TEACHING PARAPROFESSIONAL COUNSELLORS:

THE CASE MANAGEMENT MODEL

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Introduction

The Federal Government of Canada, Veterans Affairs Division, provides a variety of services. They hire their employees based on a minimum standard which is very broad and general. On the lower end of the continuum, an employee may require good health, average communication skill and a Grade XII education. On the opposite end of the continuum, the candidate may require certification within a licensing body or professional helping association such as the Manitoba Association of Registered Accountants. The same employee who hired on at the lower end of the continuum is later accepted into a position which requires certification because of his own personal initiative demonstrated through the upgrading process. These employees who actively pursue upgrading and training in order to become certified, often have two primary vehicles available to them: 1) the public education system of University and technical schools, and 2) in house workshop and training sessions.

Within the Federal Government Veterans Affairs Division, the situation exists where over a period of time the service requirements of the clientele change. Service providers must adapt new skills as required. In most cases, employees either secure training on their own, or take advantage of the training programs which are made available to them.

Within Veterans Affairs, the services have changed significantly over the past five years as a result of the changing needs of the client. Area counselors, as service providers, in the past provided primarily financial counseling and services. However, as the veteran population has become older, their service needs have changed. The Area Counselor is now providing services to a population which falls predominantly into the gerontological group. The Federal Government has responded to the changing needs of the client population in that new programs have been developed which attempt to meet the changing needs of the aging veteran population. The Area Counselor, therefore, becomes the agent who must be trained accordingly. A psycho-social model of Case Management has been adopted by

Veterans Affairs of Canada as a vehicle for service delivery. As few of the counselors have had any previous training in Case Management, it was necessary to:

1) Develop the model

2) Develop a training milieu

3) Train the Area Counselor

4) Evaluate the training, effectiveness, and efficiency of the model.

This practicum report will outline the steps taken in training Area Counselors in Case Management. Chapter I begins by defining "need" as well as outlining a framework for assessing the needs of the elderly. Chapter II provides a comparison of the elderly with their younger counterparts. Chapter III identifies the veteran's needs within the context of the Case Management System, followed by a model for service delivery in Chapter IV. Chapter V outlines the training intervention model which was used in training the Area Counselors. Chapters VI, VII and VIII describe the methodology which was used to evaluate the sessions and the results of the evaluations and chapter IX which gives a report of the Practicum experience.

CHAPTER I

Identification of Need - A Framework for Assessment

In Veteran's Affairs, counselors who have worked with veterans for a period of time say that you can pick out a veteran's home without even having the number available. There seems to be something very different about the home which sets it apart from neighboring homes. The eaves may need a coat of paint, the grass may need cutting, or a door may simply be ajar. The reality is that the experienced eye can quickly see that something is different for the veteran than for his neighbors living on the same block.

In order to help each veteran, the counselor must go beyond concern and begin to identify the needs of the Client. A need, as defined by Johnson (1983) "is the lack which inhibits the development or functioning of the person."[1]

The identification of a need must begin where the client is, or with the client's own identification of his need. Johnson called this the client's "felt need"[1] (Johnson, 1983). Through discussion, a counselor will become aware of

the veteran's unique situation. As the counselor develops a greater understanding of that situation, he or she will find that the client's experiences are far different from those of his neighbors or counterparts who have not served in a war.

Havens (1971) stated that "the needs of the elderly were best revealed by the elderly themselves."[2] Needs must be identified as perceived through the eyes of the client; they can best be identified by asking the client about his or her situation. This enquiry process is called "assessment". Assessment can then lead to the matching of available resources with identified needs in order to arrest or meet these needs. Through working with the veteran, an identification of available resources may, in fact, lead to the fulfillment of their needs.

Within Veterans Affairs, an holistic approach to client assessment has been identified and was being utilized as a means for assessing the client within his or her environment. This assessment was done within the client's home and includes asking the client about his or her situation. The holistic approach assesses the client from five different perspectives: 1) health, 2) finances, 3) support systems, 4) accommodations, and 5) status change.

The first category to be assessed is health. Within the health category there are 16 specific areas which are examined and commented on see Appendix 1. In assessing the health category, Havens asks does the older person see himself/herself as possessing good health? If he/she does not, does it interfere with any activities, which activities, and to what extent?[2]

Counselors must also assess financial need. The client is asked if he/she sees personal finances as adequate or inadequate. If resources are inadequate, Havens asks in what areas, and to what extent?[2] (Havens, 1971). Counselors provide financial counseling by assisting the veteran in completing a basic financial assessment which includes balancing income versus expenses. Those areas which are considered income are all areas where the client receives money. Examples would be War Veterans Allowance, Old Age Security, Guaranteed Income Supplement, Canada Pension Plan pensions, work related pensions, Unemployment Insurance, rental income, etc. As well, the counselor would be expected to look at all areas of expense which the client may have in order to maintain his or her normal existence. Expenses for consideration would be shelter costs, food

costs, personal care, transportation, medical, clothing, special diets, home maintenance and any other expenses which the client may indicate are part of their normal every day activities.

The third category for review is the support system. Havens identified this category as family and friends, and the community/neighborhood[2] (Havens, 1971). Veteran's Affairs identifies the support system as those individual and/or agencies which make up the network of the client. This category is divided into two components. They are the formal and informal support systems.

The formal support systems would include would include the veteran's doctor, nurse, dentist, lawyer, minister etc. The informal support system would include the following:

a) Family - i.e. next of kin or extended family members who have contact with the client.
b) Friends - those individuals who interact with the client on a regular basis.
c) Community Organizations - those organizations which the client utilizes on an informal basis: church, Legion, community club, friendship centers, etc.

In considering this category, Area Counselors are to identify those support systems which interact on a regular basis with the client.

The next category for consideration surround the accommodations in which the client lives. Havens asked if the clients see his/her accommodations as adequate or inadequate to meet their needs[2] (Havens, 1971). Veteran's Affairs identifies two primary situations that the counselor should be looking at:

1) Are the accommodations in good repair? In considering the repair of the facility, counselors should look at windows, doors, eavestroughs, painting. Has the house been kept up or is it becoming run down? Is the client physically able to repair the facility, or is he or she in need of assistance to carry out repairs?

2) Are the accommodations suitable for the client? In considering the appropriateness of the facility, counselors should assess its size, the number of stairs, locations of the bedroom and bathroom, and whether they are appropriate in terms of the veteran. If the client is having difficulty walking, and the

bathroom and bedroom are on the second floor while the client lives primarily on the first floor, this could lead to some significant problems for the client. All these factors should be considered in assessing the appropriateness of the facility.

The last category to be considered is status change. Counselors are to assess any changes which the client may feel are significant. They are to ask "what changes have you experienced over the past month/six months/year?" These changes may include retirement, death of a spouse, move to another accommodation, recent illness, etc. Counselors assess the need for intervention in a given area based upon the client's ability to cope with the situation.

In helping any client, one must first start by being concerned about the client. This concern can stem from an awareness that something is simply not right with the client's situation. In order to help a client, or in this particular case, a veteran, it is necessary to delve further into the reasons why the client is different; what aspect of his or her life is presenting a change or a problem. Once this has been determined, the counselor can present possible ways to ease the situation and may be able to improve the veteran's perspective.

The assessment phase is the initial step in the process of helping the client. Counselors must have a clear understanding of client needs and the five areas of assessment. A helpful counselor will ensure that he/she takes time and expends the necessary energy to ensure the recording of a client profile which grants a complete and accurate picture of the client's immediate situation. This profile should not only be clear to the counselor but it should be recorded in a fashion which can be understandable to cohorts and supervisors.

The assessment stage is a vital link in the helping process as it lays the foundation upon which an intervention strategy may be developed. If the counselor has clearly identified the needs, then intervention becomes the systematic approach to meeting the identified needs. A complete assessment subsequently becomes the basis upon which an intervention strategy may be developed.

CHAPTER II

The Unique Qualities of The Aging Individual

To accurately assess the client, a counselor must have a good understanding of the differences between the older client and his younger person. A Veterans Affairs Area Counselor must also be aware of the differences between the veteran and his non-veteran Canadian counterpart. These differences will be outlined within the holistic framework.

Health

The first area to be considered here is the client's health. The aging body changes during the aging process. The most obvious difference is that the metabolic rate declines. Older bodies slow down, and as a result, need fewer calories to "fuel the furnace." A lack of physical activity further decreases energy requirements. However, an older person's body has proportionately more fat and less muscle, requiring a different nutritional balance. Hence, the older person requires fewer calories and more nutrients.

It is not known why the older person experiences an appetite loss, however, it is suggested that this may be caused by chewing and swallowing difficulties. These difficulties can also cause indigestion and constipation in the older person. An older person's declining sense of smell, deteriorating teeth, and failing eye sight can make food seem less attractive. Many older people experience greater concerns with cardiovascular conditions, such as atheriosclerosis and hypertension, which may lead to a greater incidence of heart attack and stroke than their younger counterparts. Incidence of diabetes as a result of glucose intolerance also becomes heightened in the older individual. Everyone experiences some degree of muscle weakness and joint stiffness, however, joint stiffness and inflammation reduce mobility for seniors at a greater proportion than for their younger counterparts[5] (Novak, 1985).

The overall physical activity changes which occur in an older person fall into two primary categories. The first of these changes is a decrease in activity leading to sedentary conditions. The second constraint the older person feels is reduced mobility as a result of serious illness or disability. Gradually as the human body ages, it becomes less capable of high rates of physical output, and the

recovery from strenuous activity takes longer. However, Older persons who have remained in peak physical condition, find that they can usually continue their activities unrestrained well into their retirement years. Basically, the older individual is victimized by declining sensory perception, declining abilities, and less motivation to participate than his or her younger counterparts.

Finances

The major financial change the older person experiences in comparison to his younger counterpart is a reduction in income. In many cases, the senior retires without planning for retirement. The prevailing attitude today is that "I worked for years and paid into government retirement programs; therefore, I am entitled to receive the benefits from these programs." Often Old Age Security and Guaranteed Income Supplement are not sufficient to allow the retired individual to live at the same level as he did when he was working[4] (Atchley, 1985).

In this light, it is also important to note that the older individual does not have the same expenses as his younger counterparts. The younger person will have the additional

expenses of mortgages, child rearing, transportation to and from work etc. The older individual, on the other hand, will often have his or her home mortgage paid off, and the children will have left home.

Statistics indicate that there is a greater transfer of money from a senior to a younger counterpart than there is from the younger person to the senior. In other words, seniors often find a way of making ends meet without going to their children for support, whereas the reverse may not be true in many cases[5] (Novak, 1985).

It is suggested in this paper that those individuals who have planned for their retirement are often in a better financial position than those who have not. This planning may have been in the form of setting aside capital towards retirement, saving up in the form of RRSP's or through employment with organizations that have secure and long term pension plans. Those individuals who have been able to plan for their future sometimes find that their finances are not significantly reduced when they retire. In fact, they may find their disposable finances are somewhat increased when they retire, as opposed to when they were employed, because they have more time to budget expenditures they have decreased expectations.

Support Systems

In order to examine the role that support systems play, especially to seniors, it is necessary to divide the general population into three groups: the younger group of under 40, the middle group of 40 - 65, and the older group of 65+.

Cutler[6] (1976) found that community group activities were reduced for the younger population, but greater for both the middle-aged and the older population. The older group, however, began to decline in their participation as a result of poor health, dwindling finances, and the ability to secure transportation. Often, community groups are funded by participants. Reduced income limits the amount of involvement the older person can have in such groups. Activity is also limited by lack of available transportation, this may occur especially in rural communities where public transportation is not available or may be a result of limited eyesight or a fear of going out.

Interaction with family members is increased for the older population. However, contrary to popular views, dependency upon family members does not increase with age. It seems that the older individual wants to remain independent as long as possible. Interaction with friends appears to

remain the same for the aged, as for their younger counterparts, however, it does begin to diminish as the older person's friends die. The older person is less likely to form new friendships as quickly as his or her younger counterpart[5] (Novak, 1985).

The older population is more dependent on formal support systems than are their younger counterparts because older people require more medical input. Thus, contact with hospitals, doctors and similar medical support systems is increased.

Accommodation

Older individuals, by the very nature of their roles, spend more time at home than do younger individuals. In a breakdown on activities that older individuals are involved in while at home, Moss and Lawton[7] (1982) found that older individuals spend 22.7% of their time on obligatory activities, such as shopping, housework, etc. Their home becomes their total environment more than that of their younger counterparts, indicating that the scope of their environment is reduced.

Status Change

Status change for the older person primarily falls into three major adjustments, as opposed to younger generations who usually undergo more changes.

The older population is usually no longer involved in child rearing. The major reaction to this is a change in the use of one's time. There can be greater activity with one's spouse. Women often find themselves seeking employment in response to a reduced workload in the home. Social circles revolving around events such as school involvement, sporting events and car pools often disappear.

Retirement can present another major adjustment. In most cases, individuals go from full time employment to no employment. Retirement can be the result of a number of factors; it can result from a lack of opportunity to work, a lack of the ability to work, or even the lack of the will to work. Individuals forced from the work place by an inability or lack of opportunity often find the adjustment to retirement very difficult.

Perhaps the most significant status change for the older person is the death of a spouse. The adjustment to this type of loss is often longer and more heightened for an aging individual than for his or her younger counterpart. In some cases the older person may, in fact, will himself to die soon after the loss of a spouse. Death may result from starvation, lack of medication, or even depression so deep that all will to live is lost[5] (Novak, 1985). It seems that younger individuals, on the other hand, go through these adjustments more successfully in that they have more supports, more friends, and more active involvement to assist them through the grieving process.

As people experience the various changes which occur as a result of time and the natural process of aging, they tend to take on a different perspective both of themselves and their environment. The individual who is able to plan for, and then subsequently adapt to, those changes is better able to enjoy the process. Individuals who fail to plan for change and are resistant to the change process as it occurs may find that they are more likely to be in need of assistance.

CHAPTER III

Veterans' Unique Needs

Veterans as a whole have additional needs which are different from those of individuals who have never served in a theater of war. In trying to meet these needs, the Canadian government takes into account war-related experiences when assessing the needs of its veteran clients.

In 1985 there were approximately 675,700 veterans in Canada; these figures represent 3% of the total Canadian population. However, nearly one-quarter or 24% of the male population over the age of 50 years are veterans. The average age of the veteran in Canada today is 67.5 years. The average age of war veterans is as follows: World War I - 88 years, World War II - 65 years, and the Korean War - 56 years. Projections indicate that in the year 2006, the number of war veterans remaining alive will be 150,288[8] (Minister of Veterans Affairs, 1985). This indicates a total reduction of approximately 78% of their numbers. In 1991, approximately 88% of the veteran population will be 65 years old and over, and by the year 2001, all veterans will be over the age of 65, barring another war.[8] (Minister of

Veterans Affairs, 1985) With such a large segment of our population having veteran status, a system must be in place to identify the unique needs of the aging veteran. Veterans' needs are often linked to those experiences which were unique to War service. The long term effects of fear and trauma are difficult to measure. However, Veterans Affairs of Canada gives serious regard to this factor in considering its responsibility to assist clients. From a health perspective, some of the obvious results of fear and trauma are confusion and agitation. These conditions can limit the veteran's ability to function within his or her environment, home, workplace, etc. Loss of limbs and other injuries related to war service can also interfere with the veteran's ability. As well, long term health effects must be considered. For example, hearing loss caused by exposure to prolonged loud sounds, varicose veins from long hours of marching and standing, and skin conditions resulting from improper hygiene are just some of the problems common to many veterans. A variety of health problems can have developed from the natural escalating process of body breakdown caused by prolonged cold and wet conditions. These problems are all a part of the veteran's daily life and must be kept in mind as Veterans Affairs counselors work with their clients.

When the veterans came back from the the war, they found it difficult to find jobs. The boom had passed, and the country was unable to create large numbers of jobs to accommodate the returning soldiers. This is significant in that individuals who remained in Canada throughout the war years were able to hold the same position during a time when the country was experiencing an economic boom. They had the chance to gain employment opportunities, and to build up their own personal finances.

The veteran, on the other hand, was unable to build up his finances, as most of his income during the war went directly to his own or his family's maintenance. Soldiers were unable to build up pensions as a result of their service time because when they left the army, any pensionable service which was accrued was lost or discharged through payouts. This greatly reduced their income after retirement.

Soldiers were predominantly in a position of taking command without asking any questions. They were taught to respond immediately to that command. Individuals who are placed in this situation for a length of time often find it difficult to think for themselves. They find themselves feeling more comfortable receiving direction rather than giving direction. On returning from war, many veterans found

themselves seeking employment in positions where they had close supervision and where they were given specific direction. This often led them to accept low income positions in comparison to their non veteran Canadian counterparts who would be allowed to take on managerial or higher paying jobs. This limited the veteran's income from the workplace, his ability to build up savings, and subsequently, his pension income[8] (Minister of Veterans Affairs, 1985). Many veterans returned expecting to be heros and they were simply ignored. Officers also struggled with with being in charge overseas and when they returned many had lost their jobs and were given employment with no staff.

The effects of trauma on the family appear to be significant even today. However, there have been very few, if any, studies conducted on the factors which may have contributed to the breakdown of the veteran's family. Several war related situations may have played a part in family breakdown. Separation from family and friends, changes in a veteran's personality as a result of war experiences, as well as loss of hearing may all have placed a strain on the family relationship and may, indeed, have led to some family breakdown. It is clear that many families to which veterans have returned are still suffering as a result of the veteran's war time experience.

Informal support systems which veterans develop appear to fall into two groups. The veteran will either want to remember friends and service time, and will join organizations which allow for this, or he will join organizations which are neither directed nor controlled by veterans leagues. An example of this first group would be the Legions. Clients which make up a third and distinct group are the second group is represented by organizations which provide support to all Canadians within their home communities. Those individuals who find it difficult to relate to informal organizations in their communities are often left alone and distance themselves from the public. This could be a result of veterans not wanting to remember their war experiences and their inability to relate to those individuals who have not had similar experiences as themselves.

The dividing of the veteran client population into three distinct, groups allows the social work practitioner to address specific needs in their client population. Of the three groups the latter group is the most needy from a psycho-social perspective. The first two groups appear to be more adjusted, although individuals from all three groups may equally require the assistance which is available through Veterans Affairs. Although the specific type of intervention is not referred to in this report it is clearly a field which requires further followup.

Alcohol abuse or misuse may also appear and be prevelent in any of the three groups. This study is not broad enough to demonstrate the group of Veterans who maybe experiencing the most significant difficulty in this area. The writer feels that in treating veteran alcoholism, as well as other psycho-social issues, the social work practitioner must consider unresolved issuses which in part maybe linked to either killing someone or in seeing their close friends or buddies being killed or wounded. Veterans are often left asking themselves the question, Why them and not me?

Veteran clients often appear to accept the loss of a partner passively, whereas the veteran's spouses tend to find the death of the veteran to be difficult, and may experience serious trauma as a result of the loss. Statements from a spouse such as "I don't know what I'm going to do" or "he looked after everything" are not uncommon. Veterans predominantly controlled their home environment; they controlled the purse strings, and looked after the bill paying. When the veteran is no longer on the scene, the spouse is left with these duties, and is unknowledgeable, and unprepared for them.

In considering status change, it is important for counselors to ask their clients what changes have occurred during a specific period of time. Veterans have very different perceptions of time than their non-veteran counterparts. Veterans often view time in an infinite stage. They find it difficult to relate to specific points of time. This may have come as a result of serving in areas where time meant little, and where other issues were predominant, i.e. survival, long marches, battles, etc.

The aging veteran experiences many of the same effects of the aging process which were mentioned in the previous chapter. The veteran, however, is in a far more vulnerable state than his/her non-veteran counterpart because of the unique experiences received in the theater of war. Veterans have been separated from their families for long lengths of time. They have experienced the most extreme weather conditions without proper shelter and, in many cases with little shelter as all, and the very real effects of battle both emotionally and physically leave a veteran with needs which are more acute than those of his non-veteran counterpart. The unique needs of the aging veteran are the focus of this intervention strategy. Counselors within Veterans Affairs must be aware of not only the changing

needs of the aging population, but also the unique needs of the aging veteran. The counselors who were initially trained to provide a very limited financial assistance program to a middle aged population are now required to provide services which meet the global needs of a more vulnerable aging veteran population. In order for management to systematically reframe the intervention approach of Counselors within the Prairie Region it became necessary to develop a strategy for organizational change. The following strategy was utilized for the change process:

1. Develop a model for the systematic delivery of services (The Case Management System).

2. Train the service providers in the use of the model.

3. Evaluate the process.

CHAPTER IV

The Case Management System

The purpose of this chapter is to outline the model which was presented to Area Counselors for use in their service delivery. The model is called the Case Management System and Standards (see Appendix III).

The term Case Management as defined by Belazuk, Crawford, and Wimberley (1987) is "a system of locating, or meeting, and monitoring a defined group of services for a defined group of people and as a process whereby a fixed point of responsibility within the governmental agency, or its designee, is assigned to coordinate a comprehensive, community-oriented plan of services and informal support for an individual or family".[9]

Case Management and the term Case Manager evolved out of the 1960's and early 1970's in response to the need for the development of a strategy that would meet the greater needs of the system within the limiting timeframes. During the 1960's a number of new programs were developed and were funded by various components of the government. Examples

of these are Meals-on Wheels, a far expanded and integrated Child Welfare System, Counseling for Seniors, and a Community Mental Health System. These services became available as a result of the identification of needs and the available resources due to increased tax dollar.

This began to change during the later part of the 1970's and into the 1980's. The economic slowdown brought declining tax dollars which in turn brought a significant concern about duplication of services, a problem which had arisen out of more prosperous times. Organizations began to discuss the various areas of duplication. It became apparent that although some services were overlapping, no single support group could fill all of the requirements for any one family. For example, the family worker could not provide the same service as the Victorian Order of Nursing, or for that matter, the child care worker. And it was necessary to ensure that the family continued to receive all of these services. Through discussion within the source groups it was decided that most duplication surrounded the assessment of the client situation, and also the follow-up to the intervention[9] (Richardson 1974).

Another issue which began to cause funding concerns was the question of whether or not services were actually being provided, and whether or not they were producing appropriate results. On occasion, contracts to private organizations and individuals were being renewed repeatedly, without any assessment of their worth. A monitoring system was long overdue.

One example of the development of such a monitoring system occurred in 1972 with the U. S. Department of Health and Education, and Welfare under the Allied Services Act. Senator Elliot Richardson created a project to improve linkages and coordination at the state and local level. In 1974, Health, Education and Welfare expanded their service with a focus on identifying those elements essential for securing and coordinating the delivery of those services.[9] This coordination and linkage thus became known as Case Management.

Belazuk, Crawford, and Wimberley (1987) presented five components of Case Management. They were assessment, planning, linking, monitoring and advocacy.[10] Assessment included those activities which were related to reviewing the client situation and collecting data in order to analyze the client within his or her environment.

Following assessment came the planning component. Planning surrounded assimilating the information gained through assessment with the resources available to develop a consistent intervention. The next step, linking, was the process of matching the client with the resources which would provide the intervention.

Monitoring was the feedback process of evaluating the intervention in the client situation. The role of advocacy is basically one of lobbying on behalf of a client. Essentially it addresses perceived wrongs in an attempt to correct them. In recent years, the ombudsman has taken on the advocacy role from the Case Manager.

In 1983, Steinberg and Cartier previously defined the role of the Case Manager to be one of 1) entry, 2) assessment, 3) case goal setting and service planning, 4) care planning implementation and review, and 5) evaluation of client and program status.[10] The major similarity between the Steinberg et. al. model and the Belazuk et. al. model was in the assessment phase. Steinberg et. al., however, developed the other four phases quite significantly.

In the first stage, entry was added to define the role of that first point of contact and to ensure that the agency was able to meet the needs of the client. The first stage also included the early assessment stage. As was mentioned, assessment remained virtually the same.

The third stage, goal setting and service planning, identified specific goals which were to be accomplished. Stage three also outlined the roles everyone had to play within the intervention. The fourth stage, care planning and implementation, surrounded the mobilization of the intervention plan. The fifth stage of review and evaluation of client and program status was quite different from the previous model in that it set up the opportunity for effective feedback and updating of the client plan. The former model simply consisted of a monitoring role.

The Case Management System and Standards as presented by Veterans Affairs in 1987 was a modification of both models outlined, and included six very distinctive steps. These steps are 1) Intake, 2) Assessment, 3) Case Plan, 4) Decision, 5) Implementation, and, 6) Follow-up.

The Intake stage begins at any point of contact with the client, be it in the field, within the office, or over the telephone. This is simply an early assessment which

includes identifying whether the client is qualified for services and benefits, and identifying a point of contact for an assessment. The Intake stage could be performed by a Case Manager or by an Intake clerk.

The Assessment stage is a very detailed summary of the client's needs. As outlined earlier in the holistic approach to assessment, the client's needs are determined by beginning where the client is, and identifying the client's felt need.

The Case Plan prioritizes the needs of the client and ensures that the client agrees with each identified need. Each need then has an intervention strategy outlined which is intended to meet the need. Each intervention strategy identifies three factors: individuals responsible for follow-through, time frames, and cost of intervention. The case plan is developed jointly with the client to ensure his input and concurrence with the plan.

The fourth stage, called Decision, is one intended to ensure that all authorities are in place before any services are provided or funds are released. Authorities may include the signature of a client, supervisor, or collateral agency. Once the appropriate authorities are in place, the Case plan may be enacted.

The Implementation stage guarantees that the identified individuals who are responsible for following through with the Case Plan are in fact mobilized and imparting services to the client. In this stage everyone is to understand clearly his or her role. The Case Manager must be sure that letters of authority have been received and the Case Plan is being enacted.

The follow-up stage is one of review and evaluation. The Case Manager is to check with the client to see if services are being provided, if they are meeting the client's need, and if there are any problems with the service. The Case Manager should also check with those who are providing the service to review any problems and determine whether services are deemed to be meeting the client's needs. The Case Manager should ensure a complete client profile is contained in the file, and that file recording is up-to-date. Follow-up should also see the review of any new needs which may have become apparent either through the implementation of the Case Plan or as a result of simple changes in the clients' situation. Those needs should be identified and a case plan should be outlined to meet those needs also.

The Case Management model has evolved over the past decade as a result of declining funding dollars and the belief that service providers were duplicating services to their clients. Two models developed by Steinberg et. al. (1983) and Belazuk et. al. (1987) contained specific stages of service delivery. Although the models were somewhat different they both contained the critical assessment stage which was similarly applied in both models. Veterans Affairs drew from both models in developing the Case Management System. The Veterans Affairs model contains six distinct stages called: Intake, Assessment, Case Plan, Decision, Implementation, and Follow-up. The model places a great deal of emphasis upon the assessment stage in order to ensure a complete picture of the client needs is identified. The development of the model and subsequent service standards ensured a systematic approach existed for Counselors to provide the expanded services to the aging veteran population. The next task became one of ensuring that each counselor receive adequate training in the model and then be sufficiently motivated to utilize it in their practice. The process of training counselors in the Case Management Model and its subsequent evaluation is the focus of this practicum.

CHAPTER V

THE SOCIAL WORK INTERVENTION

INTRODUCTION

Within Veterans Affairs the counselors or veteran service provide required new skills in order to meet the changing needs of their clientele. In assisting the process of meeting those needs the Regional office support staff developed the Case Management System in order to provide the counselors with a systematic approach for service delivery. The Social Work intervention in this practicum is the process which was utilized to teach the Case Management System to the counselors for application in their practice. This chapter is therefore divided into three distinct sections which have the following headings: Teaching the Model, Principles of Adult Learning and The Teaching Milieu.

TEACHING MODEL

The training model was developed by using a framework which was first put forward by Freire in 1973 and later built upon by Mezirow and Baum in 1978[11]. The model took a therapeutic approach to teaching and learning.[11] It basically outlined the concept that each individual develops a representational

model which is that individual's concept of reality. This model represents the meanings and values which are attached to experiences and, subsequently, the strategies and skills which are acquired through those experiences. Each individual has a different representational model. However, models within a particular environment have similar meanings and values attached to them. As each individual's representational model develops, the individual tends to delete, distort and oversimplify various aspects of his experience. Some aspects become lost, repressed or misrepresented. Society encourages the devaluation of less pronounced models and those individuals consequently see themselves as unimportant and begin to repress or forget about them, thus making them valueless.

Within this framework, the task of the educator is to assist adults to recover lost or repressed models and traditions to the conscious level through counseling type processes. The teaching activities are issue, problem, or person centered. The learning activities include self-reflecting, transforming, reintegrating and bringing altered models of reality to the attention of others. The educator here specifically intended to assist individuals to re-awaken their representational model. In teaching Case Management to the Area Counselors, the educator applied four basic assumptions. They were:

1. The training would be skill focussed. Each counselor was to attempt to improve his or her own personal skills as well as the skills of the group.

2. The examples presented would cut across all human relationships. The experiences, discussion and interaction would be such that any individual would be able to be a part of the group and learn from the interaction within the group.

3. The session would use real examples. Those examples would be derived from real life experiences and would not be simple fabrications which would suit a particular situation.

4. The teaching milieu would utilize the combination of:
   a) lecture
   b) discussion
   c) VHS tapes
   d) self-directed reading

In conducting the training sessions, there are three prevalent teaching styles which are discussed by Brundage ans Mackeracher. They are directing, facilitating, and collaborating[13] (1980).

Directing is a teaching method which is utilized in hearing specific information. It presupposes that the educator has the information and the participant functions as a learner. The director is the expert and, therefore, directs the learning of the participant through a specific curriculum.

The facilitating mode of teaching offers participants a greater role in directing their own learning. The educator has the responsibility to assist the participant in choosing a mode of education and to ensure through support that the participant continues along that mode. This mode of education is particularly good in cases of self-discovery, conscience raising, creating new meaning and values, and the development of skills.

Collaborating supposes that the educator and the participant begin at the same level and go through a development process. They share in the defining of the learning objectives and goals, and jointly benefit from the learning process.

The teaching process is further elaborated upon in the next chapter under the heading of the "Teaching Model." All three methods were utilized. Specific material was presented to the participant by the educator. This was done through a format of directing the student's learning. Facilitating took place when participants were encouraged to discuss their representational model thus allowing personal growth and development. This took place through the discussion of various experiences, thoughts, and concerns which were linked to the training session. Collaborating took place with the discussion of specific examples which had taken place within the field. Participants were asked to share examples of real cases in which they had been involved and the educator and the participants all listened in and were part of the learning process.

Principles of Adult Learning

The process for teaching the model was tutorial, therefore it was necessary for the educator to become familiar with a model for adult learning. As a framework, the instructor

applied the Principles of Adult Learning as outlined by Brundage and Mackeracher in 1980[13]. They are described below along with examples of their application.

A) Physiological Characteristics

Adults learn best when they are in good health, well-rested, not under stress, and when their vision and hearing are in the top condition. Adults do not learn productively when under severe time constraints.

Adult learning is not directly related to changes in physical characteristics until after about age 40. Ability to learn after 40 often may be proportional to physical aging. Signs of aging can be difficult to detect, for example, visual acuity may decline.

In the application of this principle the educator was very cognizant of moving slowly through the material. I attempted to ensure the participants felt little or no time pressures. We covered topics, at what appeared to be a relatively easy pace to ensure the older members of the group did not feel rushed. It was interesting to note that in one session a younger member of the group shared some frustrations over how slow we were moving and indicated he was under some time constraints. I handled his concern by giving him a full range of what would be discussed through

the course of the day and how necessary it was for everyone to understand what was being said in order for them to grasp the rest of the material which would be presented later. The person appeared to be satisfied with my explanation.

B) Self-Concept

Each individual forms an abstract idea of himself and how he appears to others. These ideas are formed through feedback and experience which are organized as a result of cognitive and emotional elements. The cognitive element is called the self-concept and is the individual's description of himself. The emotional element is called self-esteem and is the way the individual feels about himself.

Adults enter learning activities with an organized set of descriptions and feelings about themselves which influence the learning process. The educator working with adults needs to know how he personally conceptualizes adult learners as well as how the individual adult learners conceptualize themselves. Adults with positive self-concept and high self-esteem are more responsive to learning and

less threatened by learning environments. Adults are more concerned with whether they are changing in the direction of their own idealized self-concept than whether they are meeting standards and objectives set for them by others.

Adults react to learning experiences or information as they perceive it, not as the educator presents it. They learn best when there are activities which allow them to organize and integrate new learning into their self-concept. Educators of adults should be able to model behavior which is relevant to the role of the learner.

In presenting the material the educator utilized a large number of examples which related to the counselor in his/her own workplace. I asked the participants to share personal experiences in an attempt to have them feel that what they were already doing was worthwhile and that we were building upon those experiences in a positive direction to become better service providers. It is important to note that in no cases did the educator attempt to indicate the existing service being provided was wrong and he was here to correct it. The model was always presented from the perspective of being a formalized tool which could be utilized to enhance the service delivery approach rather than replace it.

C) Emotion, Stress, and Anxiety

These three states are similar psychological processes and have similar behavioral outcomes in the presence of continuing and unresolved threats to an individual. The experience may arouse an individual to learn or it may have the exact opposite effect of tempting an individual to leave a situation.

Adults have more, stronger, and longer emotional responses to change than children do; as well, they have developed well organized strategies for defending against threat or for covering emotional reactions. An adult who is experiencing extreme stress or anxiety may communicate poorly and process information in ways which delete, distort, oversimplify or over-generalize. Adults learn best when they are stimulated, aroused or motivated to an optimum level through internal or external sources. They do not learn when over-stimulated, or when experiencing stress or anxiety. They learn best in environments which provide trust relationships and freedom from threat. Adults who enter into learning activities are often well motivated and generally do not require further stimulation in the form of pressure or demands. Stimulation or arousal can be channeled equally well into learning or into resistance to learning.

Adults who can process information through multiple channels and have learned how to learn are most productive learners. They will learn best when the content is personally relevant to past experience or present concerns. Adults also will learn best when the content is presented through a variety of sensory modes and experiences, and through effective two-way communication.

As mentioned previously the educator allowed the participants a great deal of opportunity to share personal experiences. Another approach which was also utilized to allow individualized psychological processes to take place was through the direct dialogue which took place between the educator and the participants. If the specific individuals spoke of personal concerns which appeared to be affecting either the individual or the group's learning, I then attempted to meet with the person during breaks. This allowed them to state their concern individually, separate from the group. As part of the discussion I assured them of my own personal interest in their problem and some suggestions for sorting it out at a later time. In one session this appeared to be a significant issue during the first part of the session however, after spending time with the person during the break I found the person appeared less discomforted by the problem and subsequently became more productively involved in the session.

D) Past Experiences

Adults have varying experiences. These experiences often assist them to frame their learning. They want to relate the material to past experiences, thus, experience is an asset in learning.

Adults learn most productively when the material being learned or the process being used bears some perceived relationship to past experiences. Adult learning focuses largely on transforming needs, values, strategies and skills derived from life events. All adults do not necessarily possess all the meanings, values, strategies, and skills required for new learning activities. Past experiences can be most productively employed in current learning when the divergent non-consequential and non-logical cognitive processes are utilized. The principle has already been elaborated on at length previously.

E) Time

Adults tend to perceive time differently from their younger counterparts. They tend to perceive an ever increasing past, the pressures of the present, and a finite future,

whereas their younger counterparts tend to perceive time as including the present and an infinite future. Adult learning focuses on the problems of the immediate present. Learning content should be derived from the learner's needs.

Past experience becomes increasingly important as an adult grows older. When learning focuses on problem solving, the solutions must come from or be congruent with the learner's experience. Adults tend to experience a need to learn quickly and get on with living.

The material was presented as an immediate resource to the participants, as something that could be used immediately in their practice. It was also presented as a partial solution for various problems which counselors may have experienced in the past in their practice. The educator suggested that often the basis for difficulty in one's practice, all things being equal, may be related to one of the following points:

1. The lack of fundamental knowledge of the program.
2. The lack of service delivery skills.
3. Not practicing a systematic approach to service delivery.

I suggested that counselors should examine their practice in an attempt to identify which areas could be strengthened. If the weakness lay in the area of a lack of departmental knowledge then I suggested that there was plenty of program material available in the department and if anyone was experiencing difficulty accessing it I would be glad to forward any necessary material. I suggested that if counselors were having difficulty in the area of counseling skills, then there were many programs available in their local area which could be taken or I could make myself available to provide this training if required. I suggested that the Case Management System Model would assist counselors to organize their practice so that the systematic approach which was being presented would allow for more effective service delivery on their part. This could be accomplished through a number of ways some of which were:

1. More time available due to being better organized.

2. More confidence because of a greater sense of control within the workplace.

3. More client satisfaction as a result of a more improved service. The participants were also encouraged to identify other areas in which they

experienced improvements in their service delivery and share those benefits with other members of their group. This process of teaching a model which was directly applicable to the counselors practice and subsequently the perceived answers to some of their more difficult organizational problems was intended to gain perceived support for the model and its subsequent usage. The educator in applying this principle had deduced that if the participants viewed the model as being helpful and if it was immediately applicable in the workplace, then the participants would find the learning process more rewarding.

F) Motivation

Motivation is a term which includes a tendency within everyone to produce organized behavior. Motivation can be a result of external or internal forces. Motives are the felt needs with which learners start a learning activity. These motives may relate to unmet needs or unwanted conditions in life and to the pursuit of positive growth towards desired goals. Adults who begin with motives related to unmet needs or unwanted conditions within their life are likely to feel more threatened and, therefore, require more teacher support and structure.

Once direction and goals have been clearly identified, behavioral objectives can be developed which will guide the participant and the educator in seeking and giving feedback. This feedback contributes to the feelings of success or failure thus leading to further motivation.

Success and satisfaction become reinforcers for learning and motives for further learning. Teaching behaviors can contribute most productively to clarifying direction and specific objectives, and to providing feedback. While adults have a verbal capability to clarify and specify their own learning needs, they are often reluctant to do so and may need assistance in the process.

During the session, participants were regularly encouraged to talk about their practice and how they handled various situations. This strategy not only involved the participants in the process, but was also intended to motivate them to learn based upon their own shortfalls. I surmised that individuals with significant shortfalls in their practice would be motivated to strengthen their practice because of the perceived success of their peers. I also felt the more successful counselors would be encouraged and motivated to greater heights by the reinforcement received from sharing positive experiences.

G) Paradox

Paradox is an essential characteristic of adulthood. One aspect of adulthood is the ability to cope with and respond to adversities, contradictions, dilemmas, and paradoxes. Adults have learned to deal with these and the adult educator must be aware of these issues.

As an adult learns, he needs to be able to cope with paradoxical situations in which change and stability, dependency and independency are all required. The adult learner may respond to ambiguity and instability with increased anger and self-defense. Since ambiguity and instability are seen as necessary for learning, anger will often be a basic component for any learning activity. This particular learning principle was not actively pursued during the course of the sessions although it may have surfaced from time to time.

H) Learning Styles and Abilities

Each individual has developed his own style and his own abilities as a result of his experiences. While some may utilize memorization for learning, others may utilize

interaction and discussion. The educator must be aware of the different styles which the participant has developed in the learning of material.

Adult learners each have individualized learning and cognitive styles and mental abilities. A group of adult learners will be heterogeneous in terms of learning and cognitive styles and mental abilities. The adult educator must be willing and able to respond to each learning and cognitive style. He must be aware of his own styles and of how these affect the process he uses to assist learners. When a mismatch occurs between the learning cognitive style of the participant and the educator, the result is likely to be unsatisfactory to both.

For cognitive styles which involve the developmental process, there are two types of matches between styles. One involves the educator and the learner at the same level of development, and results in satisfaction for both. However, when there is to great a gap between the two, interms of level of learning, the learning process is maybe blocked for one or both. The other involves the educator at one level higher than the learner and results in the development of the learner. Cognitive and learning styles are value neutral. There is no one best way to learn.

Adults tend to be proficient at self selecting those learning situations and teaching/learning interactions which best enhance their own learning cognitive styles. Learning activities are cyclical, sequential and unidirectional in their natural order. Adult learners prefer to start with the learning activities they are most comfortable with, and to avoid those they see as difficult. Teachers tend to start teaching with their own preferred learning activity. The starting activity will determine what the educating preparation must focus on and what the remainder of the teaching activities will look at. Adult learners and their teacher can share the responsibility for such teaching related activities. Feedback can occur only after the learner has acted overtly.

Each cognitive learning style is adaptive in some situations and dysfunctional in others. Cognitive learning styles are not related to intelligence, mental ability, or actual performance. Although overall mental ability generally declines with age after 50 years, age related declines in mental ability occur in those aspects of mental functioning which are based upon physical factors and which involve the transference of meaning, values, skills and strategies from past experiences to current activities.

The teaching style utilized in the sessions is covered extensively in the next chapter, however, the educator attempted to consider this learning principle utilizing a specific teaching style of "the educator and the learner both having something to learn in the sessions." This was an adaptation of the style which states "the educator and the learner are both at the same level and both learn as a result of the teaching process." In utilizing this style the educator clearly indicated to the participants that the reason for setting up the video equipment was so that he could review his teaching practice later for the purpose of evaluation and improvement. I also encouraged the participants to share their real life experiences so that we all could learn from them. The educator realizes that this particular style would not be the most effective with everyone, however, it was utilized because the educator felt most comfortable with this style. There were two reasons the educator felt that it would be the most successful. They were:

1. The educator had not been with the department as long as most of the counselors and he wanted to ensure the seniority and experience of the participants was respected.

2. There is an unspoken animosity towards the regional office (where the educator was employed) which periodically surface in comments by the field office staff, suggesting that staff in the Regional office were not very informed of what was happening in the field.

I. Developmental Strategies and Transitions

Each individual, as the result of his experience, goes through varying stages of development. These changes, known as transition, can be used by the educator in teaching. Adult behavior is not fixed but changes in response to both internal and external pressures. The changes tend to follow basic patterns which are cyclical. The adult learner is more apt to be responsive to learning opportunities during intervals between transition points in his development. Adult learners have not all reached the levels of cognitive development predicted. Such nonattainment may be the result of obstacles within the environment or lack of specific experience. Adults may also regress from previously attained levels of cognitive development. Some Adults are

highly motivated to learn in the areas relevant to their current development. They tend to enter new experiences in dependent modes of behavior and to change in response to their own definitions of themselves.

The educator attempted to assess the developmental level of the participants by reviewing their educational standing, work experience, and age grouping. It was found that counselor educational levels varied from university graduates to non high school graduates. The participants had worked in their positions from a matter of months to over twenty years and their ages varied at all levels of pre-retirement adulthood. The one commonality which appeared consistent to all counselors was the fact that all were counselors working for Veterans Affairs with similar experiences while on the job. It was this thread which was utilized as a transition point to move the counselors thorough the learning process. This was accomplished as already mentioned through the counselors sharing their own experiences. The utilization of the learning principles were not in and of themselves the only process utilized in the training process, but the educator's awareness of them did add greatly to the effectiveness of the sessions.

Teaching Milieu

The teaching skills utilized in the sessions were modelled after Lawrence Shulman's groupwork with adults[14]. They are outlined below:

Tuning In

Since the educator used the development of a support system, directed through the utilization of feelings, tuning in is a starting point in the unfolding of empathy. An educator who tunes in early to cues from participants will be able to respond successfully.

As I was conducting the training sessions in one of the district offices, a group, upon returning from coffee asked if I would like to come into the field and get some real life experience in working with veterans. This was an indirect cue to me that I was not experienced in working with veterans, and therefore not qualified to lead the session. My immediate response was "Yes, I would like to do that some time but right now we have to get back to the material." As the session continued, I began to reflect on this comment and the need to tune in again to where my participants were. I looked for a point in the session where I could reopen the topic, and I began with "I don't know much about working with seniors and I hope that today

you'll share some real life experiences with me which will allow me to better understand what you are going through in the field. My area is case management. Together if we can meld case management with your experience in the field, I feel that you and I can grow as a result of the session today."

After I made this statement I found that the participants warmed up and were eager to share their experiences. If one is meeting with support, encouragement, and tuning in from one's supervisor, one is better able to tune in to others.

Clarify the Roles of the Person or Persons

Outline your role within the session as well as the role of the participants, i.e. "I am here to teach, train in case management. After the session today, there will be an evaluation which will rate what you have learned as a result of the session."

"Elaborating skills" may also assist the participants to become more specific in focusing on their concerns. By elaborating, the educator can direct the discussion from general into more specific areas. "Containment" is another technique. The facilitator must allow participants to present a complete story. If solutions are presented for them, they are less likely to develop a sense of internal

growth. The educator must understand how to contain his own comments and those of the group in order to help the participant to find his own answers.

In one district office, a participant continually appeared to have difficulty in reaching solutions to her particular examples. As the group would be available to her on an ongoing basis and the educator would not, it was necessary for the educator to bring the group in to assist in finding a resolution for the participant's problem. The group quickly jumped in and began to assist in solving whichever issues were presented. The facilitator then attempted to limit the amount of input on the part of the group to ensure that the participant would be able to go through some self development and self growth. Seeing the participant six months later, I was pleased that she was able to resolve many of her own issues and would quickly utilize the group for support and clarification in cases where she was unable to gain personal resolution.

Capacity for Empathy

The capacity for empathy surrounds the ability to feel what participants are feeling both in the field and in training sessions. In building empathy with the group, the facilitator must "reach for feelings" and allow participants to express their feelings linked to a particular situation.

The facilitator should also "acknowledge" the expressed feelings of the participants. By gentle listening and supporting the participant, the educator allows him to feel good even though he feels bad. He appreciates that his feelings have been acknowledged. The facilitator can also develop empathy within the group by helping the participants to put their "feelings into words." They may not fully understand their feelings, and verbalizing them may assist in this process.

In one session, a participant was having difficulty sharing any feelings related to the experiences that he was having in the field. At coffee that participant came to me and shared feelings which were linked to a personal experience which was presently ongoing. He indicated he did not feel comfortable sharing it within the group. As I listened to him recounting the events of the incident, I felt deeply moved by his situation and I shared my feelings related to what he was saying. This helped him to feel that someone was empathetic towards him and his situation. He also felt that he was not alone in his circumstances and that his feelings were real and should not be hidden and covered. After coffee, I noted that he was better able to function within the group and appeared to be more of a sharing member.

Capacity to be Honest

The capacity to be honest surrounds sharing what we feel in a spontaneous manner. Often educators and social workers put on a professional mask which allows them to hide their real feelings from their work environment. In training sessions, often participants view trainers as being superhuman. It is necessary for the trainer to share real life situations and feelings that go with them. The participants may not be able to relate to the experiences, but they can relate to the feelings.

In doing my training session I shared, as an analogy, an example of the difference between child welfare and working with seniors. The analogy was linked to my feelings related to apprehending a child. The apprehension was difficult for the participants to understand, but in sharing the feelings related to that apprehension, the participants were able to understand and relate to the situation.

Ability to Confront

There are some situations within a group session which must be confronted in that the behavior may be inappropriate or comments may not be conducive to learning and growth. A confronting technique may be completed by ensuring that

expectations are clearly understood and by identifying road blocks which may be limiting the successful completion of tasks. The roadblocks may be comments or they may be specific behaviors.

In one training session, a participant felt the need to continually dominate the session by bringing forth her own examples which, in some cases, were simply not related. The other participants quickly began to tune out of the session and would allow interaction to take place solely between the participant and the educator. The sense of group began to deteriorate. I ralated to this participant in two forms; i) I confronted her by saying, "This is a group session; let someone else bring forward an example." ii) I would not acknowledge her comments. Later during coffee, I went to her and allowed her to share some personal concerns which she was feeling as a result of being part of the group. This seemed to allow her to feel more comfortable and also she felt that I was empathetic towards her situation. At that point, I also clarified again the goals of the session which were to ensure that all the participants had an opportunity for training and growth. She acknowledged this goal and the session seemed to flow more freely as a result.

In conducting the session, I considered the group as being a client system. This client system would have the social

worer as an educator coming in for approximately four hours every six months. It was felt that this was not nearly enough time to do the training and development that was required to assist in the growth of each district office. The educator, therefore, used a teaching process which would allow for growth and development even though the educator was not present. This growth process was presented within a "mutual aid system" framework. Shulman[6] outlined nine steps in the mutual aid system. They were:

Sharing Data or the relating of life experiences such as accumulated knowledge, views, values, etc. with others in the system. Early in the sessions, participants were told that they would be expected to share experiences with the group.

The Dialectical Process or the process of formulating changes or new ideas through the presentation of views and ideas. This interchange leads to growth as a result of verbalizing one's own thesis and listening to someone else's point of view.

Discussing a Taboo Area including such areas as sex, supervisors, religion, ethics, etc. Discussions of this sort can present a risk to the educator, but can also open up the group to freer communication and a better understanding of their own views and those of each other.

In one district office, one participant decided to verbalize some feelings which he was experiencing related to his supervisor. These feelings were acknowledged, however, other participants did not lend any support or validity to the comments. The group therefore assisted the participant to i) clarify his own feelings which were linked to the supervisor, ii) discount the information as being inappropriate, and iii) outline a course of action for resolution.

All in the Same Boat Phenomenon or the realization that others share the same feelings and situations. Sharing feelings brings a form of personal support in that others are feeling and experiencing the same things as they are.

In one district office, the participants shared their concerns related to the short time frames they were given for providing services to clients. Although I am sure these areas were discussed prior to entering the session, the formalized presentation of this concern allowed each one to develop a strong sense of support for each other in that everyone was feeling the same way about the situation.

Mutual Support fulfills the need that people have to be accepted and supported. The expression of empathy is a healer to those who give and to those who receive. In

reviewing mutual support it was interesting to note that groups who shared feelings often met more informally while groups who did not share were more likely to go their separate ways.

Mutual Demand results in the development of a group expectation. This is far more powerful than the confrontation by one member or that of the leader. In the case of the participant who stated a concern over supervision, it was the mutual demand of the group that assisted the participant to change his views and to set upon a course of action which would lead to resolution of those feelings. This was far more effective than the educator making any recommendations in this area.

Individual Problem Solving or group discussion of an individual's problem can produce a solution, and encourage the individual to bring similar issues to the group for resolution. This is in fact what happened in the case of the participant who was continually sensing dilemma in terms of her work place. The facilitator, through the use of containment, was able to allow the group to assist her in problem solving.

Rehearsal occurs when a group member uses the group to rehearse an action to be taken later. This adds to the likelihood of the action and the hopeful success as the

person will become more aware of what may take place. Within our group there were no specific planned sessions of rehearsal, however, this is not to say that participants may not have been rehearsing a particular event which may have been upcoming.

Strength in Numbers or confronting a situation as a group can assist an individual member in challenging threatening situations which he may not be willing to handle alone. This technique was not practiced overtly within the group, however, certain agendas formulated from the sessions may have resulted in a confrontation on the part of the group rather than individually at a later date.

In conducting the training session, the learning principles and teaching styles outlined by Brundage and Mackereacher[13] (1980) and the teaching skills presented by Shulman[14] (1984) were the basic principles upon which the educator taught the Case Management System to the counselors. Although there was some overlap between the two models, the most consistent direction given by both theorists was the sharing of counselor experiences and their related feelings. This was the most successful component of the sessions. In those sessions where discussion was free and easy, counselors appeared to benefit more significantly as they appeared to become more quickly involved in the process. In cases where

discussion was strained it appeared that the participants were significantly less interested and involved.

The Learning Principles And Shulman's Group Work Model all were presented within the framework of the Representational Model. The application of this approach to Adult education in teaching the Case Management Model was the social work intervention in this project.

CHAPTER VI

CONTEXT AND PRACTICE

Context

Veterans Affairs Canada (VAC) historically was primarily mandated to provide health and financial services to veterans. As their population grew older, the veterans needs became more varied. The department, therefore, adjusted its focus to meet those needs, and consequently, changes in worker roles have occurred. Front line workers have changed titles from "welfare officers" to Area Counselors" (AC's) and are now being referred to as "Case Managers." Clients in their communities were now receiving more than financial assistance. The present emphasis within VAC is on providing holistic assessments which attempt to identify all the needs of the clients. The client issues being issued were: health, financial, support systems, accommodations, and status changes.

Under the umbrella of the Veterans Independence Program (VIP), counselors are mandated to provide varied services which meet a broad base of clients needs. Program funds are

available for the following: Groundskeeping, Housekeeping, Social, Transportation, Home Care, Adult Residential Care, Nursing Home Intermediate Care, Ambulatory Health Care, and Home Adaptations.

In 1981 - 1983 all the Area Counselors within the Prairie Region employed by VAC took part in a 5 week Certificate Program in Gerontology. The program was developed to assist AC's in providing a better service by enhancing their awareness of the characteristics of the elderly.

As a result of this training and subsequent discussion, Prairie Region AC's and supervisors began requesting a consistent model within which to provide services. On the national level, Regional Directors General began recommending the need for developing a model which could be applied on a national basis hence the emergence of The Long Term Care User Manual Project in 1985. A component of this project was "Project B," charged with addressing Case Management under the chairpersonship of Doreen Newman, Regional Coordinator Client Services, Prairie Region. In 1986, Prairie Region elected to utilize The Case Management System produced by "Project B." Subsequently, the SCS's within the Prairie Region began asking for standards with

which to evaluate the Area Counselors' performance. In 1987, a set of standards for service delivery were provided by Client Services, Prairie Region, as part of The Case Management System, and ultimately accepted regionally as a valuable tool. During the Fall of 1987 a National VIP Streamlining Committee under the direction of Bob Bently was struck whose mandate included the development of a model for service delivery. Doreen Newman, a member of the national working committee, presented the Prairie Regional Case Management System and Standards as information to be used in the development of a national working model. Within the Prairie Region, Client Services has been directed by the Regional Director General to implement and evaluate the effectiveness of the model.

The goal of this project was to implement the Case Management System and Standards in the Prairie Region by teaching Case Management principles to the Area Counselors before December 15, 1987, and subsequently do an initial evaluation of the implementation of the model.

The objectives of the project were:

1. To present the model to all Area Counselors within the Prairie Regional Office between November 26 and December 17, 1987.

2. To present material in a manner which was conducive to learning.

3. To present the model in a fashion which would gain acceptance by the AC's, thus ensuring the likelihood of its usage.

4. To evaluate the model's effectiveness and efficiency in the field.

5. To facilitate and develop the increased knowledge and skills of the Area Counselor.

6. To evaluate behavioral and attitudinal changes of Area Counselors with respect to their growth and development prior to and after the implementation of Case Management System and Standards.

Goals

Veterans Affairs has 40 Area Counselor (AC) positions in 6 District Offices (DO). The largest office is the Winnipeg District Office with 9 AC's; Calgary and Edmonton DO's each have 8 AC's, while Regina and Saskatoon have 6 each, with

Brandon DO being the smallest office with 3 AC's. Each district had a Supervisor of Counseling Services (SCS) who provided line supervision to each Area Counselor along with Quality Control/Quality Assurance on service delivery.

There were approximately 126,600 veterans living in the Prairie Region with 44,200 living in Manitoba, 29,500 in Saskatchewan, and 52,900 in Alberta (Minister of Veteran's Affairs, 1986)[8].

Prairie Region Area Counselors were providing services to 41, 507 veterans within the Prairie Region with a breakdown as follows:

Manitoba - 13,556 clients
Saskatchewan - 10, 424 clients
Alberta - 17, 527 clients

The veterans were both male and female and their average age is 67.5 years old.

The mandate of service was outlined primarily in four different pieces of legislation. They are: The War Veterans Allowance Act, The Pension Act, The Civilian War Pension Act, and The Veterans Land Act. In 1981, The Aging Veteran's Program was implemented as a new initiative. This program has since been renamed the Veterans Independence Program.

As service deliverers, Area Counselors were guided primarily by the War Veterans Allowance Act, and the Veterans Independence Program. Services which counselors provide were primarily assessment, financial, and referral, hence the emergence of the term Case Managers. In special cases they provided ongoing Counseling in the areas of alcohol or financial misuse.

In developing a training package for Area Counselors, Client Services used The following activities and standards:

1. A review of the changing needs of the aging population in Canada and veterans in particular. 1988
2. A review of existing Area Counselor training. 1987
3. Feedback from the districts including Supervisors of Counseling Services and Counselors. 1987
4. Quality Control/Quality Assurance of District Offices conducted by Client Services in the Spring of 1987.
5. The new Case Management System and Standards as a service delivery model, and

6. The mandate of the Regional Director General, Prairie Region to implement the model.

Chapter VII

The Training Sessions

Methods and Procedures

During the last week of November and the first two weeks of December, 1987, the A/CSE (trainer/educator) presented training sessions of Case Management - Assessment Minimum Standards. The sessions, one day in length, were presented twice in each of the six district offices to facilitate full participation by the Counselors and to allow for continuation of Services to clients. Each counselor attended one session. (Schedule attached - see Appendix IV)

The training session utilized three different modes of presentation:

1. Centrally Directed Readings

   Reading material on Case Management was distributed to each Area Counselor. They were asked to familiarize themselves with the material prior to the training sessions. The distributed reading material included The Case Management System and Chapter 9 of Social Work Process called, The Contact Phase: Problem Identification, Initial Goal Setting, Data Collection, and Initial Assessment.[15]

2. Field Training Sessions The trainer went into The District Offices and provided lecture/discussion sessions on the training package.

3. Audio Visual Presentation

VHS tapes by guest speakers were used on specialize topics. They were:

1. Health Care Assessments - Minimum standards (Presented by Rosemary Aird - Regional Nurse).

2. Financial - Minimum Standards (Presented by Ron Labbe - Supervisor Winnipeg District Office).

3. Safety for Seniors

Training Area Counselors in The Case Management System within The Prairie Region was conducted in three steps. They were: Pre-Training Preparation, Training Sessions, and Evaluation of The Training.

Step 1: Pre-Training Preparation

The Case Management System and Chapter 9 of Social Work Process[15] were circulated to all supervisors and Area Counselors two weeks prior to the sessions through normal interdepartmental mail. This was followed up by a telephone call to ensure receipt in each office. Area Counselors were requested to prepare themselves for the training session via the avenue of centrally directed reading.

Step 2: Training Session

The model was presented to small groups of not more than four Area Counselors within each district office. Each session was approximately seven hours in length. The trainer used "directing," "facilitating," and "collaborating" teaching styles throughout the sessions. The training package was presented by using tutorial and discussion formats with the aid of handouts, flip charts and VHS tapes by special speakers. All those present were expected to participate in discussion.

(For a more in depth discussion of 1)Training Material, see Appendix II 2)Teaching Skills Appendix XIX and 3)Teaching Milieu Appendix XX.

Step 3: Evaluation of The Training

Four evaluation tools were developed to appropriately measure some of the changes which had occurred in each group as a result of the training sessions. They were titled The Pre-Implementation Observation Survey, The Observation Survey, The Evaluation Questionnaire and The Case Management Operational Survey.

PRE-IMPLEMENTATION OBSERVATIONAL SURVEY

The Pre-Implementation Observational Survey (See Appendix XV) was developed to measure the participants' views on Case Management prior to the training session. In his opening comments, the educator asked specific questions to formulate discussion so as to enable the completion of this survey. The survey was completed upon return from the first coffee break. The educator requested one survey per session group and considered a majority of the answers in deciding a yes or no to each question. A "Yes" answer was given a numerical value of 2 and a "No" was valued at 0. If the group appeared divided on a particular question a value of 1 was attached to that question. In computing the results,

all the weighting from each of the categories were added together, then divided by the number of questions used. This granted an average response between 0 and 2 to each category. The responses were rated in the following manner:

0 - .75 = Negative
.76 - 1.25 = Neutral
1.26 - 2.00 = Positive

There were eleven Pre-Implementation Observation Surveys completed through the 6 districts. This survey was developed to measure the following four categories:

A. What is the participants general awareness of The Case Management System Model? Observation Question # 1 was developed to measure this area. It asks the observer to assess, "Do the Area Counselors know what The Case Management system is? Yes or No." The overall results from the eleven groups was 1.55. This indicated the participants had a fairly good general knowledge of The Case Management System model. This general knowledge did not necessarily mean they were using the model in their practice. The response indicated that the councellors had been involved in past discussion of a general nature and had a awareness of what was refered to when the name of the model was mentioned.

B. Questions 2 and 3 were designed to measure the participants specific knowledge of the model. They were as follows: "Are the Area Counselors aware of the six steps of The Case Management System?" and "Are the Area Counselors able to identify the six steps of The Case Management System?" The overall response in this category was 0.18. This low response indicated very little or no specific knowledge of the model. This general knowledge did not necessarily mean they were, or were not, using the model in their practice. The indication of the response was that they had been involved in past discussion of a general nature and had a specific awareness of what was referred to when the name of the model was mentioned.

C. The third area of measurement in this survey surrounded the present utilization of the model in some degree or other. Questions 4 and 6 asked "have the Area Counselors used The Case Management System in their Implementation Plan?" and "Are you currently using The Case Management System?" The overall response from the participants indicated they had to some degree. The numerical response was 1.36 which is at the lower end

on the positive scale. This indicated that although the counselors knew very little specifically about the model they still perceived themselves to be using what they did know about the model in the work place.

D. The final category to be assessed by this survey was the participants view of their potential utilization of the model in the future in their service delivery. Two questions, numbers 5 and 7, "Do you consider the Case Management System a good one?" and "Will you use it again?" were developed to gain this information. Of those who had utilized or were utilizing the model, 100% responded positively in this category. The response was therefore 2.0

OBSERVATION SURVEY

The Observation Survey (see Appendix XVII) was developed to evaluate the sessions. The educator was to observe the group during each session and complete the survey immediately following the session. This survey measured two specific areas: participant knowledge gained as a result of being actively involved in the training, and participant interest in the sessions. It is felt that if there was

interest in the sessions and there would be a knowledge base developed during the sessions, then the likelihood of participant application of the model will increase. As in the previous survey, all responses were computed in a "Yes, No" fashion with "Yes" being weighted as 2 and "No" receiving a 0 weighting. All responses in each category were added together then divided by the number of questions. The responses were rated in the following manner:

0 - .75 = Negative
.76 - 1.25 = Neutral
1.26 - 2.00 = Positive

There were eleven Evaluation Questionnaires completed within the District Offices.

The knowledge developed as a result of being actively involved in the learning process was measured by the following four questions:

4. "Did participants ask questions on specifics of the model?"
5. "Did participants take notes?"
7. "Was there ongoing two-way dialogue?"
9. "Did the participants seem to understand the material?

It was felt that if the participants took an active role in the sessions then the likelihood of them learning the material would be greatly improved. The measurement response in this category was 1.6. This indicates that the participants were actively involved in learning behavior.

The second category to be measured by this survey surrounded the interest level of the participants in the sessions. The following five questions were designed to measure this area:

1. "Did participants attend to schedules?"
2. "Did participants take part in discussions?"
3. "Was participation easy and free?"
6. "Were the participants attentive?"
8. "Are the participants active as opposed to being passive?"

The educator in developing this group of questions felt that participant interest was necessary in order for the participants to learn the material. The computed response to interest by the participants was 1.45. This is considered to be a medium positive response and the participants were seen as taking interest in the sessions. The overall scores were brought down by the apparent lack of involvement and interest in one office, however, this score still indicates a good interest on the part of the participants.

EVALUATION QUESTIONNAIRE

The Evaluation Questionnaire (See Appendix XVII) was developed to gain participant feedback on the session. Immediately following the session all participants were given a two page evaluation questionnaire to complete before they left. Participants were instructed to submit the questionnaires anonymously.

The Evaluation Questionnaire was developed to measure three factors: "Did the participants feel they had a good opportunity to learn?" "Do the participants consider the subject material as having a good potential for application in the workplace" and, "Did the participants learn the model?" There were 40 Area Counselors who took part in the training and 40 Evaluation Questionnaires completed.

The first category to be measured by this survey asked for an assessment by the participants as to whether they felt the sessions granted a good opportunity to learn the material presented. Participants were asked to respond to the questions by checking the appropriate answers. The following questions measured the participants opportunity to learn and the responses were given the numerical weighting indicated below each answer.

2. The language level of the presentation was:

Difficult = 0 About Right = 2 Too Easy = 0

3. Was the length of time allowed for the presentation sufficient?

Yes = 2 No = 0

4. The pace at which the presentation was conducted was:

Too Fast = 0 About Right = 2 Too Slow = 0

5. Did the amount of time provided for discussion seem acceptable?

Too Much = 0 Just Right = 2 Too Little = 0

To compute the numerical values of this area as in the former surveys all the response numbers were added together, then divided by the number of questions, to grant an average response between 2 and 0. The responses were categorized in the following way:

0 - .75 = Negative

.76 - 1.25 = Neutral

1.26 - 2.00 = Positive

The overall result of this category was 1.82 thus indicating the respondents considered the teaching environment as most opportune in which to learn the material presented.

The second category measured by the survey was the potential application of the subject material in the work place. This potential was evaluated by the participants who would be using the model. The suggestion was that if the participants felt the model was applicable to their workplace, then they would be more likely to use it.
The following survey questions were asked and the answers were numerically valued and computed as shown below:

1. The overall quality of the material presented was:

   Good = 2 Average = 1 Poor = 0

6. Was the concept of the Case Management System linked to your service delivery system?

   Yes = 2 No = 0 Not Sure = 1

7. Will you use the Case Management System in your service delivery?

   Yes = 2 No = 0 Not Sure = 1

10. Please indicate your overall response towards the implementation and effectiveness of the Case Management System within your work place.

This last question was a subjective one which allowed a few lines for a written response. If the response indicated a systematic answer with positive content, the response was

rated as 2. If it was negative, a 0 was indicated. There were no neutral answers. The numerical values of all the questions in this category were added then divided by the total number of related questions. The responses were categorized in the following way:

0 to below .75 - low potential for application

.76 to 1.25 - neutral

1.26 to 2 - high potential for application

The overall results of the survey indicated that Area Counselors felt that the model had an excellent potential application in their work place. The overall rating was 1.89. This was a particularly exciting response because the high rating indicated that the model had met with participants approval. Having the approval of the counselors also meant they would likely be highly motivated to use it in their workplace.

In measuring whether the participants developed a working knowledge of the model as a result of the training session, the survey asked two specific questions about the material:

8. "What is your definition of the Case Management System?"
9. "What are the six steps of Case Management?"

These two subjective questions were rated according to a written response. Question 8 was rated in accordance with the relationship of the response. A 2 value was given to an answer which outlined a clear understanding of Case Management. A 1 rating for a response which had some knowledge but appeared to lack clarity and 0 was given to no answer or answers which appeared unrelated to the material presented.

Question 9 required all six steps to be identified in the response in order to be given a 2. Four or five steps received a 1 and 0 was given for three or less steps.

As before, the numerical values of all the question in this category were added, then divided by the total number of related questions. The responses were categorized in the following way:

0 to .75	-	no knowledge
.76 to 1.25	-	poor knowledge
1.26 to 2.00	-	good knowledge

The participants' response was measured at 1.55 in terms of the material learned. They are considered to have developed a good knowledge of the material as a result of the training session.

The three categories measured in this survey all indicated the participants benefited from the sessions. The result indicated the participants felt they had a good opportunity to learn in the sessions, the model was applicable in their practice and they developed a working knowledge of the model as a result of the session. Over all this survey measured the immediate results of the sessions as evaluated by the participants. The overall results were considered very favorable by the educator.

SHORT TERM APPLICATION MEASUREMENT

The short term application of the Case Management System (see Appendix XVIII) was evaluated by each supervisor (SCS) within the District Offices. The SCS's were asked to complete the Case Management Survey at the middle of each month for three months, beginning on the 15th of December, 1987. The survey was given to the SCS on the dates of the training sessions and they were instructed as to its completion. The surveys were forwarded to the trainer for assessment by normal interdepartmental mail. There were 18 surveys completed representing 6 District Offices.

The Case Management Operations Survey was developed to measure whether the model was effective and efficient as perceived by the supervisors. Six questions were developed to measure each category. The SCS's were asked to respond to the statements with one of the following responses: strongly agree, agree, disagree, strongly disagree.

Effectiveness was measured by having the SCS's respond to the following:

1. The Case Management System and Standards takes into consideration all aspects of the VIP.
2. The model is conducive to the provision of consistent program delivery.
3. The Standards assist in Quality Control.
4. The Case Management System and Standards clarify the role of the counselor in the delivery of services.
5. Clients benefit from the Case Management System and Standards model in your district.
6. The model is helpful in handling increased workload volume.

Efficiency was measured by the following statement responses:

7. The model provides a clear framework in which to provide services.
8. The Case Management System and Standards are more applicable than former models used by Counselors.
9. It is beneficial for purposes of supervision to have this model in place.
10. The more our Districts apply the model in practice, the better services are for the client.
11. The application of the Case Management System and Standards decreases time frames for processing applications.
12. Services are provided in a timely fashion utilizing the model.

The value weighting for each response was as follows:

Strongly Agree	4
Agree	3
Disagree	2
Strongly Disagree	1

In computing the effectiveness and efficiency of the model the values of each response to each of the six categories were added then divided by the total of questions in that category. This granted an overall average for that category.

The SCS response regarding the effectiveness of the model within the workplace was 2.98 on a 1-4 weighting scale. The efficiency rating was slightly less than 2.96 on the same 1-4 rating scale. (See Apendix XIX for a breakthrough)

In order to grant similar computations between the evaluation of the SCS's and other surveys, the SCS responses were calculated so as to be rated on a 0-2 weighting scale. (See Apendix XIX for calculations) The responses were categorized in the following way:

0 - .75 = Negative

.76 - 1.25 = Neutral

1.26 - 2.00 = Positive

The responses on this scale were as follows:

Effectiveness - 1.49

Efficiency - 1.48

Both the Area Counselors and the SCS's rated the Case Management System and Standards as being a benefit in service delivery to clients. The AC's were far more optimistic about the potential application of the model. However, the SCS's after viewing the application of the model for a period of at least three months, felt the model would significantly improve their service delivery in terms

of both effectiveness and efficiency. Both categories were rated in the positive area in terms of application by the supervisors although the response was in the lower end of the positive.

The four measurement tools: Pre-Implementation Observational Survey, Observation Survey, Evaluation Questionnaire and the Short Term Application Questionnaire all attempted to measure the implementation of the Case Management Model into the Prairie Region of Veterans Affairs. The results which are elaborated on in the next chapter showed clearly the change which took place as a result of the overall process.

CHAPTER VIII

RESULTS AND THEIR IMPLICATIONS

The results of these surveys indicate that Counselors had a good general awareness of the model prior to the training session. This awareness was rated through the pre-implementation survey; the results indicated a 1.55 awareness on a 2.0 scale. General awareness would likely come from inter-office discussion of the pre-training preparation, done through centrally-directed reading. It would indicate that the Counselors did do their reading in preparation for the training session.

The observation survey, which measured knowledge, indicated that the Counselors had very little specific knowledge of the training material. The survey indicated that their specific knowledge was .18 on the 2.0 scale. This is an extremely low rating. After the sessions, both the observation survey and the evaluation survey indicate that the Counselors had learned a significant amount from the training session. Their measurement scores indicated a 1.6 and 1.55 respectively on the same 2.0 scale.

This finding is significant in that the scores are somewhat similar in terms of rating. Although they are considering different variables, they are both intended to measure the same accomplishment: did the participants learn the case management system? It is obvious from the scores that the participants were able to learn a significant amount about the Case Management System as they moved their knowledge base from a .18 on a 2.0 scale to a 1.6 and 1.55 score.

During the training sessions, Counselors also applied what they had learned. The operational survey which measured the value of the model in the field demonstrated that Counselors had improved their effectiveness and their efficiency at 1.49 and 1.48 respectively on the same 2.0 scale. The very fact that the services were perceived to have improved by this amount indicated that there was learning and growth as a result of the sessions, and that participants are utilizing the model in the field. It also appears that, as a result of the training session, Counselors have grown significantly in terms of developing a knowledge base in the Case Management area.

The two evaluations which measured the training sessions themselves indicated that the sessions were successful. The observation survey rated the Area Counselors' interest level

at 1.45 on the 2.0 scale. The evaluation survey results, with the score of 1.82 bespoke that Area Counselors felt they were presented with a meaningful learning experience. The significance of these two measurement scores points out that potential for learning will greatly increase if the following two conditions exist:

1. The person is interested in the training material.
2. The person has a good opportunity to learn.

This is attested to by earlier comments surrounding material learned, which fact again attests to the success of the training session. In discussing the material, one must ask, "What did the Area Counselors think of the material which was being presented? Was it pertinent to their work and would they benefit from the training sessions?" This area was measured by the pre-implementation and evaluation survey which examined the future utilization and application for the material being presented. The Area Counselors viewed the potential utilization of the model very highly at a 2.0 out of 2.0 score. Further, they rated the potential application after the training session at a high 1.89 score. Area Counselors, therefore, felt the material was extremely pertinent to their jobs both before and after the training session. It is believed that when the material is pertinent and applicable, then utilization will ultimately be increased.

In reviewing the training session, the writer suggests that according to the evaluations, the environment had the following characteristics: It was conducive to learning; the material presented was applicable to the field; the participants were interested in the material; the participants learned what was presented and they were successfully utilizing the model in their service delivery up to 3 months after the training session. These test results, therefore, indicate that the training sessions were successful in meeting the project goals, which were as follows:

1. Implementing The Case Management System in The Prairie Region.

2. Teachings Case Management principles to Area Counselors.

3. Evaluating the above success or failure.

The training sessions, however, went above and beyond what has been outlined. There are some specific areas which had am impact impact upon at least three different groups or individuals. They are as follow:

1. The participants in the training secessions
2. The veteran or the client group
3. The trainer.

The impact upon these three areas will be discussed in specific terms in order to elaborate on the benefits of each.

1. The Participants - The Area Counselor

The survey results show training was successful in the aspects described below:

a) Area Counselors gained a specific awareness of the Case Management System.

b) The Counselors now have a specific framework for service delivery. This framework allows them to provide better services within a specific set of guidelines. They can feel comfortable moving in and out of a client situation and be knowledgeable in terms of what steps still require completion and what steps are completed. This framework can also become the basis for further publication and personal development. Counselors have been exposed to material which is referenced for supplemental reading or they have become more exposed to the Regional Office and may decide to request additional learning programs from same should they so desire.

c) The Counselors are now providing an improved service. This can only make the Counselors feel more confident in terms of their work, feel more comfortable in terms of their caseload, and feel more personal reward and benefit as a result of being in the workplace.The benefits to the veteran population are elaborated upon in greater detail later in this chapter. This fact is attensted to by the supervisiry survey.

d) A follow-up visit to a district office disclosed that the Area Counselors have developed a mutual support group. The group assists Counselors to utilize each other's strengths. Although this was an unplanned benifit it grants support to the further training and their spin off benifits.

e) Area Counselors continue to grow and develop as a result of the training session. This again was observed on a follow-up visit. They utilize each other for information and support. They are more comfortable discussing specific cases with each other and generally rely on each other to a greater extent than in the past.

f) New training packages have been developed as a result of the training session. Progress in gerontology training has been monitored since the initial training sessions, and appears to be producing favorable results. An Area Counselor orientation session was conducted on January 27 and 28, 1988. All Counselors who had been working with the department for under two years took part in the orientation session. The session was developed from information gathered at the training sessions.

In May and June, 1988, the trainer conducted sessions on Case planning. This was again a follow-up to the original training sessions and the evaluation process.

The sessions have made the trainer aware of serious deficits which the Counselors may have in the Area of gerontology. Few were aware of the changes to the human body as a result of the aging process. As a result of this, Veterans Affair has begun developing a gerontology training package with the Continuing Education Department of the University of Manitoba. A five year gerontology training program will began in January, 1989.

2. The Veterans - The Client Group

There are two specific areas which will lead to benefits to the client:

a) More clients will be helped as a result of more efficient service.

b) The service which the clients receive will be improved.

Within some social service agencies, the numbers of clients helped is in direct proportion to the number of workers in the field, the number of hours in the day, and the number of days in the year. By becoming a more efficient service provider, Area Counselors can meet with more clients and have more time to provide services. Their interview time can become diminished; their report writing time can be reduced. Consequently, they have time to meet with more clients. The quality of service, on the other hand, is also improved in that the Area Counselors are able to provide a broader service to their clients. Through the Case Management System, they look at five specific areas and identify the needs of the client within those five specific areas. Under earlier systems, many Counselors would spend disproportionate periods of time assessing financial needs and applicability, and significantly less amounts of time in measuring psychosocial, health or accommodation needs.

Through the Case Management system, there is a greater balance in terms of identifying and providing intervention for the client needs, consequently the client receives better service.

The questions which must always be asked after the implementation of an intervention of this type is:

1) did the client group really benefit, and
2) for how long?

In this case the writer is suggesting the client group may be either the counselors or the veteran population. These questions are unanswerable within the scope of this study, however various actions could be taken which would allow some insight into possible improved services. Some of those possible actions are listed below:

1. A review of whether staff turnover or staff sick days have declined since the sessions took place. This review should be fairly longitudinal and consider the year previous and the year after the study took place. This could grant a greater insight into the job satisfaction of the

counselors. This is again based upon the precept the clients receive better service if counselors are more satisfied with their position and that job satisfaction reduces worker turnover and sick leave.

2. Review the number of client complaints over the same two year period. Is there a reduced number or are the nature of the complaints changed so that they are less concerned with service and program issues and more concerned with other non-related issues.

3. Prairie Regional Office could conduct a study to assess if clients are in fact receiving a broader range of services or is there any significant change in services. This assessment could take place through the annual quality control/quality assurance review.

4. Have the numbers of clients increased significantly or has the normal growth pattern continued over the past year. It would seem that were the implementation of the model successful, then there should be a significant increase in the number of new clients entering the system.

The long term effects of the study have not been evaluate to the best of the educator's knowledge. However, should the department implement the model on a national basis, then it is felt that the impact of the intervention strategy should be evaluated by conducting pre and psot surveys to a random sample of the population being served. This would grant a clear picture of the impact of an intervention such as this.

Chapter IX

The Practicum Experience

The Educator

In providing this training session, there were a number of benefits to which the educator can personally attest. The most significant of these are discussed below:

a) A systematic framework for understanding the development and growth of individuals evolved which included the use of feelings and experiences. Building a representational model in this way allowed the trainer to see the teaching environment as more than just a classroom. This framework can be used in relationships, in supervision, and in therapy, as well as in training sessions.

b) As a result of the training sessions, the trainer was able to develop specific training skills which allowed him to improve his preparation of materials, and his presentation of materials and skills required to stimulate and maintain discussion within a group.

c) The educator developed an awareness of gerontological issues and in particular, the unique needs of veterans.

d) The educator developed a specific knowledge of the Case Management System and its applicability within the field of service.

e) Through the training sessions, the educator was able to develop a more specific knowledge of the department, and an awareness of its policies and guidelines.

Personal growth and development resulting from the training session was tremendous. Also, the ability to be flexible in developing an agenda, as well as changing training materials to meet group needs, was a significant benefit. The training session has led to an improved rapport between the trainer and the Area Counselors, and a meaningful friendship and support group for the educator. This has been useful in presenting subsequent training sessions surrounding other areas of responsibility in conjunction with the District Offices. The educator has experienced personal growth and satisfaction from seeing Area Counselors provide a more improved service to their clients and from the knowledge that clients are truly benefiting as a result of those training sessions.

Benifits to the field of Social work practise

This report has provided a systematic report on a training intervention which utilized a modified version of the case management System as a tool for change within the Veterans Affairs Prairie Region. The intervention was completed by teaching para-professionals a professional Intervention strategy which was intended to improve services to their client population. The field of Social Work has done very little if any systematic recording of services to the Veteran population. This report records some of the specific needs of veterans in order to distinguish them as a unique group who must not be treated the same, psycho-socially, as their non-veteran counterparts.

This report could point to meny areas which require further study, however, in lieu of the lack of available emperical information in the area of psycho-social work being performed with veterans, students may consider the field almost completely open for further study. As a result of this project the writer has identified a specific area, which if systematically researched, would add greatly to effective service of this client group. Reference here is being made in the area of the three distinct veteran client groups. Further study should be directed towards what distinguishes each group from the other and what are the previlent problematic issues which are unique to each group.

This report further eluded to unresolved issues related to the killing or injury of others as being the basis for psycho-social problems. If these unique needs are infact related to unresolved issues then the veteran popluation could benifit if it's service providers recieved training in assisting clients to sort through these unresolved issuses. It appears unfortunate however that Veterans Affairs Counsellors will likely never have the oppertunity to pursue further study in this area as training and staffing dollars are diminishing and the focuss is now on assisting qualified clients to recieve fiancial benifits not to ensure that clients recieve wholistic services..

Limitations

Although this study was very broad in attempting to deal with a number of areas such as: the unique needs of the aging person and comparing those with the aging veteran, the developement of The Case Management System Model and a theoretical approach to adult education. The study is quite limited in that it does not deal specifically with the client groups psycho-social problems. The writer took this appoach in presenting the report because it is felt that the study must be limited in order to remain workable. An

example of this limited focus is exemplified by the limited reference to the term alcoholism.

Another reason for limiting the study to these specific topics was, the intervention was an adult education intervention and as such priorized the intervention technique and the Case Management System Model.

Conclusion

In attempting to construct a model for organizational change, the central theme must always focus upon the client group being served. In this project the primary client group was the veteran population, however, as a result of the sessions the educator's client group became the session participants or the primary client's counselors. In planning for the overall change process the primary client needs were identified as the basis upon which the intervention was constructed. With the passage of time the veteran population are becoming older and subsequently are requiring an expanded service which meets their unique needs. The provision of the former financial service which counselors were trained to provide to their clients was limited in terms of the evolving client needs. The development of the Case Management System was specifically intended to ensure the Counselors expanded their service from being one of primarily financial to that of addressing the multiple needs of the aging veteran. The educator surmised that if the counselors had a working knowledge of the model and felt that it would assist them in their practice then they were very likely to utilize the model in their service delivery process. The theme of the practicum

became one of not only teaching the counselors the model but also motivating them to use it and subsequently evaluating the process. The implementation of the model required an understanding of adult learning principles and the planned usage of the principles in a teaching environment. The evaluation of the teaching sessions indicated that the participants had succeeded in learning the material and that there was a high likelihood that they would use the model in their practice. A followup evaluation conducted up to three months after the sessions indicated that the counselor were using the model and in fact providing a more improved service.

This recount of the events, and, for that matter, the report appears to be slightly tinted to show that the process was a bed of roses and came off without a hitch. This is of course not so. The project underwent all kinds of apparent unforeseen delays and changes. Some problems were:

1. Initial permission to implement the project was held up for three months as we awaited Regional Director permission to implement the model within the Prairie Region.

2. As mentioned the dynamics of one district office were such that no one appeared the remotest interested in what I was there for and appeared to want to be anywhere but where they were.

3. During two sessions in one district office I was unable to get the VHS equipment to work and one of the counselors allowed me to use her personal equipment.

4. I was in the middle of an Air Canada strike and all my flights were booked with Air Canada. In order to get other flights I had to wait at airports for lengthy time periods. On one occasion I was at the airport at 11:00 A.M. for a flight and didn't leave until 4:00 A.M. the next morning. On another occasion I was unable to catch a morning flight and arrived on the afternoon of a session day.

5. The training schedule did not allow for the delays which resulted from the airline strike and, therefore, the lost time had to be made up in lost sleep and reflective time. This often left the

> educator entering the session rooms, setting up the equipment, taking a deep breath and going right into the sessions. The desired development time simply was not there.

On the positive side, all of the above are issues which when shared with the groups, seemed to pull us closer together. The participants seemed to feel that the educator had underwent a certain degree of difficulty in order to provide the sessions and it seems as though this motivated them to assist as much as possible in the process.

Another positive unforeseen factor which became very apparent during the sessions was the counselors desire to do well in the sessions. It was almost like I was marking them on their performance and their scores would be recorded and used as a basis for promotion. I had assured them that everything was confidential and their scores would not be recorded anywhere, however, it did not seem to change the perception or their motivation.

There are other more global problems which are likely to limit the project success. They are listed below:

1. The increased time frames required for supervisors to maintain momentum in support of the model in each district office. Supervisors will naturally support the model because administration had indicated general support, but it will also require individual support to staff to ensure its continued use. This is periodically difficult when other issues appear to become a priority and supervision must deal with issues on a first come first serve basis.

2. The educator may have overestimated the counselors understanding of the actual benefits of utilizing such a model in their practice.

   The educator may have also overestimated the counselors ability to grasp the concepts which were being presented in the sessions. This would have left those counselors unable to apply the model outside of the session boundary.

3. The Educator may have over rated the client's desire to receive a global service from Veterans

Affairs. In fact, the veteran population on the whole may have been very satisfied receiving financial service from Veterans Affairs and be content to secure other service from the local agencies on a needs basis.

4. The most significant concern surrounds the increasing demands which are placed upon the counselors. This may leave them little or no time to provide any more than a simple financial service. There are continuously more clients qualifying for service and in order to meet the needs of this group the counselors may have to streamline their service to a very nominal point.

All these concerns, real or perceived, do not limit the changing needs of the client population. Counselors must be prepared to improve their skills to meet the changing needs of their clients otherwise the services in time become nothing more than a token. Within Veterans Affairs Prairie Region there appears to be a genuine effort on the part of management and counselors to aggressively meet the needs of their clients and they have spent a significant amount of money and effort to achieve this goal. It shall be left to be seen if this intervention strategy was significant enough to meet the changing needs of the veteran population.

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APPENDIX I

Health Assessment

1) The first of The categories included in health is The client's general overall appearance. This attends primarily to emotional and mental status. In assessing The client, The counselor through questioning and observation attempts to obtain answers to the following questions: Is the client happy, sad? Is he excited? Does he appear sharp or are his eyes cloudy? In answering these questions counselors are asked to make a statement regarding the general overall appearance of the client.

2) Eyesight - Does the client have good eyesight, fair, poor? Is he partially or totally blind? Does the client wear glasses?

3) Hearing - Is the client's hearing good, fair, poor? Is the client partially or totally deaf? Does he wear a hearing aid on his left or his right side?

4) Teeth - Does the client have his own teeth? Does he wear dentures? Are they upper or lower, are they partial? Does the client indicate having problems with his teeth, some problems or significant problems?

5) Feet - Are the client's feet swollen? Does he have pain? Does he have problems, some problems, or significant problems?

6) Relative medical conditions - This area refers to specific conditions which are reported by the client. They may entail diabetes, arthritis, chronic chest conditions, heart or circulatory problems, cancer, after effects of stroke and any other conditions which the client may mention.

7) Hospital admissions in the last year - Was the client in hospital during the past year or since the previous visit? What was the date? What was the length? What were the reasons for hospitalization? Is the client still experiencing any problems or effects from the condition for which he was hospitalized?

8) Currently under the Care of a physician - Is the client being seen on a regular basis by a physician and what are the reasons for that Care?

9) Current medication - Is the client on a prescribed drug? What is the dosage, frequency, prescription date and by whom, is the drug prescribed? Does the client know what the medication is for? Does the client manage his prescription drugs appropriately or does he feel that he has a problem with them?

10) The skeletal function - Does the client have full use of his arms, hands, hips, back, knees, feet, or does he have war-related conditions?

11) Use of aids - Does the client walk with a cane, crutches, walker? Does he utilize a wheelchair, leg brace, artificial limbs, ostomy equipment, a catheter, oxygen equipment, or any other aids? Does the client experience a problem with the use of these aids?

12) Mental, emotional status - Is the client alert? Is he oriented? Does he have memory, judgment? What is his morale? Is he motivated? Counselors are asked to respond to these specifics by stating whether the clients behavior is appropriate, inappropriate or difficult to assess.

13) Lifestyle - Does the client utilize alcohol or tobacco? Does he follow dietary practices? Does he exercise regularly?

14) Functional assessment - Activities of Daily Living

Mobility -

a) Walking/mobility - Is the client fully independent? Is he independent with a cane or a walker? Does he require some assistance in terms of mobility?

b) Stairs - Can the client manage without help or is he limited, or is the client unable to manage?

c) Functional mobility in own residence - Can the client get around within his own residence?

15 Personal Care -

a) Bathing - Can the client bathe with or without assistance?

b) Dressing and undressing - Does the client perform these duties with or without assistance?

c) Feeding - Can the client feed himself or does he require assistance?

d) Grooming - Does the client perform these duties with or without assistance?

e) Sleep - Does the client have problems sleeping or does he take medication to assist with sleep?

f) Toileting - Does the client perform this task independently or does he require assistance?

g) Continence - Is the client able to maintain continence or does the client require an aide within his bowel or bladder?

16) Household Tasks -

a) Light housekeeping - Does the client perform light housekeeping duties with or without assistance? Is the client able to function on his own? Is the client able to cook his own meals, do his own dishes?

b) Heavy housekeeping - Does the client require assistance with heavy housekeeping duties such as washing walls, taking off storm windows?

c) Groundskeeping - Does the client cut his own grass? Does he trim his own hedge, or does he require assistance with such duties?

d) Preparation of meals - Does the client require assistance in preparing meals or does he perform this task on his own?

APPENDIX II

Training Material

1. Centrally Directed Readings

   a) The Case Management System (Appendix III)

   b) The Social Work Process - Beulah Compton, Burt Galaway, Chapter 9 entitled The Contract Phase: Problem Identification, Initial Goal Setting, Data Collection, and Initial Assessment.[15] This chapter was chosen because the educator felt that the material provided was an introduction of feelings into the assessment and ways in which this stage can be applied in a framework other than the Case Management System.

2. Flip Chart

   A large flip chart was placed at the front of each training room where all could comfortably see it and refer to it during the course of the day.

   Page 1 - displayed an outline of the training goals for the session which were as follows:

   1. To have counselors utilize the Case Management System in their service delivery to clients.
   2. To have counselors develop a good understanding of the minimum standards for assessment.

Page 2 - displayed the training sessions agenda and outlined the activities and times of the day material would be covered. (Appendix V)

Page 3 - displayed Emanuel Tropp's key words[16] which I titled "What Should the Workers Keep in Mind in Their Presentation of Self to the Client?" The educator utilized the flip chart by writing down the key words in no distinct patern in order to ensure the participation would focus on the words being written at that point in time. This was done to assist participants to focus on a specific word. The key words are listed in Appendix VII.

Page 4 - displayed a group of key words which I titled "What Factors Will Affect the Assessment of our Clients?" These words were also displayed in no distinct order to assist the facilitator in focussing the attention of the participants on a specific word one at a time. The key words are listed in Appendix VIII.

3. Handouts

Page 1 - Entitled "The Case Manager (Appendix VI) This paper was developed by the educator to grant a brief background on the development of the Case Manager Model. Page 1 was utilized as a starting point for

discussion in which the educator identified the steps of service delivery, and then briefly outlined how the role of Case Manager has changed over the past two decades to meet the needs of the clients it serves. The Case Management System was then reviewed, with emphasis on how the model has been developed to meet the unique needs of the veteran client group.

The educator's objectives in presenting this page were the following:

1. To secure the groups awareness of and interest in the Case Management System.

2. To provide participants with a background knowledge of the Case Manager.

3. To show participants the value of the Case Management framework.

4. To establish a starting point for the day's session.

5. To set the tone of the day by making the participants feel comfortable with material they had seen before.

Page 2 - Entitled "What Should Workers Keep in Mind in their Presentation of Self to the Client?" (Appendix VII)

This page was developed by drawing upon Emanuel Tropp's 1976 work as outlined in Social Work Process.[8] The educator utilized key words which drew the participants attention to feelings which they may experience in dealing with clients. These key words are accompanied by short definitions which describe the meaning or application of the key word. In the presentation of this page, the educator utilized two techniques in the training process. They were facilitating and collaboration. The facilitation method was utilized in the presentation of the key word and the ensuing discussion around its meaning. Collaboration took place through the educator's encouraging the participants to share real life experiences in which they had been involved in their service delivery.

Following discussion on all of the key words, the facilitator wrapped up the session by having one individual present a specific case to the group in a detailed fashion, outlining what he or she had done in order to meet the need of the client.

Each member was asked then to comment on which of the key words had been utilized by the counselor in that particular case.

The objectives of this component of the training are listed below:

1. To assist counselors to develop an awareness of their own feelings in providing services to clients.
2. To grant specific opportunities for participants to present their representational model and have it supported by the group.
3. To allow for the further development of the mutual aid system within the group.

Page 3 - Entitled "What Factors Will Affect the Assessments of our Clients? (Listed in Appendix VIII) This page was developed from the educator's background experiences in counseling. It outlines key words, with short descriptive comments, which were intended to assist the participants to become more aware of the global nature of their practice with clients.

The group was asked to identify the various overall factors which affect their service to the client, and then see if they could be categorized under one of these headings. It was found from the discussion that

these headings were more or less encompassing. The technique in teaching this component was that of facilitator and collaborator. This material was developed between the first and second session in response to the first group's inability to pursue in-depth discussions on feelings and experiences related to Appendix VIII.

The objectives of Appendix VIII were as follows:

1. To facilitate the sharing of the participant's representational model if this did not occur in the previous portion of the session.
2. To allow participants to share real experiences without having to share those feelings related to the experience. Feelings could be shared if the participant so desired.
3. To prepare participants for further training sessions in which they would be expected to continue sharing life experiences but might in turn feel comfortable sharing related feelings.
4. To develop educator confidence in trying new material which may not have had the same preparatory time but may be more responsive to the needs of the group than preplanned material.

Page 4 - Entitled "What is Assessment? (Appendix IX)
This material was developed by the educator and outlined a definition of assessment and other words which may by used synonymously. These words may have the same meaning, depending upon the profession in which they are used. This page also outlined who is our client. The educator, in a directing and facilitating manner, attempted to associate assessment with the client.

The objectives of this component were:

1. To focus the participants on assessment.
2. To introduce assessment as part of the counselors role as service provider.
3. To set the stage for presentation of the 5 components which counselors are to assess in their service delivery.

Page 1, 2 & 3 - Entitled "Financial Assessment" (Appendix X)
This material was prepared by a Supervisor of Client Services within one of the District Offices. It outlined in detail all areas a counselor should identify in completing a financial assessment of client needs. This material was presented in a directing type of session via the utilization of a VHS tape. A guest speaker (a Supervisor of Counseling Services -

District Office) presented a systematic overview of the handout and outlined how the assessment could best be utilized in service delivery.

The objectives of this component were as follows:

1. To ensure counselors had a complete awareness of how to complete a financial assessment.
2. To grant specific instructions on financial assessments by a specialist.
3. To experiment with various training aids.
4. To grant a variety of speakers in an attempt to lessen the boredom of the participants.
5. To acknowledge the training value contained in the District Offices and to show that the Regional Office was not considered the only expert in Veterans Affairs.
6. To utilize specialists where available.

Page 1,2,3,4 & 5 - Entitled "Area Counselor Supplementary Assessment Checklist For General State of Health/Functional Abilities" (Appendix XI)

As stated in the name, this document is a five page checklist which counselors may use in assessing the health needs of their clients. The checklist was presented in conjunction with a VHS tape (120 minutes). The tape featuring a nursing specialist was a formal

presentation of issues counselors should be aware of when they complete an initial assessment of their clients' health needs. The checklist was systematically presented to ensure counselors were aware of each area and were knowledgeable in its completion. As each District Office Client Services team includes a District Office Nurse, the nurse was asked to facilitate this component of the training and answer any health related questions which the participants may have had.

The objectives of this component were as follows:

1. To provide specific information on the health needs of a client for an initial assessment.
2. To utilize a specialist where available for training.
3. To allow for district specialist input via the District Office Nurse.
4. To grant variety to relieve boredom in the group.
5. To experiment with other training methods.

Page I - entitled "Support Systems (Appendix XII)

This sheet outlines the four components which make up an individual's support system. The handout identifies each and provides supporting comments to assist the participants in developing a more specific knowledge base on the topic.

The objectives of this component were as follows:

1. To ensure the participants have an awareness of the client's support system.
2. To ensure participants are aware of audit standards on support systems.

Page 1 & 2 - entitled "Status Change" (Appendix XIII)
This component was presented to grant counselors a quick overview of what the client perceives as any changes in his or her situation which may be causing problems at present or in the future. Counselors are asked to have clients identify the recent changes which he or she have experienced, then to assess the client's ability to cope with the effects of the change. This will assist counselors is assessing the types of services the client may need or the risk potential of the client. Participants were asked to discuss real situations and related feelings in order to allow everyone to relate to the material. Audit standards were reviewed and discussed as a format for wrapping up the topic.

The objectives of this component were as follows:

1. To teach the specific component of status change in order to ensure that counselors are aware of

the material available to facilitate their service delivery.

2. To ensure participant knowledge of audit standards regarding status change.

Page 144 - entitled "Accommodations" (Appendix XIV)
This page was developed to teach two basic components to the counselors when assessing the client's accommodations. Counselors are to consider the condition from a repair perspective and the appropriateness of the facility. This component was presented in conjunction with a VHS tape called "Hazards in the Home".[17] Following the tape a short discussion was encouraged to facilitate the expression of any feelings on the part of participants which may have been aroused as a result of viewing the tape.

The objectives of this component were as follows:

1. To make counselors aware of the material regarding accommodations.
2. To ensure participant knowledge of audit standards related to accommodations.
3. To utilize alternative teaching aids where available.

Training Session Overview (Appendix V Agenda)

The agenda for the sessions in the various District Offices remained relatively constant although there were variations as a result of tuning in to the specific needs of each group. The session material remained relatively standard as outlined in the former section on Training Material, however, examples and real life situations changed from session to session as participants would share their own experiences and related feelings. The educator also would vary the examples from session to session depending upon what might seem appropriate in a given situation.

The major variation from session to session surrounded the use of the training material, titled "What Factors Will Affect the Assessment of our Clients?" As previously mentioned, the educator used this material in 3 sessions. The discussion to use the material was always based upon the response to the training material, titled "What Should the Workers Keep in Mind in their Presentation of Self to the Client?" If there was very little discussion in this area, and if the participants appeared to have difficulty in sharing their feelings related to real life experiences, then this material was added as a normal part of the training session. If the educator found that the "What

Factors Will Affect the Assessment of our Clients?" component was full of discussion and each participant appeared to take part, then the additional material was passed over with a statement of "You may find this interesting to read at your own leisure" or "This information is included for your awareness."

Opening Comments

The session first began with opening comments as an informal discussion on the utilization of the Case Management System. This allowed for the later completion of the Pre-Implementation Observation Survey covered in more detail under measuring instruments. During this time a joke was usually told to allow everyone to feel comfortable and part of the group. The opening comments set the tone of the day and the educator attempted to make all participants feel as if they were a part of the group by identifying everyone by name and greeting each person warmly.

Goal of the Session

The educator then referred to page 1 of the flip chart and outlined his goals for the sessions. Each participant was asked to think about his or her own personal goal for the session and keep it in mind during the course of the day. Participants were then

made aware that they were all expected to take an active part in discussion and the sharing of any experiences which were related to their service delivery.

Agenda (Appendix V)

The educator then referred to page 2 titled "The Agenda" of the flip chart and reviewed each item to be covered during the course of the day. Approximate times were given for each component of the session as well as breaks. Feedback was welcomed.

Changing Needs of Clients

Each participant was asked to think of a client with whom they first came in contact between 5 and 10 years ago. Those participants who had recently joined Veterans Affairs were asked to think of their parent 5 or 10 years previous. The group was asked "What were their needs then?" and, "What were you as a service provider able to provide them?" The group was then asked to consider the same person today. "What are his/her present needs and what additional services are you now able to provide?" The recent participants were unable to consider service changes, however, they were able to consider need changes.

This exercise was designed to assist the participants in understanding the need for change, improvement, and training.

Handouts

The handouts previously referred to under training materials were distributed and the educator began a systematic presentation of the material on a page by page basis.

Wrap-up

As a wrap-up to the session the following took place:

1. The educator reviewed the goals of the day and reviewed the material which had been presented.
2. The participants were encouraged to continue their development by individual readings and utilizing the group for discussion and support.
3. The participants were asked to complete an Evaluation Questionnaire on the day's session. They were told that the responses would be kept confidential and they would be used by the trainer to evaluate the training sessions for self development and growth. The analogy of a report card was utilized in that the educator wanted feedback to allow for improvement in future training sessions.

4. The group was asked for any input to further training, or any needs which arose out of the sessions.
5. Participants were thanked for their time and input into the sessions and for assisting in the training process. In some cases the educator elaborated on a specific event or experience which had aided his own development and growth.
6. The session was dismissed.

APPENDIX III

The following is the Case management and Standards as it was developed and presented to counsellors in the Prairie region of Veterans Affairs.

A CASE MANAGEMENT SYSTEM

Veterans Affairs of Canada is committed to support the economic, psycho-social, environmental, health and well being of veterans, eligible civilians and their dependents. Given the increasing health related needs encompassed in the advancing age of our client population, we are faced with addressing the complexities of assisting veterans to remain in their own homes as long as possible and ultimately facilitate long-term care placement.

This issue calls for the need of an organized approach in the delivery of programs and benefits hence the development of a National Case Management System encompassing four elements:

- case management
- standards
- risk assessment
- and quality control

1. Case Management

The concept of Case Management facilitates the development of an appropriate client case plan. As such it falls into two major areas:

A. Case Management Structure

A system to address the population served, and facilitate the delivery of services efficiently and effectively.

B. Individual Client Support

The appropriate coordination of time and resources that assists clients to engage in the process of identifying needs, exploring optional solutions and mobilizing informal as well as formal supports to achieve/maintain the highest level of independence of which the client is capable.

Program Delivery

Program Delivery is a practical application of a theoretical base.

A. PRINCIPLES

A Systematized Delivery Program:

-Is an organized approach to client support;

-Is compatible with all regions and circumstances;

-Is pro-active and reactive;

-Addresses quality assurance and control;

-Facilitates delivery of programs and services;

-Considers future implications of resource requirements;

-Is capable of integration into automated system management;

-Addresses distribution of client population;

-Incorporates flexibility and simplicity of operation and administration;

-Delegates function to appropriate level;

-Affords access to redress;

-Must drive Administrative and Financial functions;

-Identifies the area counselor as case manager;

-Establishes client's role and responsibility;

-Facilitates re-assessment/review.

B. PRACTICE

The operation of programs and service delivery encompasses both client and administrative components. These components can be defined generically as follows;

1. Intake
2. Assessment/Re-Assessment
3. Planning
4. Decision
5. Implementation
6. Follow-up

The content of items 1-5 is further defined as follows:

SUBCOMPONENTS;

1. INTAKE

ASSESSMENT/REASSESSMENT
-Gathering of information (access)
-Contact
-Recording
-Information interchange

2.

-situation review and analysis (psycho-social/economic/ environmental and health).
-Identifying the need
-Consider the options available.

3. PLANNING

-Internal/External
-Priorities
-Client's Agreement

4. DECISION

-Who/What/When
-Authorities
-Client Concurrence

5. IMPLEMENTATION

-Who/What/When
-Coordination
-Managing/Administrating

-Referral

6. FOLLOW-UP

-Who/What/When
-Coordination
-Review/Evaluation of Case Plan
-Coordination

COMPONENTS FOR SERVICE DELIVERY

ASSESSMENT

STEP	INTAKE	RE-ASSESSMENT	PLANNING
Purpose	To determine clients immediate needs and entitlement and implement problem-solving processes as necessary.	To systematically examine and analyze the client's situation.	To develop a case plan in collaboration with the client based on identified needs.
Activity	Prescreen potential clients, in and out.	Conduct assessment, re-assessment according to Departmental Standards.	Decide on priority of needs.
	Engage client in Intake process.	Review assessments/ re-assessments.	Identify resources available to meet clients needs.
	Explain agency service.		Determine who will meet the needs.
	Refer client to proper resource.		Establish mutually acceptable goals.
	Crisis Intervention. Handle immediate emergency as needed.		Establish follow-up.
	Enroll applicant as an identified agency client.		Refer for decision as required.
	Record action on false docket.		

COMPONENTS FOR SERVICE DELIVERY

STEP 1: PURPOSE

DECISION	IMPLEMENTATION	FOLLOW-UP
To ensure that the suitable intervention is made at the appropriate time and level.	To implement the case plan to meet client's needs.	To ensure services are being provided as planned and continue to be suitable to the client's needs. Monitor, evaluate and make appropriate adjustments. Encourage client responsibility.

ACTIVITY

		Ongoing Follow-up	Re-Assessment
Determine decision level.	Initiate appropriate processes to deliver services and benefits	Prioritize Cases	
Secure signatures		Monitor cases according to standards	Contact client annually. Reassess as required.
Inform client.	Disengage from the client.		
		Identify and report service gaps.	Revise care plan as required.
		Encourage client participation and and self-reporting.	Terminate cases no longer needing service.

STANDARDS FOR SERVICE DELIVERY OF THE CASE MANAGEMENT SYSTEM

1. INTAKE

To identify and establish contact with individuals who require support services and who may be eligible under departmental programs.

1.1 Procedure and Rationale

Prescreen potential clients at first point of contact, (in office or out in the field).

Intake is the point of entry/re-entry with the Department and therefore essential to establish a good relationship with the client.

1.1.1 Standard

Create a warm atmosphere where the inquirer feels welcome by:
i) reviewing available documentation prior to meeting the client, to familiarize oneself with the client.
ii) respond to client in respectful and helpful manner.

1.2 Procedure and Rationale

Determine the nature of the inquiry.

This allows the client the first opportunity to state his case. This is the first stage in generating information for the purpose of recording and taking the client through the problem solving process.

1.2.1 Standard

Clarify the purpose of the inquiry by:
i) asking appropriate questions to focus inquiries on issue at hand.
ii) listening to inquirers feedback.
iii) summarizing information received.
iv) recording pertinent information.

1.3 Procedure and Rationale

Refer the client to the proper resource, VAC or other.

The "intake" counselor determines eligibility for on-going services/benefits, therefore becoming VAC clients. Some however, will not meet basic eligibility and should be considered for referral to community resources and/or are provided with emergency assistance if possible.

Standard

1.31 Counselor to be knowledgeable of eligibility for benefits.
i) clearly explain eligibility to inquirer.

1.3.2 those ineligible inquirers considered for referral to outside agencies, the counselor should have:

i) full awareness of community resources.
ii) knowledge of how to interface resources.
iii) knowledge to assist the inquirer in interfacing if necessary by:
- identify contact person.
-phone resource to introduce inquirer.
-draft written referral (copy to file).
-terminate interview.

1.3.3 Refer eligible clients to VAC assessment stage by:

i) transferring client to appropriate worker (as per district procedure).

1.4 Procedure and Rationale

Action appropriate documentation.

This step is absolutely necessary as it registers the client with VAC CO and allows the counselor to record the client's pertinent data and the action taken. This information for updating, for review, for Quality Control and Quality Assurance and for transfer to another counselor.

Standard

1.4.1 Ensure false docket is opened where applicable or record on alternate file as per office procedure.
1.4.2 Record all pertinent data.

1.4.3 Record all counselors action.
i) Applications given.
ii) Referral for other VAC services.
iii) VAC clients referred to outside agencies.

1.5 Procedures and Rationale

Crisis intervention. Handle immediate emergency as needed.

This step has the sole purpose of returning a client who is at risk to a functional level. Counselors working with a client in a crisis require time and a sound knowledge base from which to operate.

Standard

1.5.1 Perform an emergency assessment.
i) determine the nature of the crisis.

1.5.2 Liaise with other professionals as required.

1.5.3 Explore intervention alternatives.

1.5.4 form of intervention with client's concurrence.

1.5.5 Ensure proper authorities are in place for intervention.

1.5.6 Follow through on intervention.

1.5.7 Document action.

1.5.8 Follow-up on intervention required.

2. ASSESSMENT/RE-ASSESSMENT

To understand the client as a whole person and be aware of strengths and needs in the client's situation.

2.1 Procedures and Rationale

Conduct a comprehensive assessment

This step is intended to systematize the collection of client information in a holistic fashion for the purpose of optimal decision making.

Recording should be based upon client statements, observable indicators and other information. The assessment may be supplemented/ comprised of information/documents from other sources.
eg. - medical history from physician

- nursing assessment
- provincial
- Legion contacts
- neighbors
- etc.

Standard

2.1.1 Complete appropriate personal data.

2.1.2 Provide a description of the client's physical, emotional, and mental state.

2.1.3 Comment on client's alertness and emotional state:

i. ask pertinent questions
ii. observe client's actions, eg.
- does the client appear confused?
- ability to communicate
- is the client agitated or passive (indifferent)?

iii. Does he appear cheerful, depressed?

2.1.4. Activities of daily living are a measure of an individual's ability to maintain themselves and live independently. Counselor should report all problem areas and note measures the client has taken to counter the problem (i.e. are there support persons, who are they, frequency of contact,. home care equipment, prosthesis, etc.)

i) personal care
- eating, washing, toileting, dressing and preparing meals.

ii) mobility
- walking, climbing stairs, ability to use the public transit system or drive a private vehicle and shopping.

iii) home maintenance
-heavy and light housekeeping, groundskeeping, seasonal exterior maintenance.

2.1.5 Financial state - report on client's financial situation by assessing if the client is:

i) able to handle own affairs
ii) on a fixed income
iii) eligible for any assistance programs,

VAC - completion of the appropriate form.

2.1.6 Accommodation - report on the client's type of housing by considering:
i) is it adequate.
ii) is it appropriate.
iii) recommendations to alleviate identified problems.

2.1.7 Status change - comment on the changes in the client's situation over the past year and their ability to cope with the results of change.

2.1.8 Isolation - social contacts. Identify the client's social network and any significant changes which may have occurred recently. Encourage client social interaction if appropriate.

2.1.9 Family - comment on the client's family as a support system, focus on the interaction (positive/negative), and identify the immediate next of kin.

2.1.10 Community services - identify groups which the client is utilizing at present including professional agencies, community organizations, clubs, church organizations, etc.

2.1.11 Date of follow-up

2.2 Procedures and Rationale

Review of Assessments/Re-assessments

The essential feature of an assessment review is to ensure that a systematic holistic analysis of the client's circumstances has been completed and there is sufficient information to proceed to case planning.

2.2.1 Standards

Reviewer ensures assessment is completed in accordance with 2.1.1.

3. CASE PLANNING

To clarify expectations and agree upon an individualized plan of action.

3.1 Procedures and Rationale

Review specific needs with the client which became evident as a result of the assessment. This step allows the counselor to feedback the information to the client to ensure they have captured the key points.

Standards

3.1.1 State all of the identified needs.

3.1.2 Seek clarification from the client to ensure that all his needs are identified.

3.1.3 Modify as required.

3.2 Procedures and Rationale

Prioritize needs in collaboration with the client.

This step requires a variety of counseling skills in order to help the client come to grips with the immediacy of the threat to client's independence.

Standards

3.2.1 Identify priorities.

3.2.2 Secure client's concurrence on priorities.

3.2.3 Record prioritized needs.

3.3 Procedures and Rationale

Develop goals which will meet the identified needs.

This step matches the appropriate resource (where available) to the needs of the client with the desired goal being to address the need.

Standard

3.3.1 Explain intervention alternatives.

3.3.2 Determine form of intervention with client concurrence.

3.3.3 Identify individuals/agencies who are responsible for goal accomplishments.

3.3.4 Commit departmental resources where authorized to do so.

3.3.5 In an emergency situation utilize the crisis intervention model as per procedure 1.4.

3.3.6 Explain the department's decision making process to the client and explain estimated time frames.

3.3.7 Ensure the client agrees with the case plan.

3.3.8 Set an appropriate follow-up date.

i) written communication to client.
ii) phone call/visit to monitor the success of the program.

3.4 Procedures and Rationale

Document all information.

The purpose of this procedure is:

- to develop a complete date base on the

client for reference.
-to ensure material is available for presentation in a systematic manner.
-to make information available for continuity

in transferring caseloads.
-to enable the monitoring of changes in the

client's situation over a period of time.
-to provide information for Quality Control

purposes.

Standards

3.4.1 Recording should be completed as soon as possible after the interview.

3.4.2 Recording should be completed in a manner consistent with National/Regional/District procedure and recommended form.

3.4.3 Documentation should include the following:

i) referral (report of initial contact).
ii) applications (if applicable).
iii) assessment.
iv) case plan.
v) ongoing case recording (summary).
vi) other supporting documents (as necessary). -nursing assessment, medical, income, etc.

4. DECISION

To ensure that the suitable intervention is made at the appropriate time and level.

4.1 Procedures and Rationale

Decide on decision level necessary to implement case plan.

Standards

4.1.1 Ensure that the decision addresses the client's identified needs.

4.1.2 Ensure that the decision has been made by the appropriate delegated authority.

4.1.3 Arrange for the case to be scheduled with the appropriate individual in a timely fashion, indicating urgency for prioritization as required.

4.1.4 Plan to attend on the scheduled date or arrange a substitute.

4.1.5 Designated individual ensures decisions are recorded and signed off in a prescribed manner.

4.1.6 In case of changes to the case plan refer to procedures 3.2 and 3.3.

4.2 Procedures and Rationale

Inform client of the decision.

Ensure the client is informed of the decision, their rights and obligations in receiving benefits and the process to be followed.

Standards

4.2.1 As per district procedure and departmental style and form, ensure the client is aware of the following by:

i) a letter stating:
-a decision (approved/declined).
-effective/expiry date.
-type of contribution arrangement (intervention).
-amount.
-procedure for account submission/reimbursement to client.
-references to appeal/re-dress process.
-eligibility for community services.

ii) explain the terms of:
-the contribution arrangement.
-the VIP informational pamphlet (where applicable).
-the renewal process.
-treatment benefits information.

5. SERVICE DELIVERY/IMPLEMENTATION

This is the stage when the case manager ensure the mobilization of resources/services for the optimal benefit of the client.

5.1 Procedures and Rationale

Contact appropriate agencies identified in the case plan.

Some case plans will call for services by outside agencies. These agencies should be contacted to ensure the delivery of services to the client.

Standards

5.1.1 Dependent on the client's capability, coordinate on behalf of the client, services which the client is not able to arrange.

i) notification to appropriate agency/service provider.

5.2 Procedures and Rationale

Disengage from the client and ensure the client is clearly aware of how to access the case manager when required.

Upon implementation of the case plan, the case manager becomes a monitor of the service, thus allowing the client to experience independence throughout the duration of the case plan.

Standards

5.2.1 Disengage from the client in the following manner:

i) Explain the roles of each care giver/case manager in the implementation stage.

ii) ensure the client knows how to contact the care giver/case manager when necessary/should the situation change. The case manager should ensure that if the client is unable to make care giver/case manager contact on their own behalf then a significant other should be involved (eg. wife, brother, neighbor, friend,. nurse or administrator in institutional cases). The significant other should be counseled about the client's rights, benefits, case plan and how they can access the case manager on behalf of the client. IF there is no significant other then the case manager should set up regular contact dates.

5.2.2 Case manager ensures dates for follow-up are set and recorder in the BF system.

6. FOLLOW-UP AND RENEWAL/ASSESSMENT

To keep current regarding the status of the client and suitability of the existing case plan.

6.1 Procedures and Rationale

Client follow-up.

This is a monitoring function which occurs art a pre-set time for the purpose of reviewing and updating the client situation and tot make any necessary adjustments to the case plan.

Standards

6.1.1 Case manager should review and prioritize case load based upon client's immediate needs.

6.1.2 As a minimum standard, the client must be contacted on an annual basis to review the following:

i) note changes in the client situation.
ii) comment on the likelihood of the case plan continuing to meet client needs.
iii) revise the case plan as appropriate.

6.1.3 Case manager is required to BF cases for follow-up.

6.2 Procedures and Rationale

Conduct the renewal process.

The renewal process is necessary to continue the delivery of benefits as required by the client. The process should comply with the steps taken for initial assessment.

Standards

6.2.1 Renew the contribution arrangement by completing the following as appropriate:

Assessment
Case Planning
Decision
Implementation
Follow-up

APPENDIX IV

Training Schedule 1987

Winnipeg DO -	November 26 and 27
Edmonton DO -	November 30 and December 1
Calgary DO -	December 2 and 3
Regina DO -	December 7 and 8
Saskatoon DO -	December 9 and 10
Brandon DO -	December 16 and 17

APPENDIX V

Training Agenda

8:00 - 10:00 a.m.	Case Management - Where did it come from and what is it?
10:00 - 10:15 a.m.	Coffee
10:15 - 12:00 noon	Assessment - How and what?
12:00 - 1:00 p.m.	Lunch
1:00 - 2:30 p.m.	Assessment - Minimum standards.
2:30 - 2:45 p.m.	Coffee
2:45 - 4:00 p.m.	Assessment - Minimum standards.

* Starting times are flexible depending upon each DO. Each session will be approximately 7 hours in length.

APPENDIX VI

The Case Manager

The movement toward citizen's participation and recognition of client's rights in the 1960's and early 1970's encouraged the development of strategies designed to safeguard the human service consumer from bureaucratic obstruction, coercion, and paternalism. The strategies included development of citizens' review boards, recognition of patient and consumer rights, and client participation on agency boards. The more enduring roles to originate from this movement have been the ombudsman, and the case manager.

The concept of case management evolved from concerns with service integration and coordination. The proliferation of categorical social programs during this era had resulted in a fragmented and inefficient service delivery system. Consequently, demonstration projects were created to improve linkages and coordination at t6he state and local level. In 1974, programs focused on identifying those elements essential for securing coordinated delivery of services.

Case management has been defined as a "system of locating, coordinating, and monitoring a defined group of services for a defined group of people" and as "a process whereby a fixed

point of responsibility within a governmental agency, or its designee, is assigned to coordinate a comprehensive, community-oriented plan of services and informal sports for an individual or family." More specifically, case managements is recognized as providing five basic services: (1) assessment, (2) planning, (3) linking, (4) monitoring, and (5) advocacy.

In practice, case management models vary on a continuum from information and referral agents to administrators and providers of capitated services. Regardless of the model, case managers have viewed themselves consistently as client representatives instrumental in keeping individuals from "fall(ing) through the cracks." One of the goals of case management is to "assure consumer satisfaction in making the system work for the client in a consistent and coherent manner." (Stan Belazuk)

APPENDIX VII

What should the Worker Keep in Mind in His Presentation of Self to the Client

Compassion - I deeply care about you.

Mutuality - We are here on a common human level; let's agree on a plan and then let's walk the path together.

Humility - Please help me to understand.

Respect - I consider you as having worth. I treat your ideas and feelings with consideration. I do not intrude upon your person.

Openness - I offer myself to you as you see me; real, genuine, and authentic.

Empathy - I am trying to feel what you are feeling.

Involvement - I am trying to share and help in your efforts.

Support - I will lend my conviction and back up your progress.

Expectation - I have confidence that you can achieve your goals.

Limitation - I must remind you or your agreed-upon obligations.

Confrontation - I must ask you to look at yourself.

Planning - I will always bring proposals, but I would rather have yours.

Enabling - I am here to help you become more able, more powerful.

Spontaneity and Control - I will be as open as possible, yet, I must recognize that, in your behalf, I need to exercise some self-control.

Role and Person - I am both a human being like you and representation of an agency with a special function to perform.

Science and Art - I hope to bring you a professional skill which must be based on organized knowledge, but I am dealing with people, and my humanity must lend art to grace the science.

APPENDIX VIII

What Factors Will Affect the Assessment of our Clients?

Knowledge - veteran, program, his needs

Skills - communication (listening), perception of environment

Experiences - how you (the counsellor) handled the situation before

- how your (the counsellor) wife/husband, boss/workmate treated you before you (the counsellor) met with the client.

Values - class (upper, middle, lower), cultural values

Attitude - positive-negative

Health - weak-strong, well or sick

Client - open-closed, lonely

Environment - warm-cold, nice-unkempt

APPENDIX IX

What is Assessment?

Words that are used synonymously with assessment are:

Study, diagnosis, analysis

The development of understanding about individuals, families and communities is an important aspect of assessment. A social study is an assessment.

"It is a process and a product of understanding on which action is based" (Max Siporin). It is the collection and analysis of information. It is the fitting together of available facts so they yield meaning.

WHO IS BEING ASSESSED?

- our client

WHO IS THE CLIENT?

- veteran
- near recipient - 65 and over with a Theater of War service
- CPC pensioned near recipient with Canadian only service

WHO ARE WE ASSESSING?

- client in his environment
- in a holistic fashion

APPENDIX X

Financial Assessment

The simplest way to determine a financial assessment is through Income and Expense.

Income

- look at all income from all sources. Do not restrict to what VAC would normally assess, i.e. WVA.
- use both incomes if married.
- do children contribute?
-is situation considered low income (fixed income)?
-is person over 65 - OAS, are they getting GIS?
- is it full OAS/GIS? if not look for other income.
- CPP
- pensions - is it indexed?
-Long Service, Superannuation, CPC
- working - earnings
- UIC
- rental
- rooms/property
- interest (does the person see this as available income?)
- are they getting provincial benefits?
- MB Supplement for elderly

- SAFER (Shelter Allowance for Elderly Renters)
- Handicap Supplement
- Alberta Health Care Subsidy?
- plus numerous other programs

EXPENSES

Shelter Costs

- rent
- mortgage
- taxes

** (should not be more than 30% of net income.)

- Are they in subsidized housing?
- Should that be considered subsidized housing?
    - province
    - city
    - veterans organization

- Utilities
    - gas
    - oil - Are they on a budget so payments are the same?
    - Phone/cable

Food

- An area where many people cannot tell you what they spend. They just buy. This is an area a person should keep track of for a month. It will help them get a handle on the total financial picture. Household operations are usually found in this area as well, i.e. light bulbs, cleaning supplies, etc.

Personal Care

- shampoo/toothpaste/soap. In most cases this is part of the food bill. Look for things like hair cuts, hairdressers, charities.

Transportation

- car payment
- insurance
- gas

Medical

- are they using Pharmacare in MB?
- do they have Blue Cross - would it pay?
- do they take advantage of provincial benefits offered by the various provinces?
- are they taking full advantage of VAC benefits?

Clothing

- Very few people can tell you what they spend on clothes. Clothes are usually bought on a needs basis and usually not budgeted for. This is an area to caution people about.

"BUDGET DEFICIT INDICATORS ARE USELESS" Look at actual expenses. Very few people actually live in a deficit situation. They spend what they have and that's it.

DEBTS

- what type?
- are they handling credit appropriately?
- referrals may be needed re:
    - orderly payment of debt
    - bankruptcy
    - financial counseling

Home Maintenance/Repairs

- big problem for a lot of our clients.
- referrals
    - critical home repair
    - maybe veteran organization
    - Benevolent Funds/Trust Funds
    - Province/Core Area Initiative (Winnipeg)

ASSETS

- what assets does one have?
    - cash on hand
    - bank
    - insurance
    - bonds
    - stock
    - RRSP's
- are the assets available or locked in?
- own their own home, other property?
- is there something for emergencies?
    -Emergency funds - AF, etc. VAC and other.

GENERAL

- who handles the finances?
- is the person capable?
    - third party? Are arrangements formal?
    - Public Trustee?
- is the client happy with situation?
- ALWAYS REPORT SUSPECTED ABUSE
- does the client have a will?
    - who is Executor?
    - counsel the importance.
- does the client need help from us?
    - WVA
    - Trust Funds
    - referrals

- welfare for supplement
- money management
    - Age and Opportunity
    - Consumer Bureau

- DON'T be afraid to tell a client you feel he/she is living beyond their means. He or she has choices.

APPENDIX XI

AC Supplementary Assessment Checklist for General State of Health/Functional Abilities

A. General State of Health and Emotional/Mental Status

1. General Statement on client's overall appearance

2. Eyesight — Client's Response
   - Good _____
   - Fair _____
   - Poor _____
   - Partially or totally blind _____
   - Glasses yes ____ no _____

3. Hearing — Client's Response
   - Good _____
   - Fair _____
   - Poor _____
   - Partially or totally deaf _____
   - Hearing Aid left ____ right _____ no _____

4. Teeth — Client's Response
   - Own teeth only _____
   - Dentures _____ Upper_____ Lower_____ Partial_____
   - No Problems _____
   - Some Problem _____
   - Significant Problems _____

5. Feet (Pain, swelling, etc) Client's Response

No Problem _____
Some Problem _____
Significant Problem _____

6. Relevant Medical Conditions Details/Effect

eg. Conditions (Check as reported by Client)

- Diabetes
- Arthritis
- Chronic Chest Condition (emphysema/asthma)
- Heart/Circulation Problems
- Cancer
- After effects of a stroke
- Other

7. Hospital admissions in last year

- Date
- Duration
- Reason
- Is client still experiencing any problems/effects

from condition he was hospitalized for?

8. Currently under the care of physician(s)
yes _____ no _____
Date last seen:

Reason:

9. Current Medications (prescription and non prescription)

Drug	Dose	Frequency	Route	Prescribed by	Date Prescribed

Compliance/Understanding

Does client feel he can manage his medications properly?

10. Skeletal Function

Use of:	Normal Right/left	Partial Right/left	None Right /left
Hands			
Arms			
Hips			
Back			
Knees			
Feet			

Comments:

11. Use of Aids

Comments/Problems

Cane	_____
Crutches/Walker	_____
Wheelchair	_____
Leg Brace	_____
Artificial Limb	_____
Ostomy Equipment	_____
Catheter	_____
Oxygen Equipment	_____
Other	_____

12. Mental/Emotional Status

	Appropriate	Inappropriate	Difficult to Assess
Alertness			
Orientation			
Memory			
Judgment			
Morale			
Motivation			

13. Life Style

Use of Alcohol
Tobacco
Dietary Practices
Exercising Regime

B. Functional Assessment
(Activities of Daily Living - Mobility)

1. Walking/Mobility	Limitations/Help Needed
Fully Independent	_____
Independent with cane/walker	_____
Requires some assistance	_____
Wheelchair Independent	_____
Wheelchair Requires Assistance	_____
Stairs	
Manages without help	_____
Limited	_____
Unable to manage	_____
Functional mobility in own residence	
Excellent	_____
Good	_____
Adequate	_____
Fair	_____
Poor	_____

2. Personal Care Bathing	Limitations/Help Needed
Performs without help	_____
Limited	_____
Unable to manage	_____
Dressing/Undressing	
Performs without help	_____
Limited	_____
Unable to perform without help	_____
Feeding	
Performs without help	_____
Limited	_____
Unable to perform without help	_____
Grooming	
Performs without help	_____
Limited	_____

Unable to perform without help _____

Sleep	Limitations/Help Needed
No problems	_____
Some problems	_____
Significant problems	_____
Use of Medication for sleep	Yes _____ No _____

Toileting

Performs without help	_____
Limited	_____
Unable to perform	_____

Continence

	Bowel	Bladder
Continent	_____	_____
Some Problems	_____	_____
Incontinent	_____	_____

3. Household Tasks	Limitations/Help Needed
Light Housekeeping	
Performs without help	_____
Limited	_____
Unable to Perform	_____
Heavy Housekeeping	
Performs without help	_____
Limited	_____
Unable to perform	_____
Groundskeeping	
Performs without help	_____
Limited	_____
Unable to perform	_____
Preparation of Meals	
Performs without help	_____
Limited	_____
Unable to perform	_____

APPENDIX XII

Support System

This category is divided into four components:

1. Family
2. Friends
3. Community
4. Services and Professional

This section should look at the four components and identify those systems which are utilized by the client.

1. Family - Next of kin or "extended" which have contact with the client.

2. Friends - Identify those individuals (or lack of) who interact with the client.

3. Community - Organizations, primarily volunteer, which the client utilizes, eg. church, legion, community club, friendship center, etc.

4. Services and Professional - ALL Agencies, or professional people which provide on-going services to the client, eg. doctor, VON, Meals-on-Wheels, Society for Crippled Children ad Adults.

The Area Counselor should comment on the amount of support/dependency, the harmony of the relationship. positive and negative factors, and the likelihood of the support to allow the clients to maintain independence within their community.

APPENDIX XIII

Status Change

Any change in a person's status or situation may cause him/her problems. He/she may find that their old coping mechanisms are no longer adequate/suitable and the veteran may not have the personal resources to develop new coping mechanisms which are more appropriate.

The AC should note any changes in the past year which might affect the client. Changes such as recent retirement, death of a spouse, a move to another accommodation, recent illness, etc. should all be considered as possibly debilitating if the client does not have the personal resources to cope.

Indicate how the client has been affected and what resources in place. What appropriate interventions should be considered?

Status Change	Example
No change in status in past several years.	The veteran and his wife appear to have no major changes in the past year which could have affected their physical/emotional health.
Hospitalized frequently, possible terminal cancer	The veteran has been hospitalized frequently during the last year and there is a possibility of terminal cancer. The veteran himself is very distressed by his illness and upset when he is hospitalized. The veteran's wife is also experiencing distress as her life is frequently disrupted and she is feeling depressed by her husband's condition. A referral has been made to Home Care to provide some home support for the veteran and his wife.
The veteran has moved recently from his home to an apartment.	The veteran sold his home and moved into an apartment. The move was planned and not the veteran is pleased with his new accommodations as they are

easier to manage and he has more social contacts.

Veteran has retired after Retirement was /was not for working thirty years. welcomed; veteran planned/did not plan for his retire ment and feels satisfied/dissatisfied with his situation. The veteran requires/does not require support in involving him in community activities/groups.

APPENDIX XIV

Accommodation

This section focuses on the type of shelter/housing available to the client. Is it adequate, appropriate and/or does it present problems to the veteran.

Are there appropriate interventions which would help to alleviate physical/structural problems which would further facilitate the veteran's stay in his own home? On the other hand, could the veteran continue to live independently in a different setting?

Accommodations	
The veteran is renting a small one bedroom home.	The veteran is renting a small one bedroom home. At present, he is capable of maintaining the home himself and the accommodations seem comfortable, safe, and appro priate. The bathroom has special railings and the veteran has a special bed designed to meet his needs.
Pleasant, well maintained single level bungalow	The veteran receives light housekeeping services as the veteran's wife is unable to perform certain duties. The veteran continues to maintain the outside of his home and enjoys working in his garden. This activity provides him satisfaction and a sense of independence. AS the veteran is 85, follow-up should be conducted in six months to determine if this is still the case. The veteran has clear title to a three bedroom single level bungalow which is well maintained and upgraded. The veteran requires no assistance to maintain his home.
The veteran resides in a Home which is in dire need of repair.	The veteran resides in a four bedroom home which is in dire need of repair. IT had housed his family who have all grown up. It is costly to maintain. The veteran's wife is

physically unable to keep up with the work. Housekeeping and groundskeeping are recommended. The veteran has also been referred to CHRP for aid in home and for a provincial energy check.

APPENDIX XV

Pre-Implementation Observation Survey

		Yes	No
1.	Do the AC's know what the Case Management System is?	_____	_____
2.	Are the AC's aware of the six steps of the CMS	_____	_____
3.	Are the AC's able to identify the six steps of CMS?	_____	_____
4.	Have the AC's used the CMS in their Implementation Plan?	_____	_____
5.	Do you consider the CMS a good one?	_____	_____
6.	Are you currently using the CMS?	_____	_____
7.	Will you use it again?	_____	_____

APPENDIX XVI

Observation Survey

District Office _____
Total Number in Office _____
Number in Attendance _____

		YES	NO
1.	Did the participants attend to schedules	_____	_____
2.	Did participants take part in discussion	_____	_____
3.	Was participation easy and free?	_____	_____
4.	Did participants ask questions on specifics of the model?	_____	_____
5.	Did participants take notes?	_____	_____
6.	Were the participants attentive?	_____	_____
7.	Was there ongoing two-way dialogue	_____	_____
8.	Are the participants active as opposed to being passive?	_____	_____
9.	Did the participants seem to understand the material?	_____	_____

APPENDIX XVII

Evaluation Questionnaire

Please check each of the following items. Feel free to write additional comments beside any of them.

1. The overall quality of the material presented was:

_____ Good _____ Average _____ Poor

2. The language level of the presentation was:

_____ Difficult _____ About right _____ Too easy

3. Was the length of time allowed for preparation sufficient?

_____ Yes _____ No

4. The pace at which the presentation was conducted was:

_____ Too Fast _____About Right _____ Too Slow

5. Did the amount of time provided for discussion seem acceptable?

_____ Too Much _____ Just Right _____ Too Little

6. Was the concept of Case Management linked to your service delivery system?

_____ Yes _____ No

7. Will you use the Case Management System in your service delivery?

_____ Yes _____ No _____ Not Sure

8. What is your definition of the Case Management System?

9. What are the six steps of Case Management?

   1.

   2.

   3.

   4.

   5.

   6.

10. Please indicate your overall response toward the implementation ad effectiveness of the Case Management System within your work place.

APPENDIX XVIII

Attached please find The Case Management Operational Survey. The survey is geared to assess if the Case Management System and Standards are effective and efficient.

You are requested to complete 3 surveys at different times. Please complete a survey on the following dates:

The first survey -	December 15, 1987
The second survey -	January 15, 1988
The third survey -	February 15, 1988

Please ensure that all questions are completed and the survey is returned to Joe Newransky, PRO.

When answering each question choose the sentiment which most matches your won. Only choose one as in the following examples:

All in all, I am satisfied with my job.

Definitely Disagree _____

Inclined to Disagree _____

Inclined to Agree _____

Definitely Agree _____

The Case Management Operational Survey

Date Completed:

December 15, 1987 _____

January 15, 1988 _____

February 15, 1988 _____

Effectiveness

1. - The Case Management System and Standards take into consideration all aspects of the VIP.

Definitely Disagree _____

Inclined to Disagree _____

Inclined to Agree _____

Definitely Agree _____

2. - The model is conducive to the provision of consistent program delivery.

Definitely Disagree _____

Inclined to Disagree _____

Inclined to Agree _____

Definitely Agree _____

3. - The standards assist in Quality Control.

Definitely Disagree _____

Inclined to Disagree _____

Inclined to Agree _____

Definitely Agree _____

4. - The Case Management System and Standards clarify the role of the Counselor in the delivery of services.

Definitely Disagree _____

Inclined to Disagree _____

Inclined to Agree _____

Definitely Agree _____

5. - Clients benefits from the Case Management System ad Standards model in your district.

Definitely Disagree _____

Inclined to Disagree _____

Inclined to Agree _____

Definitely Agree _____

6. The model is helpful in handling increased workload volume.

Definitely Disagree _____

Inclined to Disagree _____

Inclined to Agree _____

Definitely Agree _____

Efficiency

7. - The model provides a clear framework in which to provide services.

Definitely Disagree _____

Inclined to Disagree _____

Inclined to Agree _____

Definitely Agree _____

8. - The Case Management System and Standards are more applicable than former models used by counselors.

Definitely Disagree _____

Inclined to Disagree _____

Inclined to Agree _____

Definitely Agree _____

9. - It is beneficial for purposes of supervision to have this model in place.

Definitely Disagree _____

Inclined to Disagree _____

Inclined to Agree _____

Definitely Agree _____

10. - The more our districts apply the model in our practice the better services are for the client.

Definitely Disagree _____

Inclined to Disagree _____

Inclined to Agree _____

Definitely Agree _____

11. - The application of the Case Management System and Standards decreases time frames for processing applications.

Definitely Disagree _____

Inclined to Disagree _____

Inclined to Agree _____

Definitely Agree _____

12. - Services are provided in a timely fashion utilizing the model.

Definitely Disagree _____

Inclined to Disagree _____

Inclined to Agree _____

Definitely Agree _____

Please use reverse side for any additional comments you may have.

APPENDIX X1X

The Case Management Operational Survey - Results

	Effectiveness	Effeciency
Winnipeg Do.	3.17	3.17
	3.	3.
	3.	3.
average total	9.17 divide 3 = 3.06	9.17 divide 3 = 3.06
Brandon Do.	3.	2.83
	3.	2.83
	2.83	2.83
average total	8.83 divide 3 = 2.94	8.49 divide 3 = 2.83
Saskatoon Do.	2.83	2.83
	2.83	2.5
	3.33	3.33
average total	8.99 divide 3 = 3.0	8.66 divide 3 = 2.89
Regina Do.	2.83	3.0
	2.83	2.83
	2.83	2.83
average total	8.49 divide 3 = 2.83	8.66 divide 3 = 2.89
Calgary Do.	3.0	3.0
	3.0	3.0
	3.0	3.0
average total	9.0 divide 3 = 3.0	9.0 divide 3 = 3.0
Edmonton Do.	2.83	3.0
	3.0	3.0
	3.33	3.33
average total	9.16 divide 3 = 3.05	9.33 divide 3 = 3.11
	total 17.88	17.78

Calculations:

Average Effectiveness 17.88 divide 6 = 2.98

Average Efficiency 17.78 divide 6 = 2.96

conversion to the 2 point scale.

Average Effectiveness

$$\frac{2.98}{4} \text{ times } 100 = 74.5\% \text{ times } 2 = 1.49$$

Average Effeciency

$$\frac{2.96}{4} \text{ times } 100 = 74.\% \text{ times } 2 = 1.48$$