study both helpful and hindering categories revealed that youth valued Integrated Case Management when they experienced respect and understanding in a quality team environment with a clear and organized structure. When meetings denied their voice or treated them like a problem, they would challenge the value of their inclusion in the process. This work concludes with ten suggestions for successful care teams, based on the distilled responses from the youth participants.
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Chapter 1

Introduction

History of the Ministry of Children and Family Development

On October 3, 1986, Matthew John Vaudreuil was born in the northern British Columbia community of Fort St. John. Five and a half years later, on July 9, 1992, he died in Vancouver. Throughout his life he was a client of the Ministry of Social Services. The public learned some of the details of his life and death in the spring of 1994, after his mother pled guilty to his manslaughter. Many people were outraged, some called for accountability, and others demanded the resignations of public officials who were involved. (Gove, 1995, Letter of Transmittal Paragraph 6).

In 1994 Judge Thomas Gove was commissioned by the British Columbia Government to investigate Matthew Vaudreuil’s death. His findings were shared with the public through the “Report of the Gove Inquiry into Child Protection in British Columbia”; this document consists of two volumes. Volume one, Matthew’s Story, details Matthew’s journey through abuse and neglect, including lack of communication and lack of collaborative practice by professionals serving Matthew and his mother. Volume two, Matthew’s Legacy, identifies issues needing to be addressed to ensure that no other children in British Columbia suffer the same fate as Matthew. The Gove Report (1995) concluded with 118 recommendations; one significant recommendation was to move responsibility for children and family from five separate Government Ministries into one umbrella Ministry, initially called the Ministry of Children and Families, and
later changed to the Ministry of Children and Family Development (MCFD). MCFD was designed to increase accountability and focus on a collaborative multidisciplinary approach to practice, with different disciplines working together with a family to meet child needs of safety and wellbeing. Gove (1995) also made further recommendations, which became a focus of this study: “A child 12 and over must be consulted by the director. The inquiry concludes that all children capable of forming their own views should be consulted and their views should be considered” (1995, p.2). For consistency throughout this report child and youth are synonymous and describe people between the ages of 14 and 19 years of age.

What is Collaborative Practice?

After the Gove Report (1995), the Ministry of Children and Family Development was born, and “Multidisciplinary Teams” (Anglin, Artz, Charlesworth, & Nicholson, 1998, p. 2) were the only form of collaborative practice available to child welfare staff. Today collaborative practice has evolved to provide MCFD staff with four forms of collaborative practice: Integrated Case Management (ICM), Family Group Conference (FGC), Family Development Response (FDR), and Ulysses Agreement (advanced plans for families who have a parent with a mental illness). Each is undergirded by the values inherent to collaboration, while offering subtle differences that allow each to respond to unique child welfare concerns: physical, mental, or sexual abuse; neglect; poverty; debilitating family stress; child mental health issues; and parental mental illness.

The focus of this report will be on youth participation in Integrated Case Management in the Fraser Region. The Fraser Region is one of five program areas of MCFD. The region is geographically bounded by Burnaby (West) and Boston Bar (East)
within the Lower Mainland; it is the most populous administrative region of BC with an estimated population of 1.3 million, including numerous cities and small communities spanning urban to rural. I will briefly review other collaborative practices before completing a more detailed description of ICM.

**Collaborative Practices in the Fraser Region of MCFD**

One of the MCFD collaborative practices available is Family Group Conference (FGC). FGC, a concept that originated in New Zealand, is based on traditional Maori culture (Bazemore, Griffiths, & Taylor, 1997). The approach was first legislated in New Zealand’s 1989 *Children, Young Persons and Their Families Act*. This law emphasizes family responsibility for children in the area of safety and rights, respect for cultural diversity, and community-government partnerships for the benefit of children and young people (Pennell, 2004, p. 121).

In British Columbia the FGC is chosen by the family social worker, with the agreement of the family, after an investigation of a child welfare concern – a child is in need of protection (Ministry of Children and Family Development [MCFD], 2005, p. 2). The mechanism is meant to work with the family so that it can assume an active role in dealing with a child protection issue, such as physical or mental abuse, neglect, poverty, and debilitating family stress. It is key in FGC that the family agree that a child protection issue is present and that they are willing to expand their natural resources of extended family, neighbours, and friends to address the concern (Bazemore et al., 1997; Scheiber, 1995) The FGC process moves the child protection activity away from confrontation and state-imposed measures towards family engagement and family decision making (MCFD, 2005).
An FGC worker is responsible for organizing and convening a one-time conference but does not carry responsibility for the case as the family social worker. Although FGC workers are MCFD employees, they do not have access to the family’s confidential file. This requires the FGC worker to meet with all of the FGC participants (family and professionals) to hear each person’s view of the child protection issue and to educate them on the FGC process. Having FGC workers fill one role with the family avoids confusion and helps them focus on how to plan for the conference rather than negotiating services or revisiting the State’s view of the child protection issue (Pennell, 2004)

The Family Group Conference emphasizes an extensive preparation process before the one-time meeting and focuses on voluntary participation. The parents or key family members are asked who they wish to attend and where they would like to meet, often a neutral community place such as community meeting rooms, hotel conference rooms, or library meeting rooms. Meetings are broken into a number of specific components: presentation of the child protection issue, presentation of professional services used or offered, nutrition break, family time, and development of a family plan. Family time, the unique aspect of FGC, is an opportunity for the family to meet alone for the purpose of developing a plan that addresses the child protection issue themselves. If the plan meets all of the child protection issues it can quickly be moved by the state to become a closed file.

where investigation is not required (Ministry of Children and Family Development [MCFD], 2004, p. 6). The rationale for FDR revolves around the need to find alternative non-confrontational ways to meet a child’s safety and well-being while focusing on building the capacity of the family to manage future challenges. At the heart of the FDR is a shift away from a high reliance on investigation and removal of children from their families as the primary response to keeping children safe, to community-based options for keeping children safe within their families and communities (MCFD, 2004).

FDR is for cases where the child is assessed at lower risk yet the family needs support services to keep the child safe. The FDR worker can in some cases be a government child protection social worker but can also be a worker from a non-profit agency contracted to offer the FDR service. Due to a mixture of skill levels, training and locations of the FDR service in the Fraser Region, FDR can vary from community to community. That said, all FDR work should share the collaborative, solution-focused development of a family plan, and a comprehensive assessment based on family needs and strengths. The FDR case remains open while a worker works with the family. The expected timeframe for the FDR process to be completed is 90 days; it can be extended but requires a reassessment process first (MCFD, 2004).

A third choice available to MCFD staff for Child welfare concerns is Ulysses Agreements (UAs). UAs are advanced plans for families affected by parental mental illness, designed to meet the child welfare concern in the areas of child protection and child mental health. UAs, unlike the other collaborative processes, are currently offered only in the Fraser Region through a facilitator contracted by British Columbia Schizophrenia Society
In 2003, Child and Youth Mental Health (CYMH), a division of MCFD, developed a five year mental health plan for the province of British Columbia. There were many focuses for this plan: increasing staff levels, implementing evidenced based practice, improving resources to families, and improving relationships between agencies serving youth (Child and Youth Mental Health [CYMH], 2003, p. 5). CYMH Fraser Region chose Ulysses Agreements to meet the plans, required improvement of resources to families. A Ulysses Agreement is an important tool for parents who have a mental illness with recurrent symptoms; it provides a way for them to make plans for the care of their children in case they suffer a relapse. When parents prepare an advance plan, their family, friends, and community can come forward to help sooner, in alliance with the parent’s wishes for the best possible care for the children. Advance planning addresses both the needs of the children for ongoing care and the need for the parent to maintain their own health so as to provide care and continuity for their child. The process of developing the plan also helps the family develop a committed, responsive network of support that understands the parent’s unique expression of mental illness.

An important feature of advance plans is to allow parents to communicate their children’s particular care needs. This minimizes disruption for the child, and ensures that allergies and medical needs, preferred toys and activities, usual routines, and helpful relationships are maintained (Ulysses Agreements).

Developing an advance plan is often suggested by an MCFD social worker, CYMH Clinician or Adult Mental Health Clinician when there is a child welfare concern. These plans are voluntary in nature and have no legal merit; however, they can work well because they are a chosen collaborative process led by parents. The process can be
therapeutic in itself, as the parents’ support system understands the impact of mental illness on the child, and takes steps to build an informed support network for the family.

Parents who have made such a plan have been surprised at the positive response of friends or family when asked to make a commitment to help in the case of a future crisis. Friends, family and community workers often stand back when problems related to the illness are developing, wanting to help, but worrying about going against the ill parent’s wishes. Knowing in advance what role the parent would like them to take gives people confidence that they are doing the right thing (“Ulysses Agreements,” p. 2). At the time of writing this report there has been no empirical research about the practice; however, an evaluation is underway for the British Columbia Schizophrenia Society, as part of a Masters thesis.

**Integrated Case Management**

Integrated Case Management (ICM) is a regular meeting (an extraordinary meeting can be called by any member of the family team) for the purpose of information sharing and treatment planning for a child. The *family team* can consist of professional and non-professional people who are connected to the child’s life: family, community, school, mental health, and child welfare among others. ICM is often used when a child has persistent child welfare and/or child development concerns. ICM can occur when a child has a unique concern; however, it is less likely used in situations where one of the other practices fits the concern better.

The Gove Report (1995) reviewed case files held by the Ministry of Social Services and observed that “Social workers frequently do not coordinate plans, monitor performance of contracts or evaluate the quality of service provided by community
agencies” (Gove, 1995, p. Vol.2, p.2). Further, Gove noted that “The inquiry discovered that there is serious confusion and disagreement within the ministry respecting access to and sharing of important case information” (Gove, Vol.2, p.2). Both of these issues indicate the need for structures that facilitate collaboration. The rationale for structures to support collaboration in recommendation 29 is that the ministry should systematically audit the manner in which child welfare services are delivered, to ensure that provincial standards are being met or surpassed. This organizational structure built around continuous quality improvement of collaborative practice appears to have led to an evolution from “Multidisciplinary Teams” to Integrated Case Management, with specific practice expectations and an evaluation processes (Tate, Hubberstey, Hume, & Rutman, 1999; Anglin, Artz, Charlesworth, & Nicholson, 1998). ICM became a practice with clear guidelines for effective collaboration built on a curriculum grounded in various legislation and policy. Such documents include:

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

Literature regarding Integrated Case Management often endorses the practice; however, numerous authors agree that specific studies of how well it works are hard to
find (Nicholson, Artz, Armitage, & Fagan, 2000, p. 40). Stephen Moore (1992) went as far as to say that “The notion that case management is a mechanism for the coordination of services is a myth that has been used to rationalize the current state of fragmentation in the service delivery system. When delivery systems lack an administrative structure and adequate resources, case management is, at best, an attempt to cope with a chaotic service environment” (Moore, 1992, p. 418). These reflections require that we investigate how the practice of ICM is working in BC, or more specifically (as in this study), the Fraser Region. ICM in BC does have a solid foundation built from legislation and policy within a Ministry designed for effective collaboration between various disciplines; however, how well is it working?

Proponents for Integrated Case Management suggest that where multiple sectors and therefore multiple services exist for the children, ICM is an effective strategy for involving family, planning treatment, and monitoring progress (Halfon, Berkowitz, & Klee, 1993, p. 380). Specifically, Halfon, Berkowitz & Klee (1993) refer to three populations that were identified as “vulnerable children” in families with complex needs requiring the coordination of many services: foster children, drug-exposed infants living with their biological mothers, and young teenage families. In such complex cases as these, coordinating care, brokering services, and developing community resources are a large focus of service provision. Halfo, Berkowitz & Klee (1993) further suggest that perhaps case management is a tradition of social service provision, one in which a case manager is a symbolic representative of the community, a reflection back on to the rationale for the birth of the social worker. Therefore, I would suggest that ICM is an extension of our social responsibility to others as representatives of the social service
professional, and the question changes from “Should we collaborate?” to “When, where and how do we collaborate?” These questions can only be answered from an ineffective review of practice. This requires that we evaluate current practice and adapt organizational structure, policy, and/or practice accordingly.

Returning to Gove (1995), consider that the lack of effective collaborative practice allowed for Matthew John Vaudreuil’s death: Gove’s recommendation for reducing child fatalities was effective collaboration, or ICM. The Gove (1995) report and the literature agree that for the Ministry of Children and Family Development to effectively deal with child welfare concerns, a team approach for the integration of mental health, child welfare, probation, education, and other services to children is required; however, Gove and the literature also demand a move beyond simple cooperation between agencies to create something that is greater than the sum of its parts (Gove 1995; Tate & Hubberstey, 1997; Woods, 1999). In their report to the Prince George ICM Steering Committee and Ministry of Children and Family Development, Webb, Leeuwen, & Keli (2002, p. 5) state:

The model is characterized by an identifiable philosophical and value base, clear expectations regarding the role of the client in the process and the importance of empowerment and a set of protocols to guide processes such as information sharing, meetings, case planning, and documentation. Formally known as Integrated Case Management, the model is more commonly referred to by its acronym of ICM (p. iv).

In conclusion, the Integrated Case Management (ICM) design fits when children and families have persistent child welfare concerns. ICM’s focus on engagement and
shared decision making between professionals and family allows the approach to maximize both the expert, medical model orientation of service delivery and the benefits of family centered practice. Through effective collaboration we can improve the capacity of the family to deal with future crises – in other words, its capacity building (engaging family, developing new perspectives, sharing ideas, and identifying family and professional supports) – and can enhance strengths and solutions. In other jurisdictions, such as the England, Australia, and in some U.S. states, collaboration is now either the recommended practice or a legislated requirement (Salmon, 2004). Although collaboration has potential benefits it also has potential challenges: lack of trust between members of the team; professional turfism, or claims to a particular expertise in case management; lack of resources; communication difficulties; power struggles; accountability issues; and denial of family voice (Salmon, p. 157). In this report, many of these issues are present; however, I also found that when effective ICM occurs, the resulting youth engagement in planning appears to lead to improved treatment results and improved quality of life for youth and family.

Youth Participation

The literature on the use of mental health services by youth has primarily considered children’s demographic characteristics and clinical status (Brannan, Heflinger, & Foster, 2003). It often does not focus on youth involvement in treatment planning or youth participation as equal and valuable members of an Integrated Case Management Team.

In comparison, there has been a great deal written about youth participation in politics and community development (Calvert, Zeldin, & Weisenbach, 2002; Cargo,
Grams, Ottoson, Ward, & Green, 2003; Checkoway et al., 2003; Checkoway & Richards-Schuster, 2003; Driskell, 2002; Gurstein, Lovato, & Ross, 2003). In this area of practice, young people are seen as capable and crucial members of the process. Nixon (1997) suggests that in the social service sector, however, professionals such as social workers, support workers, teachers, and mental health clinicians are trained to see “Youth at Risk,” or, in other words, to view them from a deficit perspective. Nixon (1997) continues to suggest that from this helpless position the expectation of a young people’s involvement in planning is somewhat limited, as they are perceived to be struggling, overwhelmed, and incapable of participation. However, the literature regarding ICM, Family Development Response, and Family Group Conference (Burchard & Schaefer, 1992; Burchard & Clarke, 1990; Halfon et al., 1993; Rutman et al., 1998) suggests that this type of work increases successful accomplishment of treatment goals with children and family. It appears that the limitation of past research was that the child voice had been within the family voice. The issue of grouped family voice is important to tease apart for both parent and child, as with all family issues, sometimes children and parents do not agree. The potential disagreement between parent and child is likely exacerbated in families involved with state children’s services for child welfare matters.

**Youth Rights**

Another contribution to youth participation has been in the area of youth rights. In 1990, Canada was one of 193 countries that ratified The United Nations Convention on the Rights of Children. This convention outlines values, actions, and processes be put in place to meet the growth and developmental needs of children. In this comprehensive document, two articles clearly identify issues related to youth participation:
Article 5

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Article 12

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law. (Canada. Health Canada, 2002)

In ratifying the Convention, Canada agreed to actively adopt a process of inclusion of young people in decision-making about their lives. These articles from the convention are reflected within the Child, Family and Community Service Act (Ministry of Children and Family Development [MCFD], 2009). The act states in Division 2, section 21, item 3: “If the child is 12 years of age or over, the director must before
agreeing to the plan of care (a) explain the plan of care to the child, and (b) take the child's views into account”.

**Continuous Quality Improvement**

Gove (1995) recognized that Provincial responsibility for child welfare includes proactive quality assurance. In the child protection domain of MCFD, child death investigation and regular file audits occur to meet this requirement. Alternatively, the Child Youth Mental Health (CYMH) domain of MCFD developed a five year strategic plan (CYMH, 2003, p. 40) which includes a component called “Performance Plan.” In this component, CYMH states that “investments directed at improving children’s mental health services will be phased in over the five years of the plan.” This investment in performance in the Fraser Region focused on building an accountability structure to ensure service performance. Initially, two recognized quality assurance mechanisms were considered: Continuous Quality Improvement and Accreditation.

Continuous Quality Improvement (CQI) was recommended for its focus on building internal mechanisms for performance improvement rather than meeting external standards alone. Accreditation, in its essence, focuses on meeting predetermined standards in a process of “measuring up rather than measuring with” (R. Lees, personal communication, January 7, 2009). Although an in-depth analysis of CQI is not necessary for the purposes of this paper, an overview of the core philosophies of CQI will add context to the topic of study.

In a report written for the Fraser Region’s CYMH practice analysis team - the group supporting the CQI initiative, the basic core philosophy of CQI was described as follows:
CQI may be defined as “a philosophy of continual improvement of the processes associated with providing a service that meets or exceeds client expectations” (Shortell, Bennett, & Byck, 1998, p. 594). It has been widely used within the field of business and over the years has been transported into various healthcare fields. Some of the areas in healthcare in which it has been used are clinical practice, nursing, and hospital medicine (Hyrkas & Lehti, 2003; LeBrasseur, Whissell, & Ojha, 2002; Shortell et al., 1998). The appropriateness of the application of CQI to various arenas in healthcare is better understood once the underlying concepts of CQI are acknowledged and accepted (Latimer & Heinrichs, 2004, p. 1).

To enact the CQI method in the Fraser Region, a comprehensive organizational education program for all CYMH staff was initiated.

Another core philosophy in CQI is that those closest to the service are best placed to design and repair it (Latimer & Heinrichs, 2004). This philosophy was put into action with a comprehensive survey of parents, youth and staff. This study is one of the CQI studies initiated by the Fraser Region CYMH.

At this time the other components of CQI – strength-based approach to ensuring quality; building leadership within an organization; and applying scientific principles to improve the quality of daily work processes - are being addressed.

**Purpose of the Study**

Child and Youth Mental Health (CYMH) Fraser Region has been exploring a CQI process to improve service provision. This study was one of a number of initial efforts to collect information that formed the foundation of CQI in CYMH. These initial studies focused on both internal and external stakeholders: children, youth, staff, and parents.
The purpose of the consumer studies was to hear from youth and parents directly as to which aspects of CYMH service were important to be monitored through CQI. The results of this study directly supported the CQI initiative to improve service performance to children and family in the Fraser region.

This report was based upon a semi-structured interview study conducted with 10 youth who were receiving counselling services through CYMH and were involved with Integrated Case Management. The interviews were conducted with youth between 15-17 years of age residing within the Fraser Region of CYMH. During the study, the following questions anchored the interview process:

- What actions, processes, activities, and practices helped or hindered youth participation within the Integrated Case Management?
- What were the experiences, as conveyed by youth, of inclusion and acceptance or denial and rejection within ICM?
Chapter 2

Method

Critical Incident Technique (CIT) is a qualitative method for collecting and analyzing data that has been used in a variety of fields since the Second World War (Woolsey, 1986). CIT was chosen for this study by the Ministry of Children and Family Development, Child and Youth Mental Health (CYMH) Division. Dr. Rob Lees has described the rationale for CYMH Fraser Region to choose the CIT method:

Firstly, we believed that qualitative research is well suited to the practitioner/scientist model of practice, as clinicians can collect evidence in the course of their everyday work. The structure of CIT interviews based on the questions "What helps, what hinders" can also be easily used in therapeutic situations. Therefore, we have encouraged uptake of the method among students and staff as we want to promote the practitioner/scientist model.

Second, CIT, to our knowledge, has been described as a method that can straddle the divide between quantitative and qualitative research, with some quantitative reporting. While narrative appeals make sense to some audiences, others are interested in quantification.

Third, we have been building an infrastructure of people familiar with the method which increases the comprehension of findings as well as opportunities for credibility checks. Learning the nuances of a research method takes time and in our experience, many graduate students go through the struggle of learning it once and never using it again. Also, having a critical mass of professionals who know the method and can use it again is seen as increasing the odds of more
practice based research being developed. We have a growing number of clinicians who are familiar with the method from having completed their own study. This helps them to understand findings from other studies. It is a method that has been frequently used at University of British Columbia and Trinity Western University (R. Lees (personal communication, December 12, 2008).

The Participants

The CYMH Fraser Region research team decided that the study would attempt to recruit 20 participants from within the boundaries of the Fraser Region who were receiving CYMH services and had an Integrated Case Management Team (ICM). They also stipulated that the youth be between the ages of 14 and 19 years old. The rationale for the age criteria was that youth are capable of understanding the concept of research; youth have the ability to be reflective about a process they have been involved in; and youth can critique complicated social processes such as consensus building, inclusion and exclusion, communication activities, and group process.

Although the initial recruitment target was 20 youth, only 10 youth between the ages of 15 and 17 participated. This indicated that the perceived use of Integrated Case Management and actual implementation differs in the Fraser Region. This unintended discovery has been reported to senior staff within the organization. The study also uncovered a lack of any process for tracking data on ICM implementation.

Youth reported that they had been involved with CYMH services from anywhere between three weeks and two years. They further reported that they had been involved in ICMs for time frames between six months and four years. Lastly, youth reported that they had participated in as few as eight to as many as thirty ICM meetings. The disparity
between time spent in CYMH and time involved in ICM stems from the fact that youth may have been involved in ICM prior to and/or after completion of the services they received by CYMH. At the time of the interview, eight youth were living with their biological parents and two youth were living independently.

Participants were recruited through the seventeen mental health offices in the Fraser Region. The researcher presented the study to all mental health teams including identifying the purpose of the study and a description of inclusion criteria. The master’s level clinical staff were then asked to review their caseload for appropriate candidates. This form of recruitment had both positive and negative consequences. Positively, the research committee felt that ensuring that youth were mentally stable, as determined by their clinician, allowed for a more ethical approach to their participation. As well, therapy requires a foundation of trust and open communication in the relationship; it was consider important to allow youth to have an honest and open dialog about the process of research. Negatively, there was the inherent selection biases based on clinician perceptions.

**Procedures**

Flanagan (1954), as a member of the Aviation Psychology Department of the United States Air Force, developed the Critical Incident Technique (CIT) to train fighter pilots. The CIT technique uses a simple interview strategy aimed at having subjects reflect on their personal experience in an activity of interest. During the Second World War Flanagan asked combat fighter pilots to think of occasions when their flying caused vertigo – a deadly experience during dog fights – and what actions, behaviours or processes contributed to the experience (Flanagan, 1954). After the war, he used the
procedure to develop ethical standards for psychologists to measure task proficiency, to
select and classify personnel, to design job procedures and equipment, to identify
motivation and leadership attitudes, and to identify factors in effective counseling
(Woolsey, 1986). Flanagan’s CIT process consisted of five steps: (a) determining the
aim of the activity; (b) setting the plans, specifications, and criteria for the study; (c)
collecting the data; (d) analyzing the data; and (e) interpreting and reporting. Recently
Butterfield et al. 2005) reviewed fifty years of CIT studies to determine specific modern
practices required under each of the core steps to meet reliability and validity outcomes.
In many cases, the modern practices adopted Woolsey’s (1986) criteria for CIT. The
following sections will review the validity and reliability measures as set out in
Butterfield et al. (2005).

**Determining the Aim of the Activity**

Woolsey (1986) explained that the definition of the activity being studied needed
to be clear, as all resulting research referred back to this focusing point. The description
of the aim needed to be well defined and as simple as possible. She further suggested
that everyday language be used to convey an obvious intention of the activity in question.
It has been a foundation of the process to consult with experts in the field to obtain a brief
statement of what they consider to be the objectives of the activity under examination. In
the case of ICM, Tate & Hubberstey (1997) described Integrated Case Management
(ICM) as an interactive process through which individuals with diverse expertise,
experience, and resources join forces to plan, generate, and execute solutions to mutually
identified problems related to the welfare of children and families (p. 140). ICM is an
attempt to support youth and their families in a holistic manner. This collaborative team
approach emphasizes that the whole is greater than the sum of its parts. Given this definition by Tate & Hubberstey (1997), collaborative outcomes can only be generated when each member feels connected and included in the process, leading to true collaboration. The aim of this study therefore is to determine what increases or decreases a youth’s participation in an ICM meeting.

Setting the Plans, Specifications and Criteria of the Study

The 10 youth (6 girls, 4 boys) involved in this study were 15 to 17 years old, were receiving clinical outpatient services through CYMH, and had been members of Integrated Case Management teams. Clinical service included any combination of the following: personal counseling, psycho-educational group, and support group. Since the Fraser Region encompasses so many communities of varying cultural and socioeconomic backgrounds, it was anticipated that participants might come from a diverse range of backgrounds. However, the researcher did not collect specific data about socio-economic backgrounds.

After the clinician introduced the research project to the youth, the parent was provided with the research information package (see appendices A, B, C & D). Youth were then able to choose to contact the researcher directly or make contact though their clinician. Once youth indicated their interest in the project, the researcher made direct contact by telephone with the youth and parent/guardian. Further details were provided, confidentiality was discussed, and arrangements were made for an interview if they chose to continue. A consent form (see appendices B & C) was completed by both youth and their parents/guardians. Each youth received an honorarium of twenty dollars in appreciation of their participation and was told that he or she would have an opportunity
to see the results of the research once the study had been completed. The recruitment process depended on the cooperation of various people at different levels in several mental health centres and thus resulted in lengthy delays.

**Collecting the Data**

The researcher conducted personal interviews with youth using a semi-structured interview process (see appendix D). The researcher used the skills of empathic listening and perception checking, in which the researcher checks back with the youth to make sure he or she gets what they are saying, to extract the maximum amount of information about the youth’s experience of participating in ICM meetings. The researcher digitally recorded the interviews and then had each professionally transcribed. The interviews occurred at a time and a place that the youth chose. This turned out to be in their homes in a private room with just the researcher and the youth present.

**Analyzing the Data**

The researcher reviewed and re-reviewed the transcribed interviews looking for incidents – specific statements made by the youth regarding their participation in ICM. Butterfield et al. (2005) suggest that using Woolsey’s (1986) criteria’s for incident choice is appropriate: (a) selecting an appropriate and useful frame of reference, (b) forming categories, and (c) determining the level of specificity or generality to be used. Each of these aspects will be expanded in the following paragraphs.

Separating the incidents from the raw data requires a *frame of reference*. The frame of reference establishes applicability to the activity being studied. Selecting an appropriate frame of reference in this particular CIT study was straightforward as the
frame of reference and the aim of the activity were the same: analyzing what helped and what hindered youth participation in ICM meetings. Incidents were identifiable because they appeared to impact the ability of a youth to participate in the ICM process.

After selecting the incidents from the raw data the researcher began the process of category formation. In this CIT study an evolving data analysis process was used to form the categories. Data analysis began after four interviews had been transcribed. Incidents applicable to the frame of reference were isolated from within the body of the transcript and printed onto 12.5 cm by 7.5 cm index cards. A system of coding linked each incident back to its original location in the transcript. Incidents were initially organized around whether they were helpful or hindering, and were then sorted into tentative categories based on similarities of behaviours or experiences described in the incidents. This led to a tentative name being assigned to each of the emergent categories. Classification of future incidents then went into these tentative categories with additional categories created as needed. Another provision for incident sorting was identification of prototype incidents, an incident for each category that strongly represented the category. The researcher used the prototype incidents as a decision-making tool for incident placement and category formation. In order to decrease the level of subjectivity in incident categorization, Butterfield et al. (2005) recommended the researcher have categories reviewed by an independent expert in the field who is familiar with the CIT process. In this case, I employed a Master’s level clinician familiar with both CIT and Integrated Case Management.

Finally, the researcher needed to determine the level of specificity and/or generality to be used in reporting the findings: this study used the classifications of
category and sub-category. The Woolsey (1986) method allows the researcher to have the categories and sub-categories emerge naturally. In this way the categories reside clearly in the helpful or hindering framework. Sub-categories describe a more specific behaviour, action, or process which, when linked together, create a category.

Validity and Reliability

The CIT method has a long history of use in analyzing counseling and psychological processes, particularly within British Columbia. Recently Butterfield et al. (2005) have outlined through meta-analysis study of the CIT method a detailed process to meet reliability and validity concerns. The following represents the manner in which this present study did meet these concerns:

Reliability

1. Three raw data transcripts were provided to an independent reviewer familiar with the CIT process. The independent reviewer was provided with a description of the purpose of the study and had an opportunity to dialogue with the researcher regarding incident identification. The reviewer was then asked to review the raw data looking for what he considered incidents. His results were compared to the principal investigator’s identification of incidents. There was approximately 80% agreement for incident selection between the reviewer and the researcher.

2. After tentative categories were developed and initial placement of incidents had occurred, 25% of the total incidents were randomly removed and provided to two independent reviewers familiar with CIT. The researcher provided the independent reviewers with a title and description of each incident category. The independent reviewers then took their random allotment of incidents and placed
the incidents into the categories. The result of this process was that the researcher and the independent reviews had 76% agreement for incident placement within the categories and 68% agreement for sub-categories, considered to meet Woolsey’s (1986) standard.

3. It is routine in CIT to have a second interview with a number of the participants of the study after the initial data analysis. In this study, 5 youth were asked to review the researcher’s category development to determine if it met with the youths’ experience of Integrated Case Management. All 5 youth agreed that the categories and sub-categories were complete and reflected their experience.

Validity
1. The researcher submitted the tentative categories to two master’s level child and youth mental health experts who have participated in Integrated Case Management (ICM) meetings. They reviewed the tentative categories, compared them to their experience in the field, and stated that they found them to be complete: no categories were surprising and no categories were missing.

2. For a category to be adequately represented in the study findings, CIT standard practice (Butterfield, et al., 2005) dictates that 25% or more of the participants have experienced an incident within the category. The implication is that the greater the number of participants reporting an experience in that category, the more likely it represents, in this case, the importance of being either helpful or hindering for youth participation in ICM. All categories met this requirement, in most cases having an 80% participation rate. In this study, specificity allowed for subcategories to be formed. These subcategories appeared to fit under each
category and ranged in participation rate; however, fit was determined by a natural relationship rather than quantitative criteria.

3. The categories were compared to the literature and found to be consistent with regards to youth participation in collaborative practices.

4. The researcher also met with an expert in the area of CIT and child and youth mental health service. This expert was a member of the Fraser Region’s CYMH community research team who had reviewed a digital recording, had read a transcribed interview, and had reviewed the category and sub-category development. The expert concluded that the research process was valid.

**Ethical Considerations**

The main aim of this study was to learn from youth about their firsthand experiences of participating in Integrated Case Management meetings. The information gathered will serve as one component of the initial steps of CQI strategy for CYMH Fraser Region. The youth’s confidentiality was assured through the informed consent form (Appendix B) and through the opportunity to remove themselves from the study, with 50% of the youth participating in a second interview that included revisiting of the confidentiality and research information. Of significance with regards to the CIT method was the ability for youth to be included in the credibility check for category definition, assuring the information presented about them was accurate and complete. Each participant was assigned a number which became the only identifying mark for anyone other than the researcher. Digital recordings, interview transcripts, information and consent forms were kept under lock and key in the researcher’s office until the study was concluded. Digital recordings were erased after the study had been completed, while the
verbatim transcripts were to be stored for not more than seven years, at which time the written data would be shredded. Participants were informed that they could withdraw from the study at any time and were provided with contact information for the University of Victoria and the Ministry of Children and Family Development Research Ethics Board, along with the MCFD research coordinator Dr. Robert Lees, in case of concerns about the study.
Chapter 3

Results

The purpose of this study was to learn from youth what had helped and what had hindered their participation in Integrated Case Management (ICM) meetings. ICM is one of four forms of collaborative practice available for MCFD staff. ICM is the collaborative practice most often used by Child and Youth Mental Health (CYMH) services with youth involved in their services.

This study was one of five implemented by CYMH to initiate their Continuous Quality Improvement (CQI) initiative. Critical Incident Technique (CIT) was chosen by CYMH to complete this study as it facilitates a process similar to the CQI strategy. First developed by Flanagan to train fighter pilots, the process was later used due to the method’s flexibility as an exploratory research tool in industrial and organizational psychology, communications, nursing, job analysis, education and teaching, marketing, organizational learning, performance appraisal, social work, and counseling (Butterfield et al., 2005, p. 475). CIT was employed in the current study and yielded 285 incidents that were considered to be critical to participation – inclusion or exclusion – of youth in the process of Integrated Case Management (ICM).

Ten digitally recorded interviews with youth produced 137 pages of written transcripts concerning youth’s perspectives of what processes, actions, or structures were helpful or hindering for their participation in ICM. The incidents have been classified into seven main categories: (1) the team was collaborative; (2) the team was solution-focused and strengths-based; (3) the team involved the youth and accepted their input; (4) the team made youth feel connected; (5) the team was authoritarian; (6) the team was
disorganized and confused; and (7) the team felt unsafe. Within these categories a total of 22 subcategories were identified. An overview of the categories and subcategories with participation rate and the number of helpful and hindering incidents appears in Table 1.

Table 1: Categories with frequency rates of helpful & hindering incidents

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>No. youth reporters</th>
<th>No. of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>The team was collaborative</td>
<td>Youth had someone there they trusted</td>
<td>08</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>The ICM team worked with youth</td>
<td>07</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>The ICM team sought youth involvement</td>
<td>03</td>
<td>07</td>
</tr>
<tr>
<td></td>
<td>The team had humanistic personable conversation</td>
<td>04</td>
<td>08</td>
</tr>
<tr>
<td></td>
<td>Youth felt better about ICM meetings over time</td>
<td>02</td>
<td>04</td>
</tr>
<tr>
<td></td>
<td>The ICM team supported youth</td>
<td>05</td>
<td>04</td>
</tr>
<tr>
<td></td>
<td>The boundaries set helped youth change</td>
<td>02</td>
<td>02</td>
</tr>
<tr>
<td>The team was solution-focused and strength-based</td>
<td></td>
<td>08</td>
<td>42</td>
</tr>
<tr>
<td>The team involved the youth and accepted their input</td>
<td></td>
<td>07</td>
<td>25</td>
</tr>
<tr>
<td>The team made the youth feel connected</td>
<td></td>
<td>06</td>
<td>15</td>
</tr>
<tr>
<td>The team was authoritarian</td>
<td></td>
<td>08</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>The ICM team did not listen to youth or include them in planning</td>
<td>06</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>The ICM team was problem focused</td>
<td>06</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>The meetings were too businesslike</td>
<td>04</td>
<td>04</td>
</tr>
<tr>
<td></td>
<td>System needs were met the youth was not</td>
<td>02</td>
<td>04</td>
</tr>
<tr>
<td>The team was disorganized and confused</td>
<td>Youth was not informed about ICM</td>
<td>09</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>Youth did not choose who was there</td>
<td>05</td>
<td>09</td>
</tr>
<tr>
<td></td>
<td>The ICM team lack effective facilitation</td>
<td>05</td>
<td>09</td>
</tr>
<tr>
<td></td>
<td>What youth believe could have made it better</td>
<td>06</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Youth did not feel safe in the meeting</td>
<td>06</td>
<td>18</td>
</tr>
<tr>
<td>The team did not feel safe</td>
<td>Youth did not like private information shared with everyone</td>
<td>05</td>
<td>09</td>
</tr>
<tr>
<td></td>
<td>There was fighting in the meeting</td>
<td>03</td>
<td>05</td>
</tr>
<tr>
<td></td>
<td>Youth felt threatened in the meeting</td>
<td>02</td>
<td>02</td>
</tr>
<tr>
<td></td>
<td>Youth were punished as a result of ICM sharing</td>
<td>01</td>
<td>02</td>
</tr>
<tr>
<td></td>
<td>Youth felt attacked by ICM team members</td>
<td>02</td>
<td>03</td>
</tr>
</tbody>
</table>

Following is a description of each of the categories and sub-categories. At least one example of a critical incident is provided for each category and sub-category. Proper names that appear in the excerpts from the original transcripts have been replaced with pseudonyms. In some cases incidents have been edited to provide brevity, smoother reading, and confidentiality.
Category 1: The meeting was collaborative

This category consisted of seven subcategories: a) I had someone there I trusted; b) the ICM team worked with me; c) the ICM team sought my involvement; d) we had humanistic personable conversation; e) I felt better about ICM meetings over time; f) the ICM team supports me; g) the boundaries set helped me change. All of the subcategories referred to those processes and aspects within the relationships that facilitate effective collaborative practice.

Subcategory 1a: Youth had someone there I trusted

This subcategory consisted of incidents where youth would assert that a person with whom they had a pre-existing relationship of trust was included in the meeting, which allowed them to feel secure in the meeting.

…it’s just the fact that she was there, and I, like, could pretty much tell her anything, not just because she’s my counselor, but because I can actually trust her and just like she has a relaxedness about herself, so she’s just usually such an easygoing person and doesn’t necessarily judge anyone, so I just love her, so it makes me feel happy to be around her. – Youth #3

Subcategory 1b: The ICM team worked with youth

Here youth described incidents where some or all of the members of the ICM team worked with the youth:
Well everyone kind of like came up with different ideas of what I could do, and a lot of them I was just like, no, I don’t want to do that and then they’d be like, okay, and we’d try and come up with some other ideas and they’d listen to my ideas and stuff. – Youth #8

Subcategory 1c: The ICM team sought youth involvement

This subcategory is naturally linked to the above sub-category; however, it is subtly different in that incidents reflect an active and/or obvious process of seeking youth participation.

Um, well, like, they were discussing what college I should go to and so they were thinking, oh, well, the Art Institute of Vancouver has like a bunch of like animation courses and stuff and mom looked at me and said, “That’s what you’d want to do right,” and I said, “Well not so much the animation part, but more programming” And so, like, that way… because then otherwise it would have ended up in me going in a completely wrong direction. – Youth #2

Subcategory 1d: The team had humanistic personable conversation

This subcategory involved the ICM team members beginning or completing the meeting by talking with the youth and other ICM members about general life events. The dialogue included professionals, family, and youth discussing personal life events such as a TV show they had watched, a movie they had recently seen, and/or a story about a personal activity.
I guess like, uh... I don’t know one thing like I really liked, I’d pretty much be first one in the room and they’d... kind of everybody wouldn’t sit at the end of the table; they’d kind of sit around me and chat about stuff like sports, or what they watched on TV... – Youth #6

**Subcategory 1e: Youth felt better about ICM meetings over time**

This subcategory consisted of incidents in which youth described the benefit of multiple ICM meetings that had occurred over longer periods of time (see participant description). The incidents seemed to refer to the traditional constructs of team development: *forming (purpose of group), norming (how the group acts), storming (dealing with disagreement), and performing (accomplishing the goal of the group)*.

[Over a period of 4 years] I just learned more about a ICM meeting. It is somewhat like driving a car you know; when you first step into the car, you know, you’re kind of just like, uh what do I do here, what do I do, I don’t really understand. Once you get familiar with it, you know, you’re just cruising around a little bit and you’re comfortable with it. – Youth #6

**Subcategory 1f: The ICM team supported youth**

This subcategory included youth speaking about the way the ICM meetings felt supportive. Youth described the way that team members would show care and compassion along with encouragement. There was also a clear belief that the youth and their families could work through challenges.
... honestly, I don’t even say I have two (bad ICM meetings). Like, they were good, but they pretty much all had a bunch of little negatives to them and they were all like that. All of them would have negatives, almost all of them would have negatives, but what made them good was how much positive things they had in them. They had a lot (positives), and yeah, it was great. – Youth # 6

Subcategory 1g: The boundaries set helped youth change

This subcategory had youth identify incidents when ICM members would request that they be intentional in their change process. Youth indicated that they would be given clear expectations for their behavior in a manner that outlined consequence but that felt fair and reasonable and had an element of choice to it.

I have to be involved, because if I don’t get involved, then they think that they can’t trust me. Then they won’t listen to what I say, then I have to follow what they’re saying. I have to follow what they’re saying and if I don’t listen, then everything will screw up. So I have to listen and follow the next step, next step, and then later everything will be good. – Youth # 7

Category 2: The team was solution-focused and strength-based

In this category, youth articulated the idea that ICM meetings would focus on moving forward with concerns. Members focused on building towards solutions rather than looking for blame for failed attempts at change. They described unique ICM mechanisms such as building the youth and family up, celebrating movement and the processes for change, seeking common ground between team members, and openly
communicating about concerns. The process of the meeting reflected the journey rather than the destination.

Well, sometimes I would talk with my counselor on the phone or in person about it [a concern or issue], but then I would also talk to my social worker, the same way – phone or in person or go out for coffee with my social worker. My mom would talk about it and then in the meeting, we’d all explain what we had talked about to each other and then the different stuff that we said would be brought up in the meeting, and stuff that I wanted and stuff that I didn’t want for a foster home and stuff, and they’d try to find the right match of where I should be placed, and we’d all talk about it, so we all got our thoughts and our views and what we all wanted - it was always about trying new ideas to make it better. – Youth #3

**Category 3: The team involved youth and accepted their input**

In this category, youth spoke about being able to include people they wished to be present in the meeting. They also felt as if they had some control and influence over when, where, and how the meeting would take place.

Well, it made it easier (talking through the agenda), because I was, like, expecting everything - who was there, where it was, and what we were going to talk about, so it wasn’t like a surprise. – Youth # 8
**Category 4: The team made youth feel connected**

In this category youth described incidents where they felt as if the ICM team was there for them, to help them and their families deal with the issues, rather than meeting for a systemic professional reason, such as meeting requirement for standards of practice.

It’s cool, like, to sit around at the table and just kind of look around and see that all these people are there for you. You know all these people are there to try and help for you, you know, they don’t really have to, but it’s just like, you know, it’s cool to see that I guess. – Youth #6

**Category 5: The team was authoritarian**

This category consists of 4 subcategories: a) the ICM members did not listen to me or include me in planning; b) ICM team was problem focused; c) the meetings were too businesslike; d) system needs were met the youths were not. In this category, youth identified experiences when they did not feel listened to or included. Youth further described meetings which focused on current problems and problems from the past. Youth also had incidents where they felt as if the meetings were too businesslike; in other words, the tasks and processes were more important than the youth and family. In these cases, they described what could be negative, problem-oriented and stuck teams that felt that change would not or could not occur.
Subcategory 5a: The ICM members did not listen to me or include me in planning

In this subcategory youth described incidents in which they were physically present in the room, but felt as if they were not. They stated that ICM members would speak about them in poor ways and make decisions without including them.

...it was at the hospital and there was the psychiatrist and a couple of nurses, and I guess counselors in there and then my parents, and basically the entire time, everybody was quiet except for my parents. Like they would be, like, “oh well, she doesn’t do this, she doesn’t do that, she doesn’t listen” And then they’re just all sitting there listening to them, and I felt like they were taking power away from me and that they were making my problem feel insignificant because they were letting my parents voice their feelings, but I never got to voice mine, so I felt sort of insignificant, because I felt like it wasn’t about me anymore, it was about how they felt about me. – Youth #4

Subcategory 5b – The ICM team was problem-focused

In this subcategory youth described incidents where they felt that the team saw them as the problem. They stated that people would speak in ways that made them feel like the problems were unmanageable or that they themselves were the problem that was unmanageable.

Um, I guess a couple of times I felt like they were just kind of going at me rather than walking with me. Like it just felt like I was kind of on the spot sometimes, because you know it was like, “Yup he’s been doing this and this and this and this” and it was just like, he’s all bad, things that I’ve been doing or whatever you
know, totally screwing up at school with my grades or performance and me being late a couple of hours every day. – Youth #6

*Subcategory 5c: The meetings were too businesslike*

This subcategory included incidents where youth would feel as if the team was so focused on the tasks, such as getting through all the information, that the team felt like a business meeting rather than a caring community of support.

My principal would be…Uh well, strict, a loud voice, grumpy face and standing up very straight. – Youth #9

Well, it’s business for them, but we’re dealing with my life and I just don’t like how it’s necessarily set up like that. – Youth #3

*Subcategory 5d: System needs were met, mine were not*

This subcategory described incidents in which youth thought the needs of the school, MCFD, or professionals were the priority. This included incidents where youth described walking into a room with a number of new people they had never met. These new people would be involved for no other reason than to discuss how systems such as MCFD or the School needed to deal with the youth’s behavior – this could also be tied to threatening the youth regarding their ability to stay in the foster home, school, etc.

Incidents would also reflect the sense youth felt that people were phony or were meeting paperwork needs, for example, reviewing youth strengths, telling the youth to sign a confidentiality agreement, meeting to say that they had met, etc – to fulfill obligations.
I don’t know, I think that by the first couple of meetings I think they should have learned that what they were doing wasn’t working for me. When I told them that it wasn’t working for me, I think that they might have changed how they were going about the meetings or something like that or something, but they weren’t willing to meet my needs. Like it was all for them, it was just for them. They weren’t willing to change anything to help make it easier for me, they weren’t willing to do anything, so I’m really not sympathetic towards their needs, because you know they wouldn’t give a little for me so I really just… I don’t have any guilt or anything like that for not doing these meetings anymore. – Youth #4

Category 6: The team was disorganized & confused

This category includes five subcategories: a) youth were not informed about the ICM meeting; b) youth did not choose who was there; c) the ICM team lacked effective facilitation; e) what youth said could have made it better. Youth reported that ICM meetings went off topic and did not have clear agendas. Youth often felt that the same things were covered meeting, after meeting and there was no progress. They also spoke of ICM meetings where people behaved badly towards others and no one took responsibility to make the ICM meeting respectful. The last sub-category is unusual as it includes answers to a question about what youth think could improve ICM meetings rather than a report of direct behavior experienced. This is an extension of the method; however, it was of interest to the community research group.
Subcategory 6a: Youth were not informed about ICM meeting

In this subcategory youth identified incidents in which they were not told about the meeting. Upon arrival, the youth would see a collection of people in the room. Youth had no idea about the reasons for meeting, what the focus was, or how the meeting was going to unfold.

It felt a little surprising… well I didn’t know about it, but I didn’t worry about it too much, because I’m really passive. I just thought, oh I’ll just go and see what’s going on and then it was that they wanted to make sure that I was doing alright, and wasn’t feeling bad or anything, so it reassured me afterwards, but I was a little bit confused when it first came up as to why I was being told to go to this.

– Youth #2

Subcategory 6b: Youth did not choose who was there

In this subcategory youth identified incidents related to team composition. Youth described meetings in which they had little to no input about who was there. They also explained that the makeup of the ICM meeting was chosen by the professional deemed in charge. In some cases, the youth had never met the person in charge of the meeting. In some cases, youth stated that the room could be two-thirds filled with strangers who seemed to know personal details about the youth.

I had this one care team where I had this worker that worked with me, that would take me out and stuff and I asked for him not to be in the meeting, but they put him in the meeting anyways. I didn’t want to say anything because I would always hide on him when he came to my house, so I didn’t want to go out places
with him. So he’d be there and he would, you know, kind of make me feel offended. He’d say, “Why do you do this, you’re not supposed to do that.” So he was talking to me and all this stuff and I didn’t really feel comfortable, so I didn’t really say anything. After he left, he left early, and after he left, I got kind of mad at the people in the ICM meeting for not telling me that he was going to be there and I asked for him not to be, so that ICM meeting didn’t go well at all.

– Youth #1

Subcategory 6c: The ICM team lacked effective facilitation

In this subcategory, youth reported incidents where ICM members would talk over each other or cut each other off. Youth explained that members would be demeaning to each other, sometimes even verbally attacking each other’s ideas or thoughts. They also spoke of feeling as if the meeting was out of control, a rudderless ship.

Yeah, like she kind of talked to me like I was a little kid that didn’t know anything and that was really annoying. – Youth #8

Subcategory 6e: What could have made it better?

In this subcategory, youth were asked for ideas about how to make ICM meetings better. This subcategory was put in the hindering section, as the responses came from negative experiences and therefore were hindering to youth involvement.
I’m not exactly sure (how to make meetings better). Maybe it could be like how everything has been impacting my parents and, like, just to see how they think I’m doing and if they think that I’ve improved. – Youth #3

**Category 7: The team did not feel safe.**

This category consists of seven sub-categories: a) youth did not feel safe in the meeting; b) youth did not like private information shared with everyone; d) there was fighting in the meeting; e) youth felt threatened in the meeting; f) youth were punished as a result of ICM meeting sharing; g) youth felt attacked by ICM meeting members. Youth identified incidents that made them feel that they could not trust the process or the people that were in their ICM meetings. In some cases, information that was shared in the meeting would later be used by an ICM member to invoke a consequence for behavior not known prior to the meeting.

*Subcategory 7a: Youth did not feel safe or felt the meeting.*

In this subcategory youth indentified incidents when they felt unsafe. This included times that seemed positive.

Well, we are just like… they’re going around in a circle saying good qualities about myself – it is unnatural. It’s not like you’re having a normal conversation about it. Just like “Oh, I like this about you.” It’s like this, I like this and this and this but we hadn’t talked about anything. I hated it! – Youth #3
Subcategory 7b: Youth did not like private information shared with everyone

In this subcategory, youth identified incidents when they felt private information that they had provided to an individual would be shared with all ICM members. They remarked that they did not feel like the entire ICM team needed to know everything.

Well, sometimes my sister will say things, like personal things that go on at home, and I don’t like that, the teachers don’t need to know about it. So I’ve asked her, you know, not to be there anymore. It continued to happened about three more times where she would say things that would really embarrass and humiliate me and so I did not have a good time and always got angry because of her.

– Youth #1

Subcategory 7c: There was fighting in the meeting

In this subcategory, youth identified incidents where disagreements would escalate to include angry words, hostile behavior, and harsh tones of voice. Youth also noted times when they were aware that professionals did not like each other and so would be disrespectful to each other.

When there are people that don’t agree. When people are fighting and not listening and not respecting other people’s wishes and people are getting humiliated and embarrassed and not feeling wanted, it made me wonder why we did this. – Youth #5
Subcategory 7d: Youth felt threatened in the meeting

In this subcategory youth identified incidents where ICM members would threaten them with punishment or present consequences in ways that felt threatening.

I was screwed up on drugs – they wanted to help me, but I never wanted help. I never listened, I never followed the rules – I’d screw up and they’d get mad at me and say, If you don’t follow the rules, we’re never going to help you and you’re going to die. – Youth #7

Subcategory 7e: Youth were punished as a result of Integrated Case Management sharing

Here, youth described experiences where people would learn about behaviors that they were engaged in at school, home or in the community which were not positive. Soon after the ICM, the professional or caregiver would impose a rule or a punishment based on the information that had been shared in the care team.

Yeah, my mum told the ICM team I was bugging other kids on the playground. My resource room teacher, which was like head of the ICM team, the next day kept me in a bunch of times for lunch and I was mad at her too, but I don’t know – it was for the best I guess. – Youth #6

This chapter has provided a description of each category and their respective subcategories along with prototypical examples of incidents that comprised each of these classifications. Following is a discussion of the relationship of these findings to the current literature.
Chapter 4

Discussion

The implications of this study are directed towards ICM in the Fraser Region but also could contribute to other collaborative practices used by MCFD such as Family Group Conferencing (FGC), Family Development Response (FDR), and Ulysses Agreements.

Ten interviews led to 137 pages of transcription from which 285 incidents (137 helpful to youth participation and 148 hindering) were identified. These incidents were reviewed and organized into seven categories and twenty-two subcategories concerning actions, behaviours, structures, and processes that youth noticed about ICM. See Table 1 (p. 29) for a summary of categories, subcategories, frequency rates, and proportions of helpful and hindering incidents. A discussion of the findings, limitations, and future research opportunities appears next.

The categories arising from this study are consistent with the literature regarding collaborative practice (Burchard & Clarke, 1990; Eber & Nelson, 1997; Anglin et al., 1998; Rutman, et al. 1998; Nicholson, et al. 2000; Webb, et al. 2002; Gladish, 2006;) which concludes that effective collaborative practice is more than simple tasks; rather, it is a procedure focused on engagement, relationship building, and accountability. When these procedures are present, the team becomes interdependent and strives towards common goals through shared decision making.

The findings of this study share apparent similarities with past investigation of ICM among parents (Gladish, 2006) and professionals (Webb et al., 2002). These findings are further supported by Bruner et al. (2004) criteria for effective collaborative
practice for multi-barrier youth in the education system. The following comparison represents what youth, parents and professionals express as helpful and hindering components of ICM. The list highlights each of this study’s categories followed by a major finding from Gladish (2006) and Webb et al. (2002) with further support from Bruner et al. (2004) criteria for effective collaboration.

**Congruence between this study and the findings of Gladish (2006), Webb et al. (2002) and Bruner et al. (2004)**

1. The team was collaborative. (helpful)
   a. The collaborative process requires strategies that empower family and youth to make decisions about their future (Bruner et al., 1992).
   b. Parents identify that for effective collaboration to occur structure and function of the team is important (Gladish, 2006).
   c. In collaboration, professionals and family work for each other and learn from other team members (Webb et al., 2002).

2. The team was solution-focused and strengths-based (helpful).
   a. The process requires effective sharing of resources available to meet the unique needs of the family and youth to support change (Bruner et al., 1992).
   b. Parents want ICMs to focus on outcomes (Gladish, 2006).
   c. Professionals state that client empowerment occurs because of the focus on client strengths (Webb et al., 2002).
3. The team involved the youth and accepted their input. (helpful)
   a. When effective communication and team-work occurs, family, youth and community can better identify opportunities for problem resolution (Bruner et al., 1992).
   b. Parents state that the right team members along with effective communication helps produce positive momentum (Gladish, 2006).
   c. Professionals state that a client centred approach creates meaningful participation for youth and family (Webb et al., 2002).

4. The team made youth feel connected. (helpful)
   a. Building relationships that are empathetic and caring helps organizations and individuals support children and families (Bruner, et al., 1992).
   b. Parents report that it is helpful for them to have a positive tone for the meeting along with assuring follow-through for goals decided on (Gladish, 2006).
   c. Professionals state that working together as a team rather than working against problems improves the process of collaboration (Webb et al., 2002).
5. The team was authoritarian (hindering).
   a. Collaborative practice is impaired when providers concentrate on what they can provide rather than what their client needs (Bruner et al., 1992).
   b. Parents report a defensive attitude when professionals tell parents what to do (Gladish, 2006).
   c. Professionals report that behaviours associated with professional turfism impair working together (Webb et al., 2002).

6. The team was disorganized and confused (hindering).
   a. Collaborative processes that focus on crisis and multiple problems rather than prevention and meeting needs fail to create positive movement for family, youth, and community (Bruner et al., 1992).
   b. Parents report that poor transitions, breakdowns in communication and presentation of contradictory messages confuse them (Gladish, 2006).
   c. Professionals report that when there is confusion about who the case manager is and who is managing the meeting, little is accomplished. (Webb et al., 2002)

7. The team did not feel safe (hindering).
   a. Collaboration does not occur when conflict and disagreement turn to pressure and threats (Bruner et al., 1992).
   b. Parents state that alienation and conflict stop them from participating in the ICM meeting (Gladish, 2006).
c. Professionals report that intimidation and/or a sense of being overwhelmed will lead to refusal to attend meetings (Webb et al., 2002).

The congruence between the themes described above indicates that there is much in common between the experiences of the parents, professionals, and youth involved in effective and ineffective ICM. It underscores the idea that helpful collaborative practice is undergirded by clear organization, commitment to collaborative action, and active engagement of the child and family team (Rutman et al., 1998).

The results of this and other studies (Gladish, 2006; Webb et al., 2002; Rutman et al., 1998) regarding effective ICM in British Columbia suggest we need to continue to improve communication, accountability, and collaboration in ICM meetings. Since the Gove Report (1995), policy, training and community practice (MCFD, 2008) have shifted to provide a better structure for collaborative practice (Rutman et al., 1998). Further, I would suggest, this study itself represents a positive change as it begins a process of continuous quality improvement.

Review of the helpful and hindering categories show that the categories represent opposing behaviors, actions and processes. For example, “the incident was collaborative,” one of the helpful categories, generally relates to open communication, engagement, and shared planning; whereas, “the incident was authoritarian,” a hindering category, relates to poor communication, disengagement, and hierarchical planning. It is important at this time to recognize that most youth reported that in a single meeting both helpful and hindering incidents occurred. The shifting between helpful and hindering
incidents that occurs in an ICM meeting suggests that ICM meetings are organic or vibrant processes and that in a meeting the process can shift quickly. In this study, one youth helped us recognize that we do not have to be too concerned about unique helpful or hindering incidents as long as we have more helpful than hindering incidents occurring in the meeting: “…They pretty much all had a bunch of little negatives to them. All of them would have negatives, almost all of them, but what made them good was how much positive things they had in them.”

The recognition that a youth can experience both helpful and hindering incidents and still feel able to participate is somewhat freeing. For example, if during a meeting a professional makes a decision and forgets to gain approval from the youth, it appears this can be forgiven by youth as long as the overall meeting includes more helpful than hindering incidents. I would further suggest that over time that if a youth experiences a situation where a hindering incident occurs, the youth is more likely to take issue with the behavior, allowing a hindering incident to become a helpful incident. This allowance to make procedural mistakes can be liberating. The liberation for professionals is that they can free themselves from the need to be perfect in regards to their skills as facilitators of collaborative practice; rather, it suggests that professionals can feel secure in being active learners of the ICM process.

A CIT study is meant to solicit with people involved in an activity and learn from them what helps and what hinders meeting the activity’s aim in this case, participation of youth in ICM meetings. This study has been successful in meeting this goal by recognizing what are ineffective and effective practices in the Fraser Region.
Examination of Helpful and Hindering Categories

First we will review the categories “The team was collaborative” (helpful) and “The team was authoritarian” (hindering). These categories reflect the fact that Integrated Case Management teams are intended to allow a collection of professionals and, sometimes, non-professionals to work together for the benefit of the child and family. As one youth stated, “It’s cool like to sit around at the table and just kind of look around and see that all these people are there for you.” It seems that working effectively together as a strong team is an enjoyable experience for youth, one in which they can feel included. The results of this study show that youth are very aware of what collaborative activities are.

Youth were able to discern whether team members were following a script and filling in the protocol documentation or participating with young people as partners. They were able to recognize if members of the team asked for their input in meaningful ways or as tokens of participation. Many of the youth in this study reported incidents that indicated an openness and willingness to share information, which is an important component of collaborative practice. They expressed the understanding that effective collaboration meant that in their meetings, people would share information and ideas about solutions with them.

Integrated Case Management consists of complex forms of communication – written, verbal, and non-verbal – which can be experienced as either positive or negative. Negative forms of communication, such as denial of voice or disrespect, were reported as often as positive or helpful communication, such as encouraging and hopeful statements. One youth stated that he really did not feel as if he could work with the school because of
the manner in which the principal chose to speak to him: “My principal would be…Uh, well, strict, a loud voice, grumpy face and standing up very straight.” This description highlights the fact that youth are watching how people communicate. This also brings focus to an important consideration when including young people in collaborative practice; youth are developing their social competencies and effective communication skills, and adults must be more cognizant of the impact an adult can have on a young person. It would therefore appear even more important to provide orientation and debriefing to youth involved in the socially complicated and dynamic process of Integrated Case Management:

I guess once they realized that I did not understand what they were doing these meetings for ...they would have taught me…When I realized just what they were doing and what’s going on here, it was like now I’m going to invite people that actually are going to benefit me or already have.

In many other studies of the collaborative process, communication has been identified as one of the pillars in ICM (Bruner et al., 1996; Hubberstey, 2001; Nicholson et al., 1998; Rutman et al., 1998; Gladish, 2006; Webb et al., 2002). This has been confirmed by this current study. Nicholson et al. (1998) identified that a “commitment to communication is essential for effective collaboration,” and further recognized that “effective communication is a time consuming process” (p. 59).

In contrast to the benefit of open communication for collaborative practice are concerns regarding confidentiality. Confidentiality is, in its essence, the right of a person to decide when, where, and with whom information is shared. The concern over
confidentiality versus open communication in Integrated Case Management is evidenced in recent literature (Hubberstey, 2001; Rutman et al., 1998; Webb et al., 2002; Gladish, 2006). In these studies, team members reported that a lack of open communication undermined the effectiveness of the collaborative activity. Often asking youth for their permission to share important information while helping them understand how sharing the information will benefit them can alleviate confidentiality concerns for youth.

Youth in the study did not specifically mention confidentiality as an issue; rather they implied it by speaking about not liking it when people would share information about them without asking first. Youth spoke about a link between their ability to choose who was present and their ability to share information. Youth said that when they could not choose who was present, it led to their feeling unsafe about the meeting, which further led to their resistance about sharing information. This issue is especially relevant when young people are involved in counseling and ICM, due to the expectation of privacy for matters discussed in therapy; however, we must also recognize the value of information that can come from the counseling experience. Understanding how issues such as anxiety, depression, or other challenges are experienced by a youth often relates to interpersonal dynamics. This tension between privacy and team inclusion requires intentional focus and concern.

I’m, like, a private person. I don’t like to talk about my personal problems. Like, I don’t mind like public speaking and stuff like that, as long as it’s not about me. If you want me to, like, tell you, like talk to you about what’s the worst thing that’s happening to me in my life to a whole bunch of strangers, I don’t feel that
that’s right, and I felt like I was being forced to do that. Like, I didn’t feel like I had a choice.

It appears that a common theme in the hindering incidents revolves around the ability to decide what information will be shared and when. In tension with this need for privacy is the open communication of collaborative process, requiring a balance between youth, family, and systems needs (Rutman et al., 1998; Webb et al., 2002). As is often true with child welfare matters, people are asked to openly discuss issues such as poverty, historical violence, trauma, and so on. Confidentiality is a tension, not an insurmountable barrier or an excuse not share. Confidentiality relates to team trust.

The Gove Report (1995) stated that “the Province’s child protection, income assistance, and freedom of information and privacy legislation need to be amended so that social workers can access any information necessary to investigate and plan for children” (p. 34). Webb et al. (2002), in their study of the impact of ICM training on practitioners, noted that “fear of inadvertently sharing information which is beyond the bounds of confidentiality seems to be a stumbling block for some teams. Different agencies and professionals have different interpretations of confidentiality, sometimes informed by organizational policy or a professional’s code of ethics.” The possible solution apparent in the results of this study is to include all team members, especially youth, in a process of determining what information needs to be shared as well as when, where, how, and with whom. Along with this should come a focus on engaging youth in dialogue so they see the relevance of sharing information. This is supported by Tate and Hubberstey (1997), as they maintain that the presence of the client reduces or removes the issue of confidentiality, and therefore does not present an impediment to the
communication process. Further to this, it seems appropriate and is noted in regional ICM meeting handbooks that at the outset of each meeting, each member should become a signatory to the minutes and, in so doing, signal agreement to maintain confidentiality (Rutman et al., 1998).

Collaboration is a fundamental part of Integrated Case Management. The Gove Report (1995) indicated that “lack of interagency communication and cooperation, particularly between social workers and the medical community” (Volume 1: Matthew’s Story) was a contributing factor in the deaths of 29 children in the Ministry’s care. The findings of the current study support the position that collaborative processes are paramount to successful Integrated Case Management meetings; however, educating and informing youth and family about how collaborative practices unfold are relevant to youth and family safety and well-being.

Finally, youth noted that their lives are not business meetings. Having a meeting feel like a place of engagement, safety, and security is crucial to youth. Youth suggest that the way to accomplish this safety was to simply have a light natural conversation prior to starting the meeting. In other areas of youth participation such as politics, leadership and community building (Checkoway & Richards-Schuster, 2003; Cargo et al., 2003) the process of engagement is noted as fundamental; however, in social service practices this act of engagement does not receive as much focus, as problems are often the reason for a team to develop. It appears that effective collaborative processes require that youth feel included and accepted as people, rather than seen as problems to be solved.
The next categories to be reviewed are “The team was solution-focused and strength-based” (helpful) and “The team was disorganized & Confused” (hindering). In these categories, youth focused on how it felt when their team was supportive and goal directed. Specifically, youth related that it was not the fact that difficult ideas were being addressed, but rather how they were addressed.

Well, when we were talking about me having to go back to school, they said if it doesn’t work out for me, I could still do my home program. The principal and vice-principal just asked me if I wanted to go back to school, and that if I did I could start by doing like two days a week or three days a week, and then just keep going up until I do a full week.

Ensuring that ICM meetings focus on youth strengths and work towards solutions is also reflected in Webb et al. (2002) and Gladish (2006), where their key informants (parents and professionals) supported the idea that a positive and honest process of open communication that focused on movement towards solutions was effective at engaging their participation in the ICM process.

Webb et al. (2002) also identified that service providers see their involvement in the ICM process as providing “important opportunities for interagency role awareness, improved relationship building, and an understanding of different agency mandates and purposes” (p. 32). Fleming and Monda-Amaya (2001) found team roles and professionals group membership were emphasized more than communication. This finding appears to suggest that prioritizing each member’s commitment and clearly defined role allows for a focus on solutions and strengths from each discipline’s unique mandate and stance.

Gladish (2006) gathered from parents that they appreciated partnerships in which the
team shared responsibility for finding solutions to their child’s issues. Youth reported a similar feeling:

I really looked forward to them, once I understood them. I really looked forward to them and even if they were about bad things, and, you know, I knew we would work on them.

The hindering component of this domain of action is when incidents were found to be disorganized and confusing. Youth in this study reported that there were moments when the focus was not on strengths and solutions, but rather on the youth themselves as the problem or the issue that needed to be addressed.

Well, just that there was no control. Like, my parents would go and they would like rag on me basically. You know they just have...like, they constantly have negative things to say about me and nobody would call them out on it. And like later on, after the meeting, they’d be like, “Oh I know what you’re talking about when you say that your parents are this or that,” after the meeting and I’m like, “Well if you saw this happening, why didn’t you stop it.” Because at the end of the meeting I was shut down, I didn’t want to talk – I’d get angry, so like there was no point to that if I’m just going to get angry and shut down.

The fundamental component of ICM is effective collaborative practice. Duncan’s (2003) study in the British school system indicated that families can often experience conflict between professionals and the family, and, in this case, the family views the professionals as unhelpful people. It was further identified that these “unhelpful people” were also reluctant to receive training that would emphasize meeting the youth and
family needs by using a strengths-and-solutions-focused approach directed by the family rather than by the professional.

In contrast, Webb et al. (2002), in their study of professional training of ICM practice in Prince George, British Columbia, found that most service providers responded positively to training that was intended to help them prepare their clients for ICM activities and meetings. Several respondents in the Webb et al. (1992) study thought that more training for themselves in these skills would be helpful. If we have the opportunity to have ICM meetings incorporate a continuous quality improvement process, it stands to reason that all the participants will be able to receive further knowledge and skills for effective collaborative practice, and it makes sense that ICM teams will become better equipped to achieve their goals.

That the youth, their informal supports, and their parents, be fully involved is essential to the practice of case management (Bruner, Kunesh, & Knuth, 1992). This current study shows that positive, active involvement of family in an ICM team is the most helpful way to encourage ICM team members to participate. This participation revolves around the need for all members, whether formal or informal, to be treated as equals with the same parameters around their participation. This ability to manage or facilitate an ICM meeting so that all members are able to participate fully is discussed in Nicholson et al. (2000), when they state that “Leadership that is facilitative in style and serves to help others act towards a common purpose has been identified as positively contributing to multidisciplinary practice” (p.26).
It appears that simple processes helped youth participate: checking to make sure youth approve plans, asking youth for their goals, and facilitating a process for youth to speak.

Now we will review the following categories: “The team involved the youth and accepted their input” (helpful), “The team made youth feel connected” (helpful), and “The team did not feel safe” (hindering). These categories reflect the issues of inclusion, trust and safety. Rutman et al. (1998) found that treatment outcomes occurred because care teams were found to be profound for clients and motivating for practitioners, while Webb et al. (2002), found that among surveyed service providers, 82% observed that integrated case management led to positive outcomes for their clients, and furthermore that:

When survey respondents were asked to identify their greatest reward so far in practicing ICM, the vast majority made reference, in some form or another, to the idea that clients’ needs were being met. As one service provider expressed, “It’s rewarding to me to see the client’s needs/issues are being addressed by all the professionals involved...that they are improving their lives - that they are becoming healthier” (p. 30).

Such successes occur for all members when full engagement and safety issues are addressed. Halfon et al. (1993) explained that when emotional disorders become apparent in children, parents are often beset by confusion, anxiety, and fear. Conceivably, these emotional states would also widen to affect extended family, children, and, in some cases professionals. These emotional states require thoughtfulness and often further action by the team to determine a
process that deals with the child welfare tasks and individual’s emotional needs. The youth in this study discussed safety in terms of structures such as effective facilitation for appropriate communication of feelings of fear, anxiety and confusion. The youth stated the need for an environment that promoted an open and honest dialogue while orienting itself to the values of respect and understanding, which are structures of a safe environment. As one youth stated “When there are people that don’t agree. When people are fighting and not listening and not respecting other people’s wishes, and people getting humiliated and embarrassed and not feeling wanted, it is just scary.”

Further, when we provide safety for youth, family and, for that matter, all ICM members, we are able to perform as a collaborative network that meets the needs of youth and family. One participant speaks about how this experience of safety links to outcomes that are positive for all care team members:

…to help me get through life, because I’ve been having a lot of troubles and so they got together to talk with me and listened to what I was having problems with and help me deal with those problems.

Summary

Although the majority of incidents reported by the youth were hindering, it was a slight majority. All but one of the participants experienced ICM meetings that included both helpful and hindering moments. What appeared to be most relevant was that when youth felt valued, felt respect, and felt the team was working towards common solutions based on their strengths, they wanted to participate.
The study’s findings that professionals need to focus on engagement and open communication would suggest that effective ICM meetings need to value youth and family by including them in ongoing and inclusive processes, which allow them to be active members in the change process. The present study has provided a vehicle for youth to contribute to the evaluation of ICM meetings from their perspective, and to provide feedback that will serve to improve the experience for other youth in collaborative processes. It also highlights that all parties in collaboration require safety built from experiences of effective communication and emotional safety. This apparent congruity between all groups suggests that if we continue attaching a continuous quality improvement process to ICM meetings, positive outcomes will occur. This study has also shown that a perfect meeting is not the requirement for youth engagement; rather it is an ICM meeting that includes more helpful than hindering incidents. It is also clear that when youth feel included, they are willing to tackle difficult and complex issues.

**Benefits of the Current Research**

The present study provides data that will let ICM members know what helps and what hinders ICM from the youth perspective. Given the growing importance of client empowerment and the emerging interest in advocacy, the results have even greater salience. It has also provided valuable information to CYMH as they focus on service improvement in the Fraser Region. Bruner et al. (1996) concluded that “formative, or process evaluations not only are helpful in charting the course of collaboration, they also provide a valuable record so that lessons learned in the process are not forgotten at a later date” (p. 13). Vandenberg and Grealish (1996) point out that the measurement of basic outcomes of “Wraparound (family driven collaboration)” can be used by the team to
modify the process and develop the appropriate services in the community. This study is an example of the kind of work that can be done to meet these objectives. The present study has provided valuable feedback to people involved in the ICM process. It has provided a forum for youth voice to be heard along with suggestions about how to improve youth involvement. It has also demonstrated how CIT could be used to evaluate and monitor the ICM process as a continuous quality improvement mechanism. In the future the senior management of the Fraser Region would like the practice of ICM training and evaluation processes to use the question of “what is helpful and what is hindering” at the completion of an ICM meeting.

In research, ethical considerations are always addressed: Do the benefits of the research outweigh the risks? In this study, youth, for the first time in the Region, have had the formal opportunity for their voices to be heard. What they have said clearly articulates criteria for the characteristics of an effective ICM meeting. Of special note in this study is the fact that youth did not suggest that they were afraid or resistant to ownership of their personal challenges. They recognized they that they would have to adapt and change. To help them accomplish this, youth interviewed suggested that if we honour them and their family by inviting them into the process and listen to their expertise in their own lives, then they will honour and respect professionals and their expertise. This is what being a team is all about -- using each other’s strengths to accomplish the goal. This study addresses the fact that effective ICM teams do not just happen – that they take intention, quality training, and continuous quality improvement.
**Limitations**

The youth involved in this study were recruited through the relationships that they had with their clinicians, who in many cases (8 out 10) had been involved in the ICM process that was being evaluated; however, the clinicians were not present during the youth interviews and did not know which youth were included in the study. All interviews occurred in the participants’ homes, in private settings. This sampling challenge had to be set within the context of safety for youth that had mental health concerns.

Youth were screened by their clinician to assure that youth were mentally stable enough to participate in the research; this also could produce a possible sampling bias. That said, the findings speak to a near balance in helpful and hindering incidents, so a bias to choose youth that would only report positive or helpful experiences does not appear to exist. It is important to note that the outcome of this study only reflects the youth’s perspectives on helpful and hindering processes of a ICM meeting. A helpful incident for a youth could have been experienced by other team members as hindering for their participation. This is an important consideration, as we are speaking of a collaborative process. That said, it appears that the categories and the literature on the experiences of other participants in ICM’s, parents and professionals, reflect common themes.

Finally, all youth involved in this study had been involved with mental health services due to significant mental health issues. As mental health challenges can impact the way in which a person experiences situations and feels about others, there could be
some aspect of their mental health condition that could affect the results that are reflected in the study findings; however, in this study we are focus on an individual’s experience to feel included and this is a personal feeling.

That the study involved only 10 individuals presents a further limitation in generalizing the findings of the current study. Although some of the findings will be of interest to those doing ICM meetings in other jurisdictions, generalizing these findings to all ICM processes is not possible.

It had been the intention of the researcher to interview 20 youth, a number chosen by MCFD staff, but not enough participants could be found within the period required in this study.

The trustworthiness of the data gathered in the current study was confirmed in several ways, as is the current trend in CIT studies (Butterfield, Borgen, et al., 2005). Although the study’s reliability was checked through the use of two additional raters reviewing the data, it should be noted that inter-rater reliability has been shown to be low in a quantitative analysis of CIT (Ronan & Latham, 1974). Ronan and Latham attributed this to differences in perspective when two groups of observers are looking at the same phenomenon. This is not of considerable concern as other reliability tasks were accomplished, specifically having youth review the categories, which revealed high reliability.
Implications for Further Research

Further research might be able to determine how the “what helped and what hindered” form of self-reflection could be applied to other types of care teams as suggested by Fleming and Monda-Amaya (2001).

Practitioners in the Fraser Region receive ongoing training in the care team process, and studies have been conducted to determine the efficacy of that training (Webb et al., 2002), and whether the implementation of a CIT approach could improve strategic feedback to improve training.

In this study, the Caucasian population was overwhelmingly represented, with only one participant of Asian descent. All youth when interviewed were living with their families, although one youth had recently been reunited with her mother after being in care for approximately two years. In future studies, it would be important to review other types of care teams to offer stronger recommendations that would include traditional practices from other cultural backgrounds, particularly the Aboriginal and South Asian communities. It would also be important to listen to youth that are in different settings, such as the child protection stream of MCFD, along with paying special focus to children living in the care of the MCFD. Also, future studies might employ a different qualitative methodology, such as focus groups, to determine if similar or different information emerges on youth experience when stimulated and triggered by others.

Conclusion

The aim of this study was to learn about what helped and what hindered youth participation in the care team process. Using the CIT method, 10 youth were interviewed,
yielding 285 incidents, of which 137 were helpful and 148 were hindering. The incidents were organized into 7 categories and 22 subcategories. Several reliability and validity measures (Butterfield, et al, 2005) were implemented to ensure the consistency and trustworthiness of the categories.

The results contribute to our knowledge of what we need to do to ensure that care teams and collaborative processes are effective at accomplishing their goals. During the course of this study it was very apparent that youth are able to recognize when a care team is safe and whether people in the care team appear genuine in their wish to include youth as active members. It was also clear that when these youth were included in the process, they were better able to discuss, strategize and change their lives in a positive and productive manner. I would even go so far as to suggest that it appears that when youth are involved in care teams, it adds to their resilience, along with their ability to feel connected to a positive and caring community. Furthermore, this also appears to allow youth to see adults and their community as beneficial in their lives rather than as a cause of further disconnection to both community and family. Based on the results of this study, I have outlined some strategies and processes that could help include youth in the care team process:

1. Provide information about the process and structure of an ICM meetings to youth and family prior to the care team meeting so that they are ready to participate.
2. Include youth in real decision making and see them as equal members.
3. Value their ideas and give them equal importance and opportunity to participate.
4. Consider the youth to be experts in their experience, with important information to contribute.
5. Allow for light chatting before and after the meeting so that youth do not feel as if their life is a business meeting; however, when the meeting begins have a strong structure that focuses on the quality of the time, not the quantity of material covered.

6. In the meeting environment, have someone responsible for making sure the meeting has a tone and process that focus on respectful conversation and that focus on strengths and solutions.

7. Allow enough time to build a plan and then review the plan at the next meeting. If it is not working, the plan is wrong rather than a person.

8. Ask youth who they wish to be included. Start with a group that works for the youth. If needed, later add others when the youth sees that care teams are strength-based and solution-focused.

9. Listen to youth as you would any other member of the team. Be prepared to follow their ideas; they may work. Most importantly though, this shows that the team is prepared to work with them rather than “on” them.

10. Recognize that youth are learning about relationship and communication processes. They have limited experience with how their community can be used to build their ability to be competent citizens. The care team is a representation of a small community that needs to have values of understanding, acceptance, and appropriate risk-taking, with a relationship tone of caring and compassion.
Bibliography


Appendix

Appendix A – Descriptive Flyer for Youth and Family

This is a research project and your participation is this project is completely voluntary. Your personal information is held in the strictest confidence. Participation or withdrawal from the research project will not affect the services you receive from the Ministry of Children and Family Development. The ethics of this project have received review through both MCFD and the University of Victoria [Research ethics at UVic (250) 472-4545 (ethics@uvic.ca).] If you require further information please contact Mark Littlefield or Dr. Doug Magnuson (UVIC) or Dr. Rob Lees (MCFD)

Youth Participation in Care Team: What helps: What hinders?

Contact Mark Littlefield @ 1-888-832-0777 or Email:

- **Research**: A focused investigation of an issue. In this case we are interested in what works and what doesn’t work to have youth involved in their Care Team.

- **Method**: How do we investigate the issue. Youth will be interviewed by Mark. The interviews will be in an environment that is quite and chosen with the youth. The interview will be recorded using a small digital recorder. The recordings will be made into a written document by a transcriptionist (confidentiality is guaranteed), the document is then analyzed by Mark. Mark is looking for sentences or paragraphs where youth have identified things that work or don’t work for them to feel included and important in the Care Team process. Mark will be interviewing 20 youth receiving services from CYMH that have an active Care Team in the area between Burnaby and Boston Bar. After Mark develops some initial results he will want to show these to five of the youth originally interviewed to see if what he has found out makes sense to them. At the completion of the study each youth will receive a $20.00 gift certificate for either Cineplex Odeon or HMV as a thanks for their time.

- **Results**: What was found out. The results will be put together with two others studies occurring with youth and parents in the area. Then a tool will be developed by CYMH to measure the quality of service provided to youth and their families.

Contact Mark Littlefield
Phone: 604-832-0705
Toll Free 1-888-832-0777
Email: mlittlefield@telus.net

A project funded by the Ministry of Children and Family Development and managed by the Delta Chapter of Canadian Mental Health Association.

Contact:
Dr. Rob Lees (604) 795-8481
Questions for the interview:

1. What is your understanding for the purpose of a Care Team?

2. Do you believe Care Teams are useful for you? How?

3. Can you remember something that happened or something that someone did or said that supported you or encouraged you to be involved in the care team process? Please tell me about that.

4. Can you think of something that happened or something that someone did or said that got in the way of hindered you to be involved in the care team process? Please tell me about that.

Throughout the interview I will be asking for examples that youth have experienced personally.
Appendix B - Youth Informed Consent

Youth Informed Consent

As a graduate student, I am doing research as part of the requirements for a Masters degree in Child & Youth Care. The research is being conducted under the supervision of Dr. Doug Magnuson. You may contact my supervisor @ (250) 721-6479.

Mark Littlefield (a graduate student in the department of Child and Youth Care at the University of Victoria), The Canadian Mental Health Association, and Child & Youth Mental Health are conducting a study to understand what helps and hinders youth participation within a care team meeting.

The Canadian Mental Health Association & the Ministry of Children and Family Development are funding me to study the perception of youth who are using Child and Youth Mental Health (CYMH) services and have an active Care Team about what experiences, statements, or processes, encourage or discourage their participation. The results of this research will be used to develop ways to improve the quality of CYMH services.

You have been selected as a possible research participant because you have an active care team and are receiving Child and Youth Mental Health Services and can provide information about your experience. You are invited to participate in a 45-60 minute recorded interview with Mark Littlefield. This interview could be done at your home, at the local mental health office, or over the phone. Additionally, you may be chosen at random asked to look over some of the research findings to make sure that the findings include your experience and that they make sense, this will take an addition 45/60 minutes. If you choose to participate in the study you will be given a $20.00 gift certificate as a way to thank you for your time. If you agree to participate in this study, this form of compensation must not be coercive. It is unethical to provide undue compensation or inducements to research participants. If you would not participate if the compensation were not offered, then you should decline.

We invite you to participate in this research study. Please be assured that your participation in this research is voluntary and a decision not to participate will not affect the services that you currently receive from CYMH. You can withdraw from the project at any time.

It is important to note that participating is some research has potential risks. In this case the risks are minimal. You may experience a little frustration or other emotion relate to your experience in a care team. If you will require professional services as a result of these feelings the research will work with you and professionals services to meet your needs. The research has completed two ethical review processes one with the University of Victoria and the other with the Ministry of Child and Family Development. The results of this study will be shared with CYMH leaders so that they can improve the effectiveness of care teams. Also, information learned from this study may be published in an article, and could be used as information in lectures on how to improve youth participation in Care Team processes. At the completion of the study all digital recordings will be erased. The transcripts from the recordings and consent forms will be stored in a secured storage area for seven years.

No identifying information (name, address, etc.) about you will be used in any reporting of the results that comes from this study. There is a possibility, as the research asks youth to discuss their personal experience, that a youth maybe recognized by a member of Care Team. The research will adapt information as much as possible to guard against this potential, along with the recognition that the geographic area that youth are from is very large (Fraser Valley) and therefore this also acts as a protection against unintentional discloser of the youth’s identity and/or involvement in the study. However, this confidentiality is limited by the following factors:
1) I am required to report a concern about child abuse or neglect, if you would tell me about it.
2) I am required to report a concern about your physical safety, if you tell me about it.
3) If information about the interview is subpoenaed by a judge or court order, I am required to release it.
4) I may also use the data from this study as a basis for articles and presentations to professionals and non-professionals on the experience of youth in care teams. Within seven years of the study being completed the consent forms and transcripts will be destroyed.

If you require any additional information about this process please contact the following people as they would be happy to discuss any questions or concerns about this project with you. You may contact Mark Littlefield – Researcher (1-888-832-0777); Dr. Robert Lees - Child & Youth Mental Health (604) 795-8481; Rodney Baker - Canadian Mental Health Association (604) 516-8080; Dr. Doug Magnuson- University of Victoria (250) 721-6479. If you consent to participate in this study both the youth and parent/guardian must sign consent forms. If you agree to participate, the researcher will contact you in the near future.

Thank you.
Sincerely,
Mark Littlefield

I have read and understood the above information about the Youth Participation in care teams: What helps and hinders research project.
(Please print your name and your participating family members names in the spaces provided, and sign at the bottom).
I, ______________________________ (Your name) voluntarily agree to participate in this research project as outlined.

Date: ______________________________

A copy of this consent will be left with you, and the researcher will take a copy.
Appendix C – Parent/Guardian Informed Consent

Parent/Guardian Informed Consent

As a graduate student, I am required to conduct research as part of the requirements for a Masters degree in Child & Youth Care. It is being conducted under the supervision of Dr. Doug Magnuson. You may contact my supervisor @ (250) 721-6479.

To the Parent / Caregiver:

Mark Littlefield (a graduate student in the department of Child and Youth Care at the University of Victoria), The Canadian Mental Health Association & Child & Youth Mental Health are conducting a study to understand what helps and hinders youth participation within a care team meeting.

The Canadian Mental Health Association & the Ministry of Children and Family Development are funding me to learn about the perceptions of youth who are using Child and Youth Mental Health (CYMH) services and have an active Care Team about what experiences, statements or processes encourage or discourage their participation. The results of this research will be used to develop quality improvement processes within CYMH.

Youth have been selected as potential candidates because they have an active care team and are receiving Child and Youth Mental Health Services and can provide information about their experience. Youth are invited to participate in a 45-60 minute recorded interview with Mark Littlefield. This interview could be done at your home, at the local mental health office, or over the phone. Additionally, you may be chosen at random asked to look over some of the research findings to make sure that the findings include your experience and that they make sense, this will take an addition 45/60 minutes. At the completion of the youth participation in the study youth will be given a $20.00 gift certificate to thank them for their time. If youth agree to participate in this study, this form of compensation to youth must not be coercive. It is unethical to provide undue compensation or inducements to research participants. If youth would not participate if the compensation were not offered, then the youth should decline.

We invite youth to participate in this research study. Please be assured that their participation in this research is voluntary and a decision not to participate will not affect the services that they currently receive from CYMH. Youth can withdraw from the project at any time.

It is important to note that participating is some research has potential risks. In this case the risks are minimal. The process of discussing Care Team processes may cause the youth to become frustrated or have feels that could be of discomfort to them. If professional services are required as a result of the interview the researcher will provide connection to appropriate services. However, it is the responsibility of the researcher the University of Victoria and the Ministry of Child and Family Development to work to manage these risks. The research has completed two ethical review processes one with the University of Victoria and the other with the Ministry of Child and Family Development. The results of this study will be shared with CYMH leaders so that they can improve the effectiveness of care teams. Also, information learned from this study may be published in an article, and could be used as information in lectures on how to improve youth participation in Care Team processes. At the completion of the study all digital recordings will be erased. The transcripts from the recordings and consent forms will be stored in a secured storage area for seven years.

No identifying information (name, address, etc.) about youth will be used in any reporting of the results that comes from this study. There is a possibility, as the research asks youth to discuss their personal experience, that a youth maybe recognized by a member of Care Team. The research will adapt information as much as possible to guard against this potential, along with the recognition that the geographic area that youth are from is very large (Fraser Valley) and therefore this also acts as a protection against unintentional discloser of the youths identity and/or involvement in the study. However, this confidentiality is limited by the following factors:
1) I am required to report a concern about child abuse or neglect, if the youth tell me about it.
2) I am required to report a concern about youth physical safety, if the youth tell me about it.
3) If information about the interview is subpoenaed by a judge or court order, I am required to release it.
4) I may also use the data from this study as a basis for articles and presentations to professionals and non-professionals on the experience of youth in care teams. Within seven years of the study being completed the consent forms and transcripts will be destroyed.

If you require any addition information about this process please contact the following people, as they would be happy to discuss any questions or concerns about this project with you. You may contact Mark Littlefield – Researcher (1-888-832-0777); Dr. Robert Lees - Child & Youth Mental Health (604) 795-4841; Rodney Baker -Canadian Mental Health Association (604) 516-8080; Dr. Doug Magnuson-University of Victoria (250) 721-6479. If you and your child consent to participate in this study you both must sign the consent form. If the youth agree to participate, the researcher will contact the youth in the near future.

Thank you.
Sincerely, Mark Littlefield

I have read and understood the above information about the Youth Participation in care teams: What helps and hinders research project.
(Please print your name and your participating family members names in the spaces provided, and sign at the bottom).
I, ______________________________ (Your name) voluntarily agree to allow the youth _________________________ (Their name) to participate in this research project as outlined.

Date: ______________________________

A copy of this consent will be left with you, and the researcher will take a copy.
Appendix D - The Interview Process

Introduction: This is an interview that uses a semi-structured format. This means there are some guiding questions, included here, along with some follow-up questions. The interview will require about 1 hour. The interview will be digitally recorded, transcribed and given a code number. Your name and any identifying information will be removed. Once the research has been completed the digital recordings will be erased. The transcripts will be stored in a secured and locked area after the study is completed for seven years – traditional protocol. After this time has passed, the transcripts will be shredded. You can ask to have the interview terminated at any time.

Starting Questions:
1. What is your understanding for the purpose of a Care Team?

2. Do you believe Care Teams are useful for you? How?

3. Can you remember something that happened or something that someone did or said that supported you or encouraged you to be involved in the care team process? Please tell me about that.

4. Can you think of something that happened or something that someone did or said that got in the way of or hindered your involvement in the care team process? Please tell me about that.

Follow-up and clarifying questions:
(a) What happened? (b) Could describe that further? (c) How did it turn out? (d) What was it like for you? (e) How did you feel about that? (f) Would this make you want to continue to participate in care teams (g) what happen before that occurred (h) what happen as a result of that.
Appendix E - Recruitment Instructions

The following are the recruitment instructions for the research “What helps, What hinders youth participation in Care Team”.

We will interview 1 to 2 youth from each office in the Fraser region to get the twenty youths involved in the study. Our hope would be that approximately 10-15 youth from each office could receive packages by the end of June, 07, then 1 or 2 youth will participate. Could the team leaders keep track of the #’s of packages sent out.

Please call Mark Littlefield to clarify any issues 1-888-832-0777 or email mlittlefield@telus.net

Team leaders could you please provide a number of packages to your staff team. Clinician then review there caseload and with the input of the team leader identify appropriate youth for the study. A youth is deemed appropriate if they are between 14-19 yrs of age and receive any mental health service. They must also have an active or recently active (within the past three months) care team. The clinician will determine if a youth can participate in the study by simple considering age and whether the believe the youth can be reflective (a 30-45 conversation) about their experience of participating in a care team meeting (for further information please call mark at 1-888-832-0777 or email mlittlefield@telus.net)

We are simple interested in what words, actions or process helped the youth feel included or excluded in the care team process, we will not reflect on therapeutic issues.

The clinician will share potential referrals with their team leader. The youth and if possible the caregiver will be provide with the handout package which includes the following (Flyer [Youth participation in Care teams] both pieces, both consent forms [youth & caregiver], and the “The interview” page.

1. As we are all focused on confidentiality and protecting the youth please provide information about this study to the youth and caregiver/parent in a private setting.

2. Assure the youth and Caregiver that neither you nor any member of the care team will know who participates in this study. This can occur because many youth and families will be referred to the researcher and the researcher does not provide information back to the clinician or the care team members regarding youth involved in the study.

3. Please tell and confirm with the youth and caregiver that their participation is complete voluntary and whether they chose to or not to participate in the study it will in no way affect any of the services that they receive.

4. The role of the clinician in this study is to identify appropriate youth and then provide the youth and family with the information package.

5. Contacting the researcher does not obligate the youth to participate in the study.

6. Youth under 19 must have consent from their guardian otherwise they cannot participate

7. Participation in the research is voluntary and the youth/guardian’s decision to participate, not participate or withdraw from the research will not influence the services they receive from any of the Care Team members.