

{INSERT PLACE NAME} ICM PROTOCOL

Integrated Case Management for People with Complex Needs

1 Purpose

This protocol outlines the agreed approach of participating agencies to the provision of integrated case management assistance to people occupying public spaces in {INSERT Place Name} and who have complex needs and / or who are intoxicated.

2 Target Group

The Target Group for this initiative is:

People occupying public spaces in {INSERT Place Name} and who have complex needs

As part of the broader XXXX initiative, {INSET Agency Name} will endeavour to “register” all persons in this target group. Similarly, the {INSET Agency Name} separately record and track members of the Target Group

However, persons within the target group will only enter ICM if they consent to it and to the sharing of basic information about themselves within the ICM Team.

3 Integrated Case Management (ICM)

Integrated case management is a multi-agency team approach to coordinating services for clients with complex and longer-term needs through a cohesive Service Plan.

ICM places the client at the centre of the service planning and delivery process and commits us to creating holistic, respectful, responsible, and trusting relationships amongst all those who assist in the development and implementation of Service Plans.

We use integrated Case Management to:

- Mobilize resources, services and supports
- Collaborate and share responsibility
- Strengthen individual and family functioning
- Create proactive human service practices

3.1 Principles of Integrated Case Management

The following principles that guide the ICM Team are described more fully in [Appendix A: Statement of ICM Principles](#)

- | | |
|------------------------------|----------------------------|
| ▪ Client centred service | ▪ Participation |
| ▪ Building on strengths | ▪ Accountability |
| ▪ Advocacy/Self-advocacy | ▪ Holistic approach |
| ▪ Recognizing diversity | ▪ Continuity |
| ▪ Collaboration and teamwork | ▪ Well-planned transitions |
| ▪ Mutual respect | |

3.2 Goals of the Integrated Case Management Team

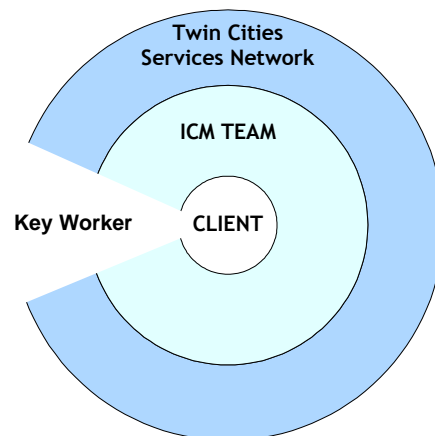
In assisting clients through these ICM arrangements, the ICM Team share the following goals:

- To have clients involved in making decisions that affect their lives
- To provide proactive planning for clients
- To share decision-making responsibilities
- To decrease the dependency of clients on multiple services
- To collectively support each other (i.e. service providers)
- To collectively support the client and show respect for their culture, needs and situation
- To deliver against an action plan with timelines and follow up
- To access and share resources and to help connect clients to the appropriate resources
- To identify who needs to be involved with the client and who doesn't need to be involved and to reduce duplication of services/workers
- To enhance community and individual protection and wellbeing

4 The Key Players

There are four sets of key players involved in Integrated Case Management, any of which can initiate the process:

- **The Client**
- **The ICM Team** - those personnel/agencies developing, executing and monitoring a Service Plan
- **Twin Cities services network** - the broader set of agencies which may deliver services to the client
- **The client's Key Worker** - a member of the ICM Team who: coordinates case management with the cooperation and support of other Team members and the broader service network; who oversees the ICM Team process; and who has overall responsibility for the case.



4.1 Integrated Case Management Team

(ICM) is a team approach used to create and implement a Service Plan with clients.

The ICM Team:

- Is made up of those key agencies involved in the planned and actual provision of services to the client.
- Values each person as an equal member of the Team
- Will have a changing membership as clients and client needs change
e.g. {INSET Agency Name} are likely to have a key role in bringing clients into the ICM system but not have as significant ongoing role once the client has been stabilised

- Works together to identify a Key Worker, and to develop, implement, review and evaluate a Service Plan.
- Will generally agree, monitor and review Service Plans at a regular meeting of the Service Coordination Group.

4.2 The Service Coordination Group

The Service Coordination Group is comprised of those agencies who have a significant role in servicing the target group - through ICM or otherwise.

The Group meet regularly to monitor and identify operational issues in the day-to-day management and interaction of the programs and services in place to assist the target group.

The Group reports to the {INSERT Auspicing Body}, in particular to identify best practices and operational and policy issues arising from their ongoing program monitoring. Group members also individually report to their respective agencies.

The role of the Service Coordination Group is to:

- provide leadership in the development and implementation of public space service coordination issues;
- Promote the development of a coordinated service response to people occupying public spaces in {INSERT Place Name} by facilitating the development of collaborative relationships with and between local service providers;
- Monitor trends and changes at a local level and provide advice in regard to people occupying public spaces in {INSERT Place Name} and who have complex needs;

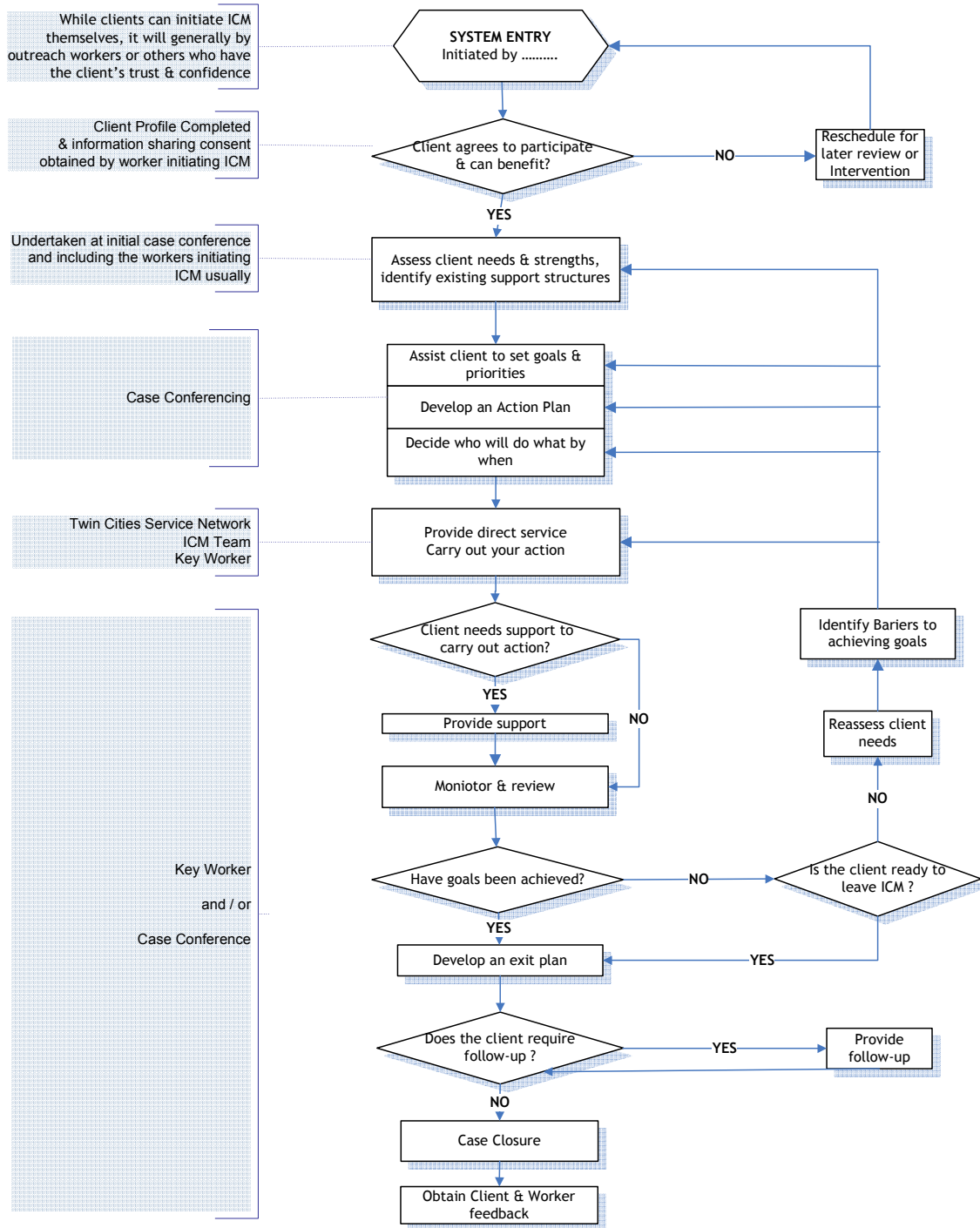
Generally, ICM case discussions are held in conjunction with the Service Coordination Group Meetings.

However, ICM case discussions held in this way will only involve those agencies that need to be involved and who are included in the client's consent for information sharing.

The Group aims to keep its own operations simple and streamlined:

- Administrative support for Service Coordination Group Meetings is provided by the {INSET Agency Name}.
- Administrative support for case conferencing is initially provided by the agency bringing the case to the group and subsequently by the Key Worker unless decided otherwise by the ICM Team.

5 The ICM Process



5.1 Initiating ICM

ICM is most appropriately used when multiple service providers are involved with the same client whose needs are complex and potentially long-term.

No particular service sector or profession is responsible for initiating Integrated Case Management.

The initiating worker / service provider will seek the client's initial consent and agenda the case for discussion at the next most appropriate Service Coordination Group Meeting.

See: [ICM Client Profile Form](#) and [ICM Information Sharing Consent Form](#)

ICM can be initiated when it is appropriate and when any of the conditions below are present:

- There is more than one service or worker involved
- The client requests Integrated Case Management
- A consistent approach in working with the client is required
- There are gaps in services and/or information and a need to share vital information exists
- The client does not fit any one service or mandate
- There is a need to ascertain collective goals and priorities for services so that there are not many different plans being made for the client
- There are legislative requirements, service needs and mandates that conflict
- There are multiple issues and the clients circumstance is complex

The more of these conditions that exist (i.e. the more complex the clients needs), the more crucial it is to use an Integrated Case Management approach.

5.2 ICM Case Conferencing

Case conferencing is used to make, monitor, and review a plan *with* the client and other service providers, not *for* the client.

Case conferences will be initiated when:

- There is a need to create a Service Plan to which all people can agree
- There is a need to review what people have been doing to support and maintain client services
- There is a change in circumstances for the client or service providers
- The client requests a conference

Case conferences will only be attended by those agencies with a role or potential role in the case and who are included in the information release signed by the client.

Case Conferences will generally be conducted within the regular Service Coordination Group Meeting cycle.

Case conferences are **not** a substitute for the day-to-day contact, collaboration, and dialogue between agencies / service providers.

5.3 The First ICM Case Conference

Preparation for an initial ICM case conference for a client will include:

- Completing an ICM Client Profile Form ([ICM Client Profile Form](#)).
- Deciding who needs to be involved - e.g. which service providers, any family members, and support person / advocate chosen by client.
- Deciding on the level of client involvement - it can be limited initially and increase, as the clients feel ready to take on more responsibility.

If conferencing occurs without the client, part of the discussion needs to focus on how the client will be involved in decision-making and future conferences.

- Working with the client to:
 - explain why the case conference is being held
 - explain what a case conference process consists of
 - explain what their role will be
 - Gain their consent for information sharing ([ICM Information Sharing Consent Form](#)).
- Informing service providers. Make sure those invited understand the purpose of the meeting, what they need to bring and that they are prepared to discuss their piece.
- Deciding on what really needs to be accomplished at a first meeting - don't try to resolve all the issues at once. Start the process by identifying critical needs, and deal with least contentious issues first.

5.4 Developing an Integrated Case Service Plan

Once the Team has gathered sufficient information regarding the client's current situation, members can work together to build a Service Plan and to agree who the Client's Key Worker will be.

See: [ICM Client Service Plan Template](#)

Initially, this step requires the Team to identify and set priorities among the areas where action is required to improve the Client's well-being. These could include:

| Issue Area | Indicative issues |
|--------------------------------------|---|
| Immediate and critical issues | Crisis accommodation, physical health need |
| Safety | Alcohol and drug use, violence, sexual abuse. |
| Health | Speech, hearing, vision, hygiene, illness, ongoing medical conditions or disabilities, sleeping patterns, nutrition, substance misuse, etc. |
| Self Care Skills | Making a home, using public utilities (e.g. phone, buses), managing time and money, dealing with public services, getting medical help. |
| Social Presentation | Hygiene, clothes, communication skills, job skills, etc. |
| Crisis Management | What are triggers for crisis? What does the crisis look like? |

| Issue Area | Indicative issues |
|---------------------------------------|---|
| Emotional And Behavioural Development | Range of emotions and how they are managed, behaviours that express emotions, criminal involvement (victim or perpetrator), involvement with mental health professionals. |
| Family and Social Relationships | Place to live, friends, caregiver(s), relationships to family. |
| Income, Employment & Education | In-appropriate benefit, special needs, recent change in status. |
| Identity | Birth language, culture, religion, sense of self, spirituality, sexuality. |
| Recreation/Leisure | Hobbies |

In most complex cases, trying to do all at once would be unrealistic and discouraging. It is essential at this stage of the process to plan for success.

Successful selection of action plan priorities will require:

- choosing areas that will support the immediate health and safety of the person.
- encouraging the clients to identify their priorities,
- considering choosing priorities that are less complex rather than more complex,
- choosing areas where there is likely to be general agreement about the desired outcomes or goals,
- choosing areas where an immediate impact is likely to be felt (early win)

The next step is to describe desired outcomes or goals for each of the selected priority areas of focus. The outcomes should describe a desirable and observable future condition relating to the client’s health or well-being.

Once the Team has established measurable outcomes, they identify specific strategies or activities for each of the priorities, the people who will be responsible, and the timelines involved.

It is important that the Service Plan incorporate any individual case planning that has already happened between the client and service providers.

In the simplest case, Team members will already have individually worked with clients to develop outcomes and services. The Service Plan and ICM Team’s activities will simply ensure that all members are aware of the one another’s planning and provide opportunities to improve the co-ordination of services.

Service Plans will be most effective if they are developed following the ICM Principles, and when outcomes and associated activities are:

- concrete and observable,
- clearly related to the strengths and concerns already identified, and
- focused on the best interests of the client.

5.5 Reviewing the Plan & Staying Connected

In developing the Service Plan, the ICM Team will set a date to review the plan and agree on how often meetings / case conferences may be required.

How often the Team should meet will depend on:

- **Stage of planning** - In the early phases of implementing a plan, more frequent meetings can help ensure the plan is working. In later stages, fewer meetings may be required.
- **Changes in the wishes or life circumstances of the client** - Stressful circumstances in the lives of clients may render them more vulnerable.
- **Milestones** - Progress against Service Plan Milestones.
- **Changes in the Team** - New Team members may need more frequent meetings to become familiar with the needs of the client, as well as with the planning process.

Regular review meetings:

- help prevent and/or address crises in the life of the client.
- help keep all Team members informed,
- provide opportunities to measure progress,
- review issues of confidentiality,
- allow Team members to change the plan when it is not working,
- allow Team members to change the plan to respond to new circumstances.

5.6 Conflict Resolution:

In any group of individuals from different backgrounds, it is inevitable that conflicting opinions will arise.

This is a natural and important part of the group process -- encouraging creativity in producing solutions and decisions.

Unproductive conflict can often be avoided by:

- Adequate preparation before the meeting,
- referring back to the principles of ICM,
- re-framing the contentious issue in a positive way, and/or
- firmly but respectfully suggesting deferral of discussion on the particular issue to another time and place, in order for the group to move forward.

The services of an outside mediator might be required where conflicts remain unresolved.

6 ICM Toolkit

ICM Client Profile Form

Surname: First name: AKA:

Date of Birth: ____ / ____ / ____ or approx. age ____

Gender: Male Female Transgender (tick appropriate)

Contact Number: Yes No If yes list number:

Identification: Yes No If yes record details

Cultural:

ATSI NESB OTHER

Is Interpreter Required: Yes No If yes what language:

Physical Descriptors:

First Engagement with client:

Place of 1st Contact: Time & Date of 1st Contact:.....

Presenting Reason: PUBLIC DRINKING BEGGING OTHER

Where stayed last night:

Last Permanent Address:

Current Period of Homelessness (if applicable):

IMPORTANT

Has client been turned away from service: Yes No if yes

Where was request made?:

Did client refuse service: Yes No

Reason for refusal:

IMPORTANT - HISTORY OF VIOLENCE/AGGRESSION

Has client a history of violence or being aggressive in any way: Yes No

If yes give details:

Has client exhibited any violent or aggressive behaviour towards staff: Yes No

If yes give brief details:

Health

Physical Illness: Yes No

Doctor: (name) Ph. No:

Details & follow up needed:

Mental Illness: Yes No

Psychiatrist: (name) Ph. No:

Mental Health Case Manager: Ph. No:

Medications/Treatments: Yes No If yes list:

Financial

Income Source:

NEWSTART DSP PENSION OTHER CRN No.

Guardianship: Yes No

If yes Case Manager is:..... Ph. No:

Legal Issues Yes No (if yes answer questions below)

Probation & Parole: Yes No

If yes Officer is: Ph. No:

Legal representation: Yes No

If yes Name: Ph. No:

If no, is representation required: Yes No

Previous Incarceration: Yes No

if yes Location: Approximately When:

Housing

Previous DOH: Yes No If yes T Number: _____

DOH Application lodged: Yes No If yes when: _____ Where: _____

Other Services Used by client:-

Hostels day centres food vans material aid Diversionary Centre

ATODS other

Referred by:

Other agency self current or previous client of service

Engaged on street member of public other

ICM Information Sharing Consent Form

Consent for Sharing Information in the ICM Planning Process

A client benefits most when those providing care are coordinated and consistently supportive of that client and of each other.

Exchanging information is necessary so that the ICM can identify and respond to the needs of a client.

However, all ICM Team participants are asked to share only the information required for this purpose.

I, _____

give my consent for the following persons to share information regarding myself as part of the ICM planning process. Only relevant information is to be shared.

Name/Relationship/Organisation

I understand that I may add or remove any names from this list at any time, or specify any limitation to this consent.

Date: _____

****Client Signature:** _____

Witness: _____

****Consent is valid for one year from date of signing.**

ICM Client Service Plan Template

| Priority | Outcome Goal | Action | Who | Date to Do By | Tick When Done | Progress/Review Notes (relates to Action) |
|----------|--------------|--------|-----|---------------|----------------|---|
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ICM Case Review Report Template

First Name: _____ Family Name: _____
Case Worker: _____ Agency Worker: _____
For the period from _____ to _____
Strengths: _____

Original Goals/ Desired Outcomes: _____

Progress Towards Meeting Goals: _____

Current Needs: _____

New goals/desired outcomes: _____

Strategies: _____

Comments? _____

Date of Next Review: _____ Or File Closing Date _____

Signed

Signed

Signed

Contact History:

Date: _____ Participants: _____ Nature of Contact: _____

Notes: _____

ICM Case Closure Form

Client Name:

Forward address:

Number and street:

Suburb:..... Postcode:

Phone:

1. What achievements have you made?

.....
.....
.....

2. What goals are you still working on?

.....
.....
.....

Follow-up support required:

.....
.....

Appendix A: Statement of ICM Principles

The following principles are essential for the success of Integrated Case Management Team:

Client-centred Service

Our agencies are committed to putting clients at the centre of all Service Planning and practice. That means supporting clients to identify and achieve their own goals, and direct their own lives to the greatest extent possible. This approach challenges all Integrated Case Management Team members to adapt services to fit client needs, rather than to expect clients to adapt to administrative or service structures.

Building on Strengths

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

Advocacy

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

Recognizing Diversity

Our clients have diverse needs, backgrounds, and abilities. The Integrated Case Management Team needs to respect and responds to the social, cultural and economic factors that shape clients' perceptions, experiences and need for service.

Collaboration

Integrated Case Management Team brings together the varied disciplines, talents, perspectives, knowledge and experience of a broad range of people and encourages them to share their individual skills, knowledge and expertise with each other. This process not only supports the best possible outcomes for clients, but it also offers opportunities for increased growth and understanding for all Team members.

Mutual Respect

It is essential that Team members show their respect for clients. Likewise, they must show respect for one another's knowledge, skills, experience and perspective, regardless of age, level of training, position, job classification, particular discipline, or the ministry or agency represented.

Participation

Team members need to participate fully in the activities of the Team. At the outset, full participation may involve a significant investment of time as Team members become familiar with one another and the process. As time goes on, however, they will find that this initial investment is likely both to save time for all Team members and to improve outcomes for clients.

Accountability

Our agencies are committed to creating a system that is accountable to the people who use it. Clients must be informed to the greatest extent possible for all activities that might affect them, and Integrated Case Management Team activities must be recorded. The review of this documentation will allow us to enhance our practice and to better understand what approaches work best with which clients.

A Holistic Approach

Integrated Case Management Team should provide for a complete understanding of the various aspects of a client's circumstances and needs, including family considerations, and the development of a Service Plan broad enough to meet those needs.

Continuity

Clients need continuity in the services they receive - not only in how the services relate to each other, but also in how the services develop over time. To ensure continuity during a client's involvement, at least one member of the Integrated Case Management Team should be constant from the beginning to the end of the process.

Planning for Transitions

Integrated Case Management Teams should take special care to anticipate and plan for transitions in the lives of clients - for example, changes in family structure.

APPENDIX B. KEY DEFINITIONS

Activity

The type of services or interventions used to achieve the goals. For example, training, education, counselling, mentoring, assessment.

Case management

The process of developing a plan to improve outcomes for clients.

Goal

Statements about what you hope to achieve during Integrated Case Management

Indicators

Observable and measurable data or information that would indicate progress toward achieving desired results. Used to track the success of Integrated Case Management outcomes. Some examples of indicators of outcomes might be improvement in child's school grades,

Integrated case management - (team case management, team work approach, care planning, case coordination, Service Planning)

The application of a team approach to case management. Integrated case management is used when the client has complex and longer-term needs requiring clients and service providers to develop a single integrated Service Plan.

This calls for joint decision-making, development, implementation and monitoring of the plan and clarification of the roles of all Team members. If multiple service providers are involved with a single client, a process of integrated case management should begin.

Integrated case management Team (care team, case team, core team, multi-disciplinary team)

The group of people.

Integrated Service Plan (integrated care plan, integrated Service Plan, integrated case management plan)

A Service Plan that coordinates the supports of all service providers.

Integrated service delivery

The coordination of a range or continuum of services in order to present a seamless service system for clients.

Key Worker (Integrated Case Manager, Case Manager, case coordinator)

The person who coordinates case management with the cooperation and support of other Team members. They oversee the Integrated Case Management Team process and have overall responsibility for the case.

Some criteria for selecting a case manager are:

- the person who the client wants to have as the case manager
- the person who has a relationship with the client
- the person who will likely be involved with the client the longest
- the person who has the statutory mandate

The case manager might be identified after a Service Plan is made at an initial case conference.

Outcome

Desired results for participants from the Integrated Case Management process. Often outcomes are changes in participants' knowledge, attitudes and skills, their behaviour or sense of self and ultimately their condition or status.

Output

The products of a Integrated Case Management Team process. For example, number of counselling sessions attended, assessments completed, number of Integrated Case Management Team meetings, number of participants in the Integrated Case Management Team process.

Service Plan (care plan, Service Plan, service delivery plan)

A series of outcome, activity, and responsibility statements which, taken together, describe the set of approaches chosen to address the strengths and difficulties identified at the information-gathering stage.

Supports (interventions, services, programs, treatment)

Approaches or actions designed to meet stated outcomes and goals in the Service Plan to build on child, youth and family strengths and address areas of difficulty.