The Good Recording Guide

Children and Youth with Special Needs

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WHY DOES RECORDING MATTER?

It is hard to get away from the importance of good social work recording.

Good records help…

…you think.

Brain science shows us that recording your daily activities helps you remember what happened, increasing your ability to base practice decisions on accurate information. Writing summaries help you step back and reflect on what you see as important, to analyse the situation, consider the evidence for your analysis and make links between what you are seeing and experiencing and your professional knowledge.

…you communicate with other professionals.

One of the most efficient ways to communicate key facts of a case to others is through the written record. Good records perform a particularly important role in supporting service continuity when other workers need to step in unexpectedly. What you write today also becomes a vital source of information to future workers seeking to understand a family's history, to find out what does and does not work for a client, or to identify the past relationships and strengths on which effective permanency and support plans might be built.

…you show your work.

The tendency for people to turn to the records whenever service quality is questioned has made it important to write down what you have done and tried to do with families. It is probably the best way to counter the position, increasingly taken in inquiries and accountability processes that 'if it is not written down it did not happen' (O'Rourke, 2010). Perhaps most importantly, keeping good records of your actions helps to keep you accountable to the children and families with whom you work.

…you support client understanding and voice.

Reading their written record can help families understand why we are or were involved. The picture painted in the file of a child and their family can play a vital role in helping children who were in care to understand their experiences and construct their identity later in life. Capturing clients' views and wishes in writing both reminds us to take them into account and helps clients to feel heard.

HOW CAN THE GOOD RECORDING GUIDE HELP?

The introduction of computerised technology has increased the importance of good recording by raising expectations about quick access to quality information (Gillingham, 2014). If these expectations are not met, we easily become disillusioned and stop adding information to, and accessing, the shared information system. This reduces the ability of the entire system to support good practice (Peckover, White & Hall, 2008). The problem is that most workers get little training or support to help them record well (O'Rourke, 2010). They tend to learn 'on the job', from reading the files of others.

This Guide gives workers the help with recording that many have requested. It is informed by research into best social work and child welfare practices, and the experiences of similar agencies in other jurisdictions. It is also informed by the knowledge gleaned from focus groups and consultations with MCFD practitioners, supervisors, managers and support staff over the course of ICM redesign. It has been guided by the work of the ICM Practice Committee, who sought to ensure that decisions about the design and use of ICM were evidence-based, supported good practice and made sense in the real world of frontline Ministry work (Oliver, 2014a). The goal of the Guide is to help workers record on ICM in such a way that they quickly find the information they need, are motivated to add the new information that keeps ICM useful for others, and see good recording as an integral part of good practice with children, youth and families.

Data Entry or Reflective Practice?

Research tells us three things about work in today's statutory child serving agencies:

1) That the best practice is reflective practice (Ruch, 2005; Taylor, 2010)
2) That there is little time to reflect (Oliver, 2014b; Thompson, 2007)
3) That workers spend a lot of time in front of their computers (Wilson, 2013)

You have to sit at your computer and write, so how can you do it in a way that helps you reflect on your practice? How can you use the time to think through 'What am I doing with this family? Why am I doing it? How is the work going? How did I influence what happened with the family? What can I learn from this?'

This is what the Good Recording Guide and the headings and prompts in ICM have been designed to help you do. The goal is that good recording becomes about more than simple data entry, but about supporting reasoned and reflective practice.

HOW ARE ICM RECORDS READ BY WORKERS?

Workers appear to read ICM-type records in three key ways (Huuskonen, 2011):

1) To check single facts like a date of birth or address
2) To "skim-read" for the main elements of a client's story
3) To read in detail the record of the client's life and service delivery

The most common method for reading these records is skim-reading. This is why many workers prefer to read Summary Recordings like Opening, Review or Transfer Recordings. These support skim-reading by gathering together the most important features of a case in one easily digestible package.

Chronological Case Notes and Summary Recordings have different purposes. Keeping them separate means you can more quickly find the information you need from ICM.

Less frequently, workers read in detail the kind of information about past events captured in the diary-type record of daily activities often called Case Notes, Running Records, or Black Book Notes. The chronological account of 'I did this, then this, then this happened' can become important reading for workers who are preparing reports, making key decisions or stepping into crisis situations. A worker unexpectedly taking over a colleague's case, for example, may read the Case Notes back from the most recent entry as far as (s)he has time for before meeting with the client.

What's in the Name?

The chronological diary-type record of daily activities is known by various names, including 'Case Notes', 'Black Book Notes', 'Running Records' and 'Case Records'. In this Guide and in your training the term 'Case Notes' is used. The name was chosen because:

1) Staff said this was the most intuitive option.

2) The name is already widely used within MCFD, as well as in the social work literature. This makes it preferable to the name 'Black Book Notes', which appears to be somewhat idiosyncratic to British Columbia and is less familiar to workers transferring from other jurisdictions.

3) The name describes what the record is: Notes about a Case

4) The name avoids the potentially confusing word 'Record', which has other meanings elsewhere in ICM

HOW SHOULD I RECORD?

Think about this from the perspective of the reader.

You want to keep the reader's attention, so the best records are concise and clear. Only include information that you think will be relevant, now or in the future, to understanding the client's situation and service delivery.

You want the reader to see the picture as you see it, so the best records include the important descriptive details. Finding the right balance between being concise and providing detail can be hard. It can help to ask yourself what details you might draw on when explaining the situation to a colleague or supervisor.

You want the reader to understand your perspective as fair and balanced. The best records contain non-judgmental language. Avoid words that trigger emotional reactions or that can be interpreted in multiple ways. Think about using language that does not diminish or stereotype, for instance "child diagnosed with autism" rather than "autistic child" or "child uses a wheelchair" rather than "child is wheelchair-bound".

You want the reader to know whose opinion is being expressed. Use phrases like "I believe that…", "it is my opinion that…" and "my impression is…" to indicate that you are expressing your opinion. If it is somebody else's opinion, make this clear.

You want the reader to know the reasons for your opinion. Immediately back up each of your opinions with the concrete observations or information on which the opinion is based. It should be easy to see the criteria you used in forming your opinion.

Opinion and Evidence

Avoid: "Sandy has mental health issues".

Better: "Sandy's mom says that Sandy has rapid changes in mood, hallucinates and talks to herself. Impression: Sandy may have mental health issues.

Avoid: "Sam is doing well".

Better: "I believe Sam is doing well. His parents say he is happy and Behavioural Consultant report shows progress".

WHAT SHOULD I RECORD?

1. Case Notes

Case Notes contain the day to day details of professional activities and the client`s situation. A good rule of thumb is to only include details that are relevant to understanding the purpose, plan and process of service delivery (Kagle & Kopels, 2008). This type of record contains much less analysis than the Summary Recordings and is the place for simply tracking from day to day what has happened in the life of a case.

Case Notes should contain information about actual and attempted case-related **Interactions** with the client, family, community members and professionals. This includes noting any case consultations with Team Leaders or other decision-makers, in addition to missed appointments, unsuccessful home visits and messages you leave for others. Case Notes should also contain information about relevant **Actions** taken to assess or address client/family needs, like submitting a passport application for a child in care.

Essential Information for Case Notes

For each case-related **Interaction** or **Attempted Interaction**:

- date of the interaction
- type of interaction e.g. meeting, phone call
- parties to the interaction
- significant details e.g. topics discussed
- decisions made

For any other **Action** taken to assess or address client/family needs:

- date of the action
- who the action was taken by
- description of the action

The writer of each Case Notes entry should be clearly identified.

The essential information for Case Notes includes the 'significant details' of your interactions. The level of detail you include in your Case Notes will depend on what is recorded elsewhere. If you have completed a Priority for Service Tool at a meeting with the parents, for instance, the detail to document regarding that meeting might be as simple as "PST completed". The reader can go to the PST itself to find out more, or will later be able to see a summary of the information in your Summary Recording.

Another way to gauge the level of detail needed in Case Notes is to ask yourself what a child or worker in the future might need when they look back over the file. For instance, the concrete details of the issues discussed, of a child's behaviour or of how a family describe their progress might be important to a future worker thinking about what might be an effective plan or to a child in care seeking to understand their past. Is this information already documented? If not it might well need to be included in your Case Notes.

Beyond writing in a clear, balanced way and including the necessary content, details like how you format the date and whether you refer to yourself in the first or third person really come down to your personal writing style. Find what comes most naturally for you, and then try to stick to it: a consistent writing style will make reading these records easier.

> It is hard to write in a legible, comprehensive and comprehensible way while engaged in discussion. Rough notes made during interviews will almost always fall short of being 'file-ready' Case Notes. They tend to be hard to read, in the worker's own shorthand and lacking the essential information identified on page 8. They are of little value if filed in this state. Rough notes have always needed transforming into a 'file-ready' format, no matter whether the end product is handwritten or typed.

2. Summary Recordings

Summary Recordings help you pull together the key features of the story as you see it. They summarize the information that you perceive to be at the heart of understanding the case and your approach to it. This is enormously helpful to the reader, and provides you the chance to step back and reflect on how you are thinking about the case. In addition to providing the core information in an easily digestible format, Summary Recordings ask you to look back on what has happened and reflect on these key questions:

- How is this family/child doing?
- To what extent is service delivery meeting their needs?
- What is needed now?

Summary Recordings enable you to provide your current answer to each question and to consider and present the evidence for your answers. The level of detail you use for the supporting evidence depends on what is written elsewhere. You do not have to duplicate your Case Notes by listing details like the dates of your visits. Only refer to these visits if they are important to your analysis of how the family is doing, how services are meeting their needs and what is needed next.

If you find yourself duplicating information ask yourself whether it is so important to your analysis that it needs repeating, or whether it can simply be summarised, with readers pointed to the details elsewhere. It is a delicate balance to include enough information to adequately summarise the story and support your analysis, but not so much that you are needlessly repeating what has already been recorded. Readers will often be skim-reading and unwilling both to wade through too many details in the Summary Recording and to dig too far for information in assessment and planning tools. If you are referring them elsewhere for more detailed evidence for your analysis, try to make it easy to find.

The Summary Recordings should paint a clear enough picture of how the child and family are doing that a client looking at the record will understand (although not necessarily agree with) why the worker is intervening as (s)he is. They should offer a client looking back over their file snapshots of their functioning over time. These snapshots will help you regularly assess change in relation to baseline details about the client.

Summary Recordings should also allow the reader to hear the client's voice. Stopping regularly to reflect on and document the perspectives of key figures involved in the case will help you take these perspectives into account in your work.

The Different Purposes of Case Notes and Summary Recordings

Imagine applying for a new job, asking your supervisor for a reference and receiving from her a list of supervision dates, topics discussed and decisions made. This would give your future employer little idea of who you are and how you perform. This information is like the **Case Notes**. It is best used as the raw material on which your supervisor can base her description of your qualities as a worker and her analysis of your suitability for the new position. This kind of summary description and analysis lies at the heart of the **Summary Recording**.

WHAT ABOUT ASSESSMENT AND PLANNING TOOLS?

Specialist assessment and planning tools are working documents intended to support your practice. They are of vital importance in enabling you to do good work with clients. The key to using them most effectively is to understand their purpose. Some, like the Care Plan for children in care, are intended to be used directly with clients to generate the goals of the work. They help workers to attend to the many different areas of a child's life in sufficient detail to be able to craft child-specific plans. Often they are also intended to hold each party accountable for their contribution to the plan. Others, like the Priority for Service Tool, guide workers in making informed decisions as to service need.

Some of these tools are uploaded or embedded into ICM. This is because they contain valuable information for others. This information may justify key decisions or help readers looking to check discrete facts or to understand a particular feature of a case, like a client's needs or plan.

The difficulty with these records is that they tend to offer information in a fragmented way, rarely containing the holistic story of the interaction between the family and the Ministry that both readers and writers of the record find most helpful. This is why, despite their importance, they cannot replace Summary Recordings and Case Notes.

WHEN SHOULD I WRITE CASE NOTES AND SUMMARY RECORDINGS?

1. Case Notes

Case Notes are most valuable when written close in time to the events they capture. This increases the likelihood that they will be accurate. The act of writing will help you remember key details of case events and take these into account when deciding about next steps. Some people will be able to document a phone call into the Case Notes as they take it. For others, try to document the action or interaction at the earliest opportunity after it has taken place.

2. Summary Recordings

Summary Recordings are done at regular intervals through the life of the file. Workers complete an Opening Recording when a Case is opened, a Closing Recording at its end and a Transfer Recording whenever the file is transferred.

The frequency of Review Recordings depends on Priority Level. Priority 1 cases typically involve a high level of complexity and require the thoughtful analysis that Review Recordings are intended to promote. These cases need regular Review Recordings. A Recording is needed whenever the priority level of a case changes to Priority 1, as this indicates an increase in the child's vulnerability and the need for Team Leader approval of the Support Plan. The less frequent family contact and support required of Priority 2 and Priority 3 cases is reflected in the requirement for an annual Review Recording only.

Review Recordings are required:

- Every 6 months for Priority Level 1 cases
- Every 12 months for Priority Level 2 and 3 cases
- When the Priority Level is raised to Level 1
- When directed by Team Leader

This means that a case that is assessed at a Priority Level 2 in February 2014 will need a Review Recording 12 months later in February 2015. If it is reassessed as a Priority Level 1 in March 2014 it needs a new Review Recording then, with the Support Plan signed off by the Team Leader. The next Review Recording after this will be in September 2014.

Question: Does reprioritisation of a case from Priority 3 to 2 or down a Priority Level trigger a new Review Recording?

Answer: No. Simply document in your Case Notes the consultation that led to this decision. Note the reasons for the decision and outline the new Support Plan. Your next Review Recording is not due until 12 months after your last.

WHERE SHOULD I WRITE CASE NOTES AND SUMMARY RECORDINGS?

1. Case Notes

Your Case Notes can be documented in one of two places. Choose the place that fits best for you and stick to it. This makes Case Notes easier to understand and means you and others do not have to spend precious time later piecing together the chronology of your file.

The first location is in **ICM**:

For many people the most efficient way to write a legible, meaningful and accurate chronological account of case activities is to write the Case Notes directly into ICM. If you are working in Memo the place to do this is the **Additional Information** box. If you are working in Case use a **Case Note**.

The alternative location is the **Handwritten Case Notes Template**:

It is recognised that some workers prefer to reproduce their rough notes into handwritten Case Notes rather than type them into ICM. This is not possible during the Memo and Service Request stages. These stages often see more than one worker making case decisions, and a higher degree of uncertainty and activity than in later stages when working relationships and plans are more stable. This is the time when it is most important to keep the record together in an easily understood and quickly shareable chronology. Workers are already writing Case Notes directly into ICM at these stages, and there is little reason for this to change.

When you are working in Case, however, you may choose to continue your current practice of documenting the Case Notes in a legible handwritten document if this helps you to write this record quickly and accurately. If you choose to handwrite your Case Notes as an alternative to keeping them on the ICM Case Notes tab, do this on the **Case Notes Template** in your Black Book or binder. The template prompts you to include all the necessary information, ensuring a more consistently professional standard for these records. Legible notes on other pieces of paper containing all the information needed for an entry in the Case Notes can simply be stapled into the template at the right date. Remember to start a new template on a regular basis so your Case Notes can be made accessible to others on the physical file.

Do You Handwrite Your Case Notes?

Remember to keep copies of the template in your Black Book, bag or car so you can write up what happened as soon as possible after a home visit or off-site meeting.

"Pertinent Updates": For Case Note Handwriters Only

In addition to keeping your handwritten Case Notes, it is important to record in an ICM Case Note brief details about any situation in which immediate action is required by a social worker. Title the Note "Pertinent Update" so readers know you keep your regular Case Notes in their handwritten format.

Examples of when these "Pertinent Updates" are appropriate include:

- A single parent is required to go immediately into hospital
- A significant change occurs in the family dynamic e.g. death of a family member
- The child is excluded from school and immediate support is required
- Parents separate or divorce

If you choose to keep your regular Case Notes in the ICM Case Notes tab these additional updates are unnecessary as this important information is already accessible to others.

Question: "I type my Case Notes into a Word document. Can I continue to do this?"

Answer: Yes, if you 'copy and paste' from the Word document into the correct chronological place in ICM's Case Notes tab. The proper location to store the typed running chronology is this Case Notes tab, rather than in the Attachments tab or in personal/shared computer drives outside of ICM. This is because:

1) Copying and pasting into Case Notes helps simplify the search for information. Workers will know this record of case-related activities is stored in one of only two places: either in ICM's Case Notes or, if handwritten, on the physical file. It can be very hard for workers to locate information within multiple attachments or drives.

2) It is relatively easy for workers to copy and paste information from typed Word documents into the more accessible location of Case Notes. Scanning and attaching creates more work.

ICM Case Notes have been modified to more closely replicate Word Documents. If you are at your desk typing into Word, why not type directly into the Case Notes tab instead?

Question: Why are ICM Case Notes organised by the month?

Answer: To strike a balance, that would work across program areas, between making the information easy to read and easy to find.

It is easier to read and interpret the information if it is organised into bigger 'chunks' than single activities. This is why it was decided that ICM Case Notes would no longer lock. After any case activity in the month, you can now return to that month's Case Note to update it with an entry.

However, it becomes hard to find information when a Case Note gets too long. This is why it was decided to break the Notes into monthly increments.

WARNING!!

Organising your Case Notes into months does **NOT** mean you have to do a Case Note every month.

If you have not done any work on the case during that month, do not do a Case Note for that month.

If you have a busy January on a case, with ten separate case interactions/actions between the 1st and 31st, record all of those activities in one Case Note labelled 'January 2015'. If you then hear and do nothing related to that family until you receive a phone call in December, your next Case Note will start with this phone call and be labelled 'December 2015'

2. Summary Recordings

Summary Recordings are written in the **Opening, Review, Transfer** and **Closing Summaries** on the **Case Documentation** tab.

The templates for these Summary Recordings contain prompts and headings to help you identify the important information to include. These prompts and headings were developed by Ministry workers with extensive experience of frontline CYSN practice.

WHAT DOES THIS ALL MEAN ON ICM?

Memo

Document the key facts of the call in the **Call Information** box. This might look something like this:

Call Information

Betty Salta called about son Mark (4yrs) - diagnosed with Autism this January. Said she and husband Jack are feeling overwhelmed by his behaviour and the steps in the autism funding/intervention process. Mark's behaviour includes head banging, hitting and head swinging. Said both she and Jack have anxiety and depression and they are good at knowing when they need help. They want as many support services as are available for Mark.

Betty says Mark is a very sociable boy – has lots of friends at his daycare, loves the company of others. He loves playing physical games like baseball, running – very active and good gross motor skills. Betty wants information on the "Active Kids" workshops.

Betty has not yet received the full assessment report but wants SW to see this when it arrives. Discussed process. She will submit all required documents this week.

The **Additional Details** box is for Case Notes about any case-related activities that happen while the intake is in progress, before you open a Case. The **Additional Details** box for the Salta family might look like this:

Additional Information

Feb 3rd 2011 – Phone call to duty child protection worker Yokshan Shui (604 325 1127) to follow up PCC. File closed, no current concerns. See PCC Summary (Ron George)

Feb 12th 2011 – Received BCAAN, Application for Autism Funding, BC Health Card and Birth Certificate (RG)

Feb 12th 2011 – Consulted with TL Slater re above documentation. TL confirmed information complete and Mark eligible for CYSN services (RG)

Tip: How to Sign Your ICM Entries

Each **Additional Information** textbox and **Case Note** might well contain more than one entry, and these might well be written by more than one person. ICM does not automatically capture and display the identity of each of these writers.

The reader, however, needs to be able to identify both who has performed the action or interaction described in the entry *and* who has written the entry. This will most often, but not always, be the same person.

For many years social workers have identified themselves as the writers of handwritten records by signing or initialling their entries. To 'sign' entries in ICM, simply put your name or initials in brackets at the end of the entry. Use your initials when it is easy to tell (either from the entry you have written or from the entry before it) to whom the initials refer. If you are not the person who wrote the last entry, make sure you identify yourself by your whole name either within the entry or in the brackets. If you have a different role with the family, like a Social Worker Assistant, Administrative Assistant or Team Leader, this should also be made clear.

For example:

2014Jul08 SW Jane White phone call to home – left message (JW)

2014Jul15 Home visit – No answer (JW)

2014Jul24 Phone call from Mom – rescheduled visit for July 30th 1pm (TL Alice Moran)

2014July30 – Home visit by TL Alice Moran. Mom only at home. PST completed (Jane White)

Case: Notes

Remember these are for the diary-type record of activity on a case. Don't forget to start a new Note for a new month's activity. Always include:

1. Your actual and attempted interactions with client, family, collaterals, other involved professionals and community members.
2. Your actions to address the identified needs of the client or family.
3. Your consultations with the Team Leader and any other decision-makers.

Below is an example of what SW George's Case Notes might look like on ICM. If he chose instead to do handwritten Case Notes, he would write the content below into the paper Case Notes Template and would use ICM Case Notes for "Pertinent Updates" only.

February 12th 2011 – Phone call to home – Left message to call (Ron George)

Feb 14th – Phone call from Betty. Agreed office meeting Feb 17th 2pm (RG)

Feb 17th - Office meeting with Betty and Jack. Completed Orientation for Autism Funding. Reviewed MCFD CYSN website/applicable forms. Betty and Jack talked about their shock at Mark's autism diagnosis and their own history of anxiety and depression - both diagnosed in early adulthood and manage without medication. Encouraged them to take one step at a time. They requested respite. Agreed they will get the autism interventions underway and SW will do home visit within five weeks to review CYSN Family Support program services and complete Priority Ranking Tool (RG)

Feb 28th – Phone call from Betty taken by SW Kiran Desai. Asked SW George to call (KD)

Feb 28th – Consult with TL Slater. Agreed...

To be continued….

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Case: Summary Recordings

These are the analytical summaries enabling you to stop at key points in the case, summarise it in a way that is easy for others to quickly grasp, and examine the basis for the plan you have made. The headings and prompts have been designed to help you capture the core components of the case and analyse the following key questions:

- How is this family/child doing?
- To what extent is service delivery meeting their needs?
- What is needed now?

Your answers to these questions, and the evidence for those answers, will change through the life of a case as you move from Opening, Review, Transfer and Closing recordings. In all Summary Recordings you will be prompted to describe the current views and goals of service users. These should also change throughout the case.

Some things, like the reason for opening the case and key information about the family's circumstances, will not change. Use the COPY button to import these from the previous recording, or copy and paste the information that is still relevant. You can then simply edit or add new information as you need. This means that as you proceed through the life of the case you will build on what you have previously written, with your picture of the family becoming more complete. Keep in mind, however, that the goal is to give readers a quick overview of the core components of the case and your work with it, so only carry over the information that helps achieve this.

On the following pages are examples of how you might complete these Summary Recordings for Mark:

Opening Recording

Reason for Referral

Include a brief summary of the child's diagnosis, disability related needs, age and profile (e.g. interests, preferences, communication style). Include the originating record number from which this case was opened/reopened.

File opened at parents' request for support following 4 year old Mark's diagnosis of autism. Mark's behaviour includes head banging, hitting and head swinging. Mark enjoys physical activities and engaging with peers and has good gross motor skills.

Case opened from Memo 1-146578. Service Request sent to Autism Funding Branch February 12th 2011.

Family Circumstances

Document information regarding the family structure and dynamics, aboriginal status and band involvement, legal status of child, where the child lives, family/parental stress and/or health, other children in the family with disabilities

This is a two parent family of British and German heritage. Father works full time, mother works Mondays - Thursdays. Mark resides full time with his parents and has no siblings.

Both parents report long-term problems with anxiety and depression which they manage without medication. They report currently feeling overwhelmed by managing Mark's behaviour. They have had previous child welfare involvement for these issues. In 2007 it was reported that Betty was suffering from post-partum depression and might harm Mark. Assessment concluded that Mark was not at risk of harm but that both Betty and Jack suffered from anxiety and depression and this and marital difficulties were impeding their parenting. Protection file open for 6 months to monitor/support. In 2010 Jack called the Protection office requesting assistance with childcare as Betty's depression was bad. Jack found childcare and file closed.

Support/Service Plan

Summarize the family's and child's goals, strengths and support needs, services requested/received, views of child and key family/community members, outcome of assessments/tools completed with family. Taking these into account, describe initial plan.

Betty and Jack want support in managing Mark's behaviour and relieving their own stress. They identify their highest priority as addressing Mark's social issues. They both appear insightful into Mark's needs – can describe them clearly and proactive about getting help. SW assessment is that support is needed due to parents' current feelings of being overwhelmed and history of anxiety and depression. Mark's strengths are that he is very socially motivated and physically able, and loves attending his pre-school.

The initial plan is for:

1) Mark to continue to receive Supported Childcare support at pre-school
2) Betty and Jack to work with Behavioural Consultant Johan Steib to develop a Behavioural Intervention Plan focussing on supporting Mark's prosocial behaviour and learning behaviours such as sustained attention.

Plan for Review

Document the plan for future contact with the family, consultations with Team Leaders, and next case review date. Include review dates for any active support services/respite funding agreements.

Home visit planned for March 11, 2011 to complete PRT and review CYSN Family Support services.

Review Recording

Summary of Involvement

Briefly summarize reason for opening. Provide a brief summary of significant events and key planning with the family as well as contact with involved service providers and other professionals.

File opened for supports following 4 year old Mark's diagnosis of autism in 2011. Both parents indicated long-term problems with anxiety and depression and feeling overwhelmed managing some of Mark's challenging behaviours and needs. Mark is now 5.

Autism funding orientation has been completed. The family received their Behavioural Plan of Intervention (BPI) from the Behavioural Consultant. It is focused on communication (social reciprocity) and prosocial play involving opportunities for peer interaction. Recommendations also made regarding emotional regulation – helping Mark to recognize when he is frustrated and providing non-aggressive ways of responding. Regarding cognitive skills, plan is to work on basic numerical and alpha fluency. Recommendations have been made about how the parents can support these areas. Copy of BPI on file.

Current Family Circumstances

Summarize key family information from previous recording. Update with a brief description of any changes to the family/child circumstances.

This is a two parent family of British and German heritage. Father working full time, mother works Mondays - Thursdays. Mark resides full time with his parents and has no siblings.

Both parents report long-term problems with anxiety and depression which they manage without medication. This contributed to child welfare involvement in 2007 and 2010. No current involvement. Jack and Betty report that Betty's parents occasionally provide 'date night' breaks, although they are not able to manage Jack's behaviour overnight. Betty has said the couple are having marital problems, for which they are currently in counselling.

Support/Service Plan

Summarize family's and child's current goals, strengths and support needs, services requested/received, views of child and key family/community members, outcome of assessments/tools completed with family. Taking these into account, describe the plan (incl. transition plan).

Mark's primary support issues are communication, social skills and delayed learning. He does not have an intellectual disability. He enjoys engaging with peers and has good gross motor skills.

Parents say Behavioural Consultant Johan Steib is pleased with Mark's progress on goals re: emotional self-regulation and pro-social behaviour e.g. he is not hitting the other children as often in daycare. Betty and Jack also feel Mark is moving forward – his incidents of head-banging have decreased to a couple of times a week.

Mark started fulltime daycare in September at Tater Tots (group daycare setting for children with autism – has Supported Child Development funding). He also attends a community play group on the weekend with a Behavioural Interventionist who is working on social reciprocation and turn taking. Mark is very physically active and says he wants more Tater Tots time because he loves the games.

Betty and Jack report they are coping better although some days are easier than others. They are trying to follow up with BPI recommendations and their goal is to consistently manage Mark's behaviour without becoming overwhelmed. They are accessing counselling through Jack's EAP. They have asked for respite to help them manage their stress. Jack and Betty are a resourceful couple who are open to services and good at identifying their needs.

The family's Priority Ranking score is 62. Based on the parents' stress level, mental health and current supports, the family has been rated Priority 2. SW assessment is that the combination of parental mental health difficulties and Mark's challenging behaviour means the family continue to need help.

Plan: Continue with current services and begin respite when available.

Plan for Review

Document the plan for future contact with the family, consultations with Team Leaders, and next case review date. Include review dates for any active support services/respite funding agreements.

SW to contact family once respite support is available, or after 6 months at the latest. Family have been encouraged to call with any questions or concerns.

Next case review: March 2013.

Transfer Recording

Summary of Involvement

Briefly summarize reason for opening. Provide summary of contact with the child and family (i.e. home visits, significant issues/telephone conversations), agreement renewals and contact with professionals.

File opened for supports following 4 year old Mark's diagnosis of autism in 2011. Both parents indicated long-term problems with anxiety and depression and feeling overwhelmed managing some of Mark's challenging behaviours and needs. Mark is now 6.

Since file opened SW George has had 1 office meeting and 2 home visits with the parents and attended Sinley Kindergarten entrance meeting with parents and Supported Child Care (Sept 2012). The family received Provincial Autism funding from March 2011 until present. Direct funded respite started June 1 2012, renewed September 1 2012 for 6 months.

Current Family Circumstances

Summarize key family information from previous recording. Update with a brief description of any changes to the family/child circumstances.

This is a two parent family of British and German heritage. Father works full time. Mark resides full time with his parents and has no siblings. Both parents report long-term problems with anxiety and depression. This contributed to child welfare involvement in 2007 and 2010. No current involvement. They both say that they have resolved their recent marital difficulties.

The family moved from Courtenay to Nanaimo on September 1, 2012, to be nearer Jack's sisters. Until the move, childcare by maternal grandparents enabled them to take the occasional 'date night'. Mark's behaviour continues to challenge Betty and Jack. Betty has started a part-time job Mon - Fri while Mark is in school.

Support/Service Plan

Summarize family's and child's current goals, strengths and support needs, services requested/received, views of child and key family/community members, outcome of assessments/tools completed with family. Taking these into account, describe plan (incl. transition plan).

Mark's primary support issues remain communication, social skills and delayed learning. He does not have an intellectual disability. He enjoys engaging with peers and has good gross motor skills. He now attends Sinley Kindergarten with the support of a half-day Special Needs Learning Assistant. He says he is happy with his new school and enjoys going to respite and playing soccer for local team. A Behavioural Interventionist attends soccer with Mark and redirects him, provides time outs or removes him from the game when he is not able to manage. The current primary goal of his work is to help Mark use non-aggressive communication when frustrated.

Parents report that Mark's behaviour deteriorated, with increased head banging, head swinging, yelping and spitting, over the period of the move. Mark started taking Risperidone

in October 2012, monitored by community psychiatrist. Parents feel this has reduced these behaviours. They feel that the current plan is working well although they struggle at times. Their main goal remains to meet Mark's needs without feeling overwhelmed. The family has been receiving direct funded respite support and both Betty and Jack report feeling refreshed at the end of a respite weekend. They are requesting continuation of respite.

Jack and Betty are a resourceful couple who are open to services and have been insightful in identifying what support they need. They have lost some of their natural supports in their new community and the combination of Mark's challenging behaviour and their self-described mental health issues mean they continue to need support. The family is Priority 2, with Priority Ranking score of 62, based on the parents' stress and mental health, including the challenges of re-establishing themselves in a new community.

Plan is to continue with current services, including respite. This SW will give family information about sports associations for children with special needs and Betty and Jack to explore sister's availability to babysit for date nights.

Reason for Case Transfer and Considerations

Provide detailed information regarding the reason for transfer and considerations for future services. Include information about active support or respite benefit agreements. Document the receiving office's information.

Family moved from Courtenay to Nanaimo in September 2012, to be closer to Jack's sisters. Jack transferred to an equivalent position within his company. Betty and Jack hope that Mark will build relationships with his aunts and cousins.

Autism Funding is in place. Direct funded respite renewed September 1 2012 until March 1 2013. SW recommends that if Betty and Jack ask for respite to continue beyond that date, this be considered seriously as respite has been crucial to supporting the family.

The file can be transferred to: Ginny Smith (CYSN SW)
#101 - 488 Albert St., Nanaimo V9R 2V7
Tel: 250 741-3600

Closing Recording

Summary of Involvement

Briefly summarize reason for opening. Provide a brief summary of significant events and key planning with the family as well as contact with involved service providers and other professionals.

File opened for supports following 4 year old Mark's diagnosis of autism in 2011. Both parents indicated long-term problems with anxiety and depression and feeling overwhelmed managing some of Mark's challenging behaviours and needs. Mark is now 7.

The family received Provincial Autism funding from March 2011 until present. They received direct funded respite support from June 2012. This contract was cancelled May 2013 when Betty moved to Winnipeg, Manitoba.

Family Circumstances at Case Closure

Summarize key family information from previous recording. Update with a brief description of any changes to the family/child circumstances.

The family is of British and German heritage. Mark resided full time with his parents until February 2013. He has no siblings. Both parents report long-term problems with anxiety and depression, which they manage without medication. This contributed to child welfare involvement in 2007 and 2010.

The family moved to Nanaimo in September 2012. Betty reports that in the last six months Jack's mental health deteriorated and in February 2013 Betty separated from Jack. She and Mark moved to her parents' community of Winnipeg, Manitoba. Betty says she now has full custody.

Support/Service Plan Outcome

Provide a brief summary of the effectiveness of services provided, transition planning and considerations for further services, as required.

Until the move to Winnipeg the plan appeared to be working well: Betty said that respite provided her with a valued break which allowed her to manage Mark's behaviour. Both parents reported that Mark was no longer head-banging and although he continued spit when frustrated, incidents of physical aggression towards his peers had become rare. He was working at grade level. Parents and BI were implementing Behavioural Plan of Intervention developed by Behavioural Consultant Johan Steib on goals of communication (social reciprocity) and prosocial play. Mark taking Risperidone since October 2012 and parents reported this helped him to focus at school.

The move to Winnipeg is a significant transition for Betty and Mark, both of whom find change stressful. While they will receive some help from Betty's parents, they are likely to continue to need formal special needs services in Winnipeg. SW has provided contact information and

Betty has made contact with Winnipeg CYSN. SW has notified Autism Funding Branch to close file.

Reason for Closing

Describe the circumstances under which the case was closed.

Mark is living with Betty in Manitoba with Betty's parents. She has reported this as a permanent move.

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