



Intensive Case Management Team Model of Care Standards and Guidelines



2014

Suggested Citation

British Columbia Ministry of Health, *Intensive Case Management Team Model of Care Standards and Guidelines*. 2014, British Columbia Ministry of Health: Victoria.

This report is available online from the British Columbia Ministry of Health website.

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Purpose

The purpose of this document is to provide a provincial framework and the requirements for an Intensive Case Management Team (ICMT) model of care for British Columbia based on the current evidence as to the effectiveness and efficiency of ICMT. It was developed through the following process:

1. Develop criteria and a working definition of ICMT to determine the scope of literature included in the review.
2. Review current literature (peer reviewed and grey) and develop an annotated bibliography that includes a range of evidence to inform the development of ICMT and assertive outreach program standards and guidelines.
3. Undertake a series of consultations with experts and key stakeholders to provide input into the overall direction and development of ICMT program standards and guidelines.
4. In collaboration with the Provincial ICMT Steering Committee, develop and finalize the program standards and guidelines for ICMT in British Columbia.

These standards are intended to guide the development of ICMT for adults over age 19 years. Additional guidelines and standards will need to be developed to meet needs of youth as well as other specific groups in the population who may benefit from such standards.

Qualifying Statement

This document identifies best practices and clinical guidance based on expert consultations and a review of research up to January 2011. It reflects the clinical knowledge and evidence as of that time. Practice should be informed by the most current evidence, so mental health and substance use policy makers, managers, clinicians and physicians are encouraged to consult further with other resources and with links provided in this document for updated information. Details regarding the overview, methodology and findings of the literature review and key informant interviews in the development of these standards and guidelines are located in a separate document titled *Promise, Potential and Evidence: Review of the Literature and Perspectives on Intensive Case Management Teams*.

Acknowledgements

The *Intensive Case Management Team Standards and Guidelines* have been developed through a collaborative, iterative process among a number of stakeholders and informants on behalf of the Provincial Mental Health and Substance Use Planning Council.

The development of this framework was informed through consultations with key experts in the field and peer support groups; including local advocacy groups representing people who use drugs and mental health client groups.

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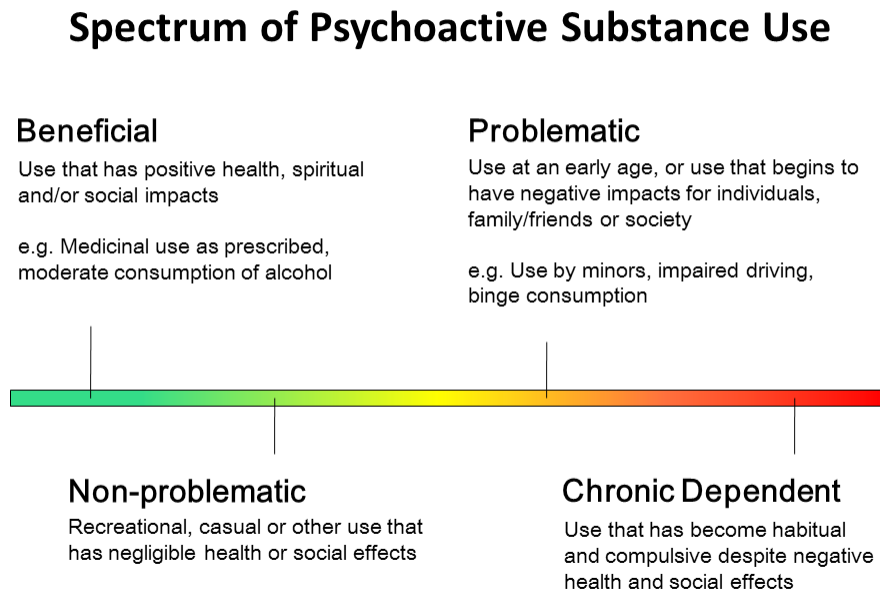
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Introduction

Burden of Substance Use and Mental Illness in British Columbia

Substance use and mental health problems are the third largest contributor to the overall provincial burden of disease (after cancer and cardiovascular disease), particularly for those between ages of 15-34 years and are the leading cause of disability in the province [1].

Substance use is recognized as a normal feature of human existence and ranges from beneficial to non-problematic to problematic use or chronic dependent use (i.e., addictions) as shown in the illustration below [2]:



Increasingly, problematic substance use is understood as a response to a variety of life circumstances including grief, trauma and abuse. The harms of substance use are often exacerbated by poverty, homelessness, and other socio-political factors including stigma and discrimination.

Mental health is essential to daily functioning and overall well-being [3]. Positive mental health is reflected in one's ability to realize one's full potential, cope with daily life stresses, major life events and transitions [4]. Mental health promotion assists individuals and communities to take control over their lives and improve their mental health [1]. This benefits the entire population as well as those at risk of poor mental health or with mental illness. There is a strong association between poor mental health, problematic or chronic dependent substance use, and poverty. The burden of harms of problematic substance use and the impacts of poor mental health are increased among those living in disadvantaged circumstances such as poverty, unemployment, and homelessness [3].



Healthy Minds, Healthy People [2] specifically highlights the need for population level interventions to ensure positive outcomes for the whole population, as well as those at risk of substance use and mental health problems, those with mild to moderate problems, and those with severe and persistent substance use and mental health problems.

A 2008 B.C. report [5] identified addiction as the most prevalent mental health problem among those who are street homeless and those at risk of homelessness followed by concurrent disorders (i.e., both a mental illness and substance use problem) and, less frequently, mental illness alone. Of the estimated 130,000 people in B.C. living with severe addictions and mental illness, approximately, 39,000 are inadequately housed and a subset of these are both inadequately housed or absolutely homeless and inadequately supported to live in the community.

There are a variety of models in B.C. that support the integration of public health, primary care, substance use and mental health services. For those with severe and persistent mental health and substance use problems, an integrated system of care that includes both health services and housing is needed [6]. Assertive community treatment (ACT) and intensive case management teams (ICMT) are two recommended models of wrap-around services for this group. Developing intensive case management team (ICMT) program standards and guidelines is part of B.C.'s overall response to improving care and reducing negative outcomes for people who experience complex and multiple problems associated with problematic substance use, poor mental health, and socio-economic disadvantages such as poverty and homelessness.

ICMT in B.C.'s System of Care

B.C.'s Ministry of Health has identified the integration of primary and community health services as a provincial strategic initiative for a targeted population of individuals with complex and chronic health needs. This has the potential to benefit people with severe substance use and/or mental health conditions by making care more comprehensive and easier to access.

Defining ICMT

The goals of ICMT are to improve health, social functioning, and access to care for ICMT clients. ICMT is a wrap-around service including street outreach and provision of services in the community, where people are located geographically. Clients are engaged via multi-disciplinary teams, integrating the provision of direct services with the coordination and navigation of services and systems to support individuals and families in the community.

Target Population

Integrated case management is a form of case management that meets the needs of clients with problematic or chronic dependent substance use, concurrent disorders and/or mental illness, and this is part of the continuum of community-based case management services.

The target population for ICMT are adults 19 years of age or older with problematic substance use or chronic dependence with or without mental illness, concurrent disorders (substance use and mental illness) or co-existing functional impairment. Individuals will be facing complex challenges related to health, housing (e.g., being homeless or unstably housed), poverty, and face barriers in

accessing existing health or social service. Some may be involved with the criminal justice system and in need of additional services. They require more intensive services than are available in the traditional mental health and substance use system of care.

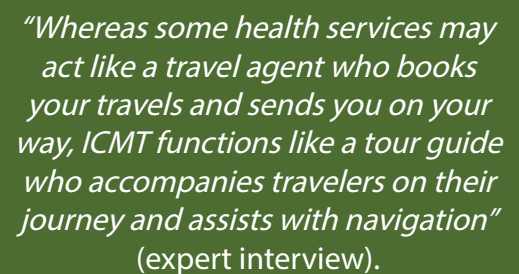
ICMT in Continuum of Services in B.C.

ICMT is part of the continuum of case management services in British Columbia. ICMT is a client-centered and strengths-based approach. A review of the literature and key informant interviews undertaken for this project affirmed that, in many jurisdictions, ICMT has emerged as a form of case management to fill a gap in services. Key informants interviewed for this project indicated that there are individuals whose needs exceed that of standard case management – at the same time they do not meet the criteria for Assertive Community Treatment (ACT). In essence, there are individuals who are served inappropriately – they may have little access to services or may be frequent users of acute services; and others who may be disengaged or disconnected from services. The table in Appendix A highlights where ICMT fits into the continuum of case management services in British Columbia.

ICMT services may be provided to a broad range of individuals who are in need of more intensive services than standard, office-based case management but do not meet the criteria for ACT services¹. Such individuals often fall through gaps in health and social systems. In other cases, individuals may be poorly or inappropriately served by existing services. ICMT clients may be people with unmet health needs and low or inappropriate levels of health system access and ICMT can be a strategy to engage individuals in needed services.

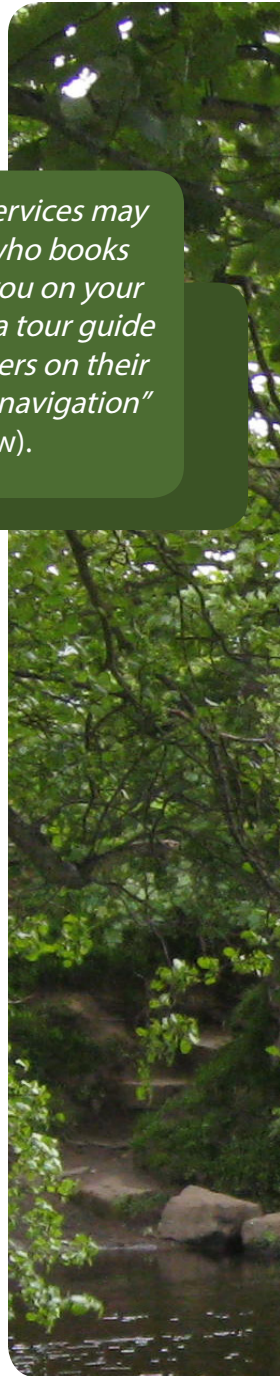
ICMTs consist of a partnership of professional and non-professional team members who share responsibilities for outreach and services provided in the client's community and family environment. Services are tailored to the needs of the client within the available community resources. As such, clients receive the best of all team members' skills and expertise and are never dependent on the availability/resources of one care provider.

ICMTs draw on a strengths-based philosophy and provide care that respects and acknowledges client differences. A strengths-based philosophy promotes a focus on the assets and abilities of clients and their environments rather than deficits. Team members will be knowledgeable in trauma-informed care, harm reduction, strengths-based case management and cultural safety. A respect for differences means that providers recognize and acknowledge differences in socio-economic status, culture, gender, age, and sexual orientation and plan care with an awareness of these differences. This can be achieved by implementation and application of clinical frameworks and skills in cultural competency, cultural safety, harm reduction, trauma informed practice, and by bringing a gender and sexuality perspective to their work.



*“Whereas some health services may act like a travel agent who books your travels and sends you on your way, ICMT functions like a tour guide who accompanies travelers on their journey and assists with navigation”
(expert interview).*

¹ www.health.gov.bc.ca/library/publications/year/2008/BC_Standards_for_ACT_Teams.pdf.



Comparison of ICMT and ACT

Given that ACT Teams have already been established in B.C., it is important to consider how ACT and ICMT are both similar and different. ICMT can further be distinguished from ACT on a number of elements outlined in Table 1.

Table 1: Comparison of ACT and ICMT

Element	ACT	ICMT
Primary diagnosis or concern	Psychosis	Severe substance use dependency with or without: psychosis, severe anxiety or depression, panic disorder, fetal alcohol spectrum disorder/pervasive developmental disorder, mood disorders
Functioning – level of severity	Severe	Moderate to severe
Emergency department/ Inpatient days	Significant (>50 bed days)	Moderate to significant; more emergency department and withdrawal management days. May have unmet needs but limited contacts with the health system.
Age	Adult	Adults – may apply to transition age youth, elderly, families as well as people from a range of ethnic backgrounds
Involvement with correctional services	Varied - expect moderate to substantial for many	Varied – expect moderate to substantial for many
Housing status	Homeless Challenges in accessing housing Supports required Private accommodations with rent subsidy	Homeless Inadequate income to access housing Challenges in accessing housing Supports required Private accommodations with rent subsidy

Element	ACT	ICMT
Hours of service (after hours & holiday/ weekend)	24/7 coverage	Extended hours – evenings & weekends
Team vs. individual case manager	Team case management, integrated, multidisciplinary team	Primary worker, integrated, multidisciplinary team
Psychiatrist –addictions medicine role/access	Psychiatrist 0.8 FTE team member	Access to consulting psychiatrist – may be part- time contract to team. Addictions medicine expertise contracted to team.
Location of service provision	In community	In community
Client-to-staff ratio	7 to 10:1	16 to 20:1
Direct vs. brokerage	Direct	Direct & brokerage
Role/access of primary care	Contracted to team or partnership with clinic Nurse practitioner may be a part of team	Family physician or nurse practitioner contracted to the team Partnership with primary care clinic Access to opioid substitution treatment ² practitioner
Budget	\$1.5-1.8M (12.8 FTE)	\$1M (8 FTE)
Service coordination	Direct	Direct
Crisis assessment & intervention	Direct	Direct
Symptom assessment & management	Direct	Direct
Individual counseling & psychotherapy	Direct Refer for long-term psychotherapy	Direct/refer
Self-management skills	Direct	Direct

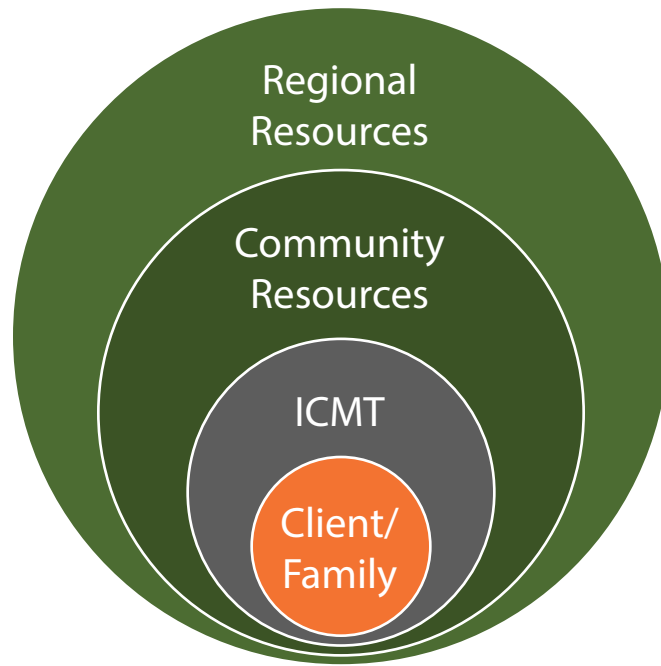
² Opioid substitution treatment includes a broader range of potential medications that may be used for maintenance purposes (e.g., methadone, suboxone, hydromorphone, diacetylmorphine).

Element	ACT	ICMT
Medication <ul style="list-style-type: none"> • dispensing • prescribing • administration • monitoring 	Direct	Direct
Substance use services (including harm reduction services)	Direct/Indirect	Direct
Work-related services	Direct	Direct/indirect
Employment & education	Require significant supports	Requires moderate to significant supports
Psychosocial rehabilitation (activities of daily living/life skills)	Direct	Direct/refer
Education, support, consult with family	Direct	Direct/indirect
Other supports (e.g., housing, income assistance, home supports)	Direct	Direct/liaise
Geography	Urban/Rural	Urban/Rural
Money management support	Direct	Direct

ICMTs provide services directly as well as help individuals navigate other services. Since ICMT is not a stand-alone service, it is important to consider how ICMT services link with and are integrated into existing systems of community health and social services and the not-for-profit sector that currently provide many services to the ICMT target population. The configuration of rural and urban teams will differ, depending on the client population, geographic considerations and availability of resources in the community to augment the ICMT. In particular, community resource availability will inform the development of geographic specific teams so that ICMTs complement and integrate with existing services provided by other agencies in the community.

Given this, ICMT services can be specifically tailored to fill existing gaps in services for target populations. Figure 1 below outlines the nesting of ICMT as a wrap-around service for clients and families within other local and regional services. The ratio/size of the circles can change depending on the community setting (i.e., some teams may have increased provision of direct services if services are not available in the community). This configuration depends on existing resources and available services in the community.

Figure 1: ICMT Services Nested within Community and Part of a Continuum of Services



The client/family is central to the work of the ICMT. Within this context, ‘family’ refers to whomever the client defines/identifies as having the relationship of a family member (including support persons) and is not restricted to immediate/biological or legal definitions of family.

The second circle includes all members of the ICMT whose responsibility it is to provide direct services to ICMT clients. Not all professionals and community resources needed by ICMT clients will be located in this sphere, as teams may access outside resources to support and be involved in the care of clients.

The third circle encompasses community resources that may be accessed outside of the ICMT but are part of a comprehensive community team. These may vary widely and will be dependent on available community resources and needs of the clients (e.g., housing outreach workers, probation officers, primary care providers, and crisis response workers). Links between community resources and ICMTs take various forms (e.g., consulting on a regular basis, part-time team members, dedicated resource on an as-needed basis). This circle also includes professional services and para-professionals and community service providing agencies with which there should be a close affiliation. The availability and scope of community resources is dependent on where the team and client are located including public health, community and acute care services.

The fourth circle includes regional resources that may be available, dependent on the location of the team and the needs of clients. For example, the development of formal relationships with public health, acute and tertiary care services (i.e., access to harm reduction supplies and services and/or detox/treatment services) in any particular community would ensure appropriate and adequate responses for clients, but are developed through a broader community partnership commitment.

The following types of resources could be available or utilized by ICMTs to meet needs of the clients. ICMTs may offer these resources/services directly or through partnerships with other services/providers. Table 2 contains examples of potential ways to fill these types of resources.

Table 2: Examples of Community Linkages and Resources

Resource	Examples of how teams may access the resource
Primary care resources	<ul style="list-style-type: none"> • General practitioner (GP) with an office-based practice • GP doing outreach with and/or consulting for the team • Community primary care clinic located in the community • GP or nurse practitioner contracted to the ICMT.
Psychiatric expertise	<ul style="list-style-type: none"> • Psychiatric expertise may be located within the ICMT or contracted as a community resources (i.e., consulting psychiatrist)
Substance use/addictions expertise (including harm reduction supplies and services)	<ul style="list-style-type: none"> • GP, nurse practitioner or case manager with substance use/addictions expertise located on the team (including physicians with training and authorization to provide opioid substitution therapy) • Addictions medicine specialists located in the community • Public health or other community harm reduction services • Harm reduction supplies and services may be provided by a nurse, social worker or peer
Housing resources	<ul style="list-style-type: none"> • Relationship between ICMT and a community-based housing provider or single resident occupancy manager • Rental subsidies available to the team • BC Housing or other government agency link
Income and food security	<ul style="list-style-type: none"> • Collaboration with Ministry of Social Development income security and disability services • Linkages to local resources for food security (e.g., community kitchens, community gardens) • Nutritional expertise contracted or consulted by team
Justice system	<ul style="list-style-type: none"> • Case manager with experience working in the justice system on the team • Linkages with the local police department • Linkages with local representatives from the justice system (e.g., parole officers, correctional facilities)

Resource	Examples of how teams may access the resource
Peer supports	<ul style="list-style-type: none"> • Peer located on the ICMT • Peer group facilitated by the ICMT • Linkages to community peer groups (e.g., Alcoholics Anonymous, Narcotics Anonymous; drug user/advocacy group for people who use drugs)
Health Home Supports	<ul style="list-style-type: none"> • Medication administration
Family Supports	<ul style="list-style-type: none"> • Case manager with expertise in family supports on the team • Consulting Ministry of Children and Family Development case worker • Linkages to family-oriented community resources (e.g., Al-Anon)
Community integration	<ul style="list-style-type: none"> • Recreation and leisure opportunities provided by team • Linkages to local parks and recreation • Direct referrals to not for profit community agency programs
Basic Living Skills	<ul style="list-style-type: none"> • Links to community resources
Volunteer/Employment	<ul style="list-style-type: none"> • Vocational skills training in the community • Volunteer and employment opportunities with the team or through community agencies

Evidence for ICMT Services

A wide range of relevant qualitative and quantitative evidence was reviewed to determine benefits or potential uses of ICMT for populations including people with severe mental illness; women, youth and others with substance use problems; concurrent disorders; older adults, individuals involved with correctional services, and people experiencing homelessness. Additionally, a number of key informant interviews were conducted.³

Intensive Case Management Teams (ICMTs) have been identified as an effective approach for engaging and supporting people experiencing problematic substance use, mental illness, and social disadvantages such as poverty and homelessness [7-11]. Expertise in problematic substance use and addiction was identified as of particular importance. Some teams were found to have high levels of mental health expertise but lacking in expertise related to substance use and addiction [12]. Evidence related specifically to ICMT services for women with substance use problems [13-17]

³ The literature review is located in a separate document: Promise, Potential and Evidence: Review of the Literature and Perspectives on Intensive Case Management Teams

as well as youth with mental illness [9, 18, 19] is promising, with positive outcomes reported in a small number of studies. In a series of three studies on women with problematic substance use, ICMT services were found to be more effective in assisting women to engage in treatment over time as the relationship with the team developed [14-16]. Introducing ICMTs for adults who have been incarcerated also showed positive results in connecting individuals to services – including primary care, housing and other supports as well as reducing rates of misdemeanors and reoffending [20-22].

Engagement and development of trust is seen as essential to the provision of ICMT services. Several studies highlighted the effectiveness of ICMTs as means of engaging clients with services [7, 12, 23, 24]. Key informants highlighted the fact that ICMTs may specifically be engaging people who have unmet health care needs but are disenfranchised from the system--so re-engagement takes time [12]. Developing trust and feelings of safety are particularly relevant to situations in which clients are experiencing marginalization and discrimination and the need to develop trusting relationships with both individuals providers and the team is an important aspect of providing care [25]. Boundaries and limit setting have been identified as issues that may need specific attention in the process of developing effective relationships between providers and clients [26].

ICMTs have been specifically identified as a relevant approach to working with individuals who are homeless and experiencing substance use problems with or without mental illness [17, 26-28]. ICMTs are viewed as an approach that can increase access to services and supports for this population. In both the literature and key informant interviews, addressing factors that contribute to the harms of substance use, such as lack of adequate housing, was identified as important to the effectiveness of ICMTs [12, 21, 25, 29-31]. Both in the literature and key informant interviews, housing was identified as essential to stabilization and well-being for ICMT clients [12, 21]. ICMT has been found to be effective in maintaining stable housing for adults and youth who are experiencing mental illness and have previously experienced homelessness [18, 31].

Current evidence as to specific adaptation and effectiveness in rural settings is limited. One approach identified in the literature and by key informants is the configuration of ICMTs as complementary to, and coordinated with, existing community resources in both rural and urban settings as part of the continuum of services.

Findings related to the role of ICMTs in reducing hospital admissions and hospital lengths of stay have been mixed. Several of the studies reviewed did not specifically focus on frequent users of services, or the ICMT interventions were too integrated to be able to determine their effect. Other studies lacked rigor. However, one key finding that did emerge is that the way ICMTs are organized and work as a team is more important to reducing hospitalizations for frequent users of services than the size of the team or type of staffing [32, 33]. So, while ICMTs may be effective in reducing use of acute care services, it is important to recognize that ICMTs have been identified as an approach for connecting people who often have unmet needs but may not currently be frequent users of services.

Other outcomes of ICMTs, including access to and the provision of primary care, changes in psychiatric symptoms and psychosocial outcomes (e.g., functional status, caregiver burden, and quality of life) have been the focus of additional research. Although the quantity of research is limited for these outcomes, the results in these areas are promising. Research to date shows that ICMTs can facilitate connections to primary care and have a positive impact on functional status, but no effects were found on reducing caregiver burden or improving quality of life [18, 22, 34-37]. However, these studies were conducted with small samples of youth and those living with developmental disabilities.

Based on our review of the literature, it was determined that this model of care may best serve the population of individuals with substance use/addiction issues with or without a mental illness that have experienced significant challenges related to poverty and homelessness as well as limited access or engagement in with the traditional system of care.

Philosophy of ICMT

In B.C., six primary philosophical perspectives guide the development of the ICMT model of care. These include: 1) health equity; 2) social justice; 3) strengths-based including empowerment; 4) lifespan development; 5) community collaboration; 6) systems integration.

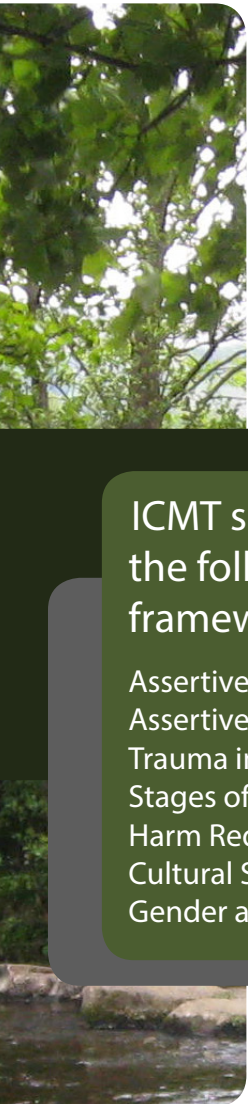
- 1. Health Equity:** The promotion of health equity is concerned with closing the gap in health outcomes between groups in the population. Concern with health equity focuses attention on the structural conditions that create unfair outcomes in health that can be addressed [38]. Incorporation of an equity lens is central to the work of ICMTs and means a focus on the social determinants of health, reducing systemic inequities and enhancing family and individual empowerment [39]. The social determinants of health are variously defined and include housing, income, social status, education and literacy, social support networks, employment/working conditions, gender, culture, healthy childhood development, health services, social inclusion [40], and food security. All of these are essential to good health and wellbeing. Also key are respect for and acknowledgement of differences related to socio-economic status, age, gender, ethnicity and sexual orientation. Addressing issues related to housing, income, and food as well as incorporating clinical approaches to care that address systemic inequities such as cultural safety, harm reduction, sex and gender sensitive care, and trauma informed practice are key strategies for the promotion of health equity by ICMTs [41]. Social inclusion is central to the process of care.
- 2. Social Justice:** Social justice is concerned with the fair distribution of resources including resources such as power and respect [42]. The goal of social justice is to ensure that systems operate fairly and do not further disadvantage those with the least power and resources. In working towards social justice, we strive for a sharing of power in decision-making. People receiving ICMT services are accorded respect and opportunities to participate in decision-making relevant to their interests and not their social status or position. This highlights the importance of including client voices in their plan of care, as well as in the design and delivery of services. Social inclusion in decision making and design of services will increase fairness and equity.



Philosophical Underpinnings

Health Equity
Social Justice
Strengths-based
Lifespan Development
Community Collaboration
System Integration

3. **Strengths-based Approach:** A strengths-based approach focuses on the capacities of individuals rather than deficits [43]. Engagement and the development of relationships are central to taking a strengths-based approach. The focus is on recovery or improvements in health and well-being. Recovery refers to opportunities to enhance quality of life in a means best suited to the individual client and family.⁴ Empowerment is an outcome of a strengths-based approach through enhanced delivery of client-focused services and strengthening capacity of individuals to make choices and live independently.
4. **Lifespan Development:** Young, middle or older age adults may be recipients of ICMT care. A focus on lifespan development recognizes that growth and change are continual and occur over one's lifetime. Knowledge of stages of development is important to understanding people and their behavior. In particular, ICMT care is provided with recognition of the systemic historical, political, social and economic factors that have impacted individuals in unique ways throughout their lives and continue to impact current situations of health and well-being. For example, recognizing how colonization has impacted Aboriginal peoples and how current drug policies have shaped forces such as stigma and discrimination against people who use drugs, particularly illicit drugs.
5. **Community Collaboration:** The success of ICMT services is dependent on collaborative community partnerships to make the best use of resources and expertise. In some cases, ICMT services may be based on what is or is not available in the community and will require referrals and interagency collaboration for the benefit of clients and provision of shared client care.
6. **Systems Integration:** Systems integration is essential when addressing the needs of people with multiple needs and disadvantages. Systems integration refers to the interface of different sectors such as health (primary care, public health, mental health, substance use services), housing, social assistance, corrections, and so on and the ability of sectors and agencies to collaborate in meeting the needs of clients.



ICMT services incorporate the following clinical frameworks:

- Assertive Engagement
- Assertive Outreach
- Trauma informed practice
- Stages of Change
- Harm Reduction
- Cultural Safety
- Gender and Sexuality Considerations

Clinical Frameworks Guiding ICMT

Within the philosophy and principles outlined above, a number of clinical frameworks assist in operationalizing ICMT in British Columbia. These include:

Assertive Engagement: Since potential ICMT clients may often be disengaged from systems and services, there is a specific focus on engagement of clients as a key part of the ICMT service. Engagement is critical to the development of trusting and therapeutic relationships and the successful provision of ICMT services. Trusting and therapeutic relationships provide a safe environment in which individuals can access services without fear of rejection or reprisal.

⁴ Within this context, family refers to whomever the client defines/identifies as having the relationship of a family member and is not restricted to immediate/biological or legal definitions of family.

Engagement embodies values including non-judgmental acceptance and unconditional positive regard. This is critically important as many ICMT clients may have experienced systemic stigma and discrimination related to substance use, poverty, ethnicity, gender, sexual orientation and other factors such as their health status (e.g., mental illness, HIV) throughout their lives. Establishment of trust and relationships is ongoing. Clients are actively engaged and participate in the development of their care.

Assertive Outreach: Outreach means both opportunities to reach potential ICMT clients and an approach to provision of services in the community for new and existing clients. Services are provided to individuals where they are physically: on the street, in shelters, in their homes. Assertive outreach is central to reaching and supporting ICMT clients in the community. Outreach is an important aspect of ICMT services because individuals may be disengaged from current health and social systems and providing care where clients are is a strategy that supports assertive engagement. ICMT will connect with other outreach services in the community as a means of enhancing opportunities for engagement with clients and to strengthen collaboration with other agencies.

Trauma-informed Practice: Trauma informed practice is focused on recognition that people receiving care have experienced some form of trauma in their lives. For example, homelessness is a form of trauma as well as being associated with other sources of trauma and abuse [44]. This recognition can help providers to understand client behaviors and inform approaches to working with clients that are sensitive to histories of past trauma. Trauma informed practice does not focus on treatment for trauma but rather ensures that health and social services are provided in a manner that is sensitive to a history of trauma and provided in a way that does not further traumatize individuals.

Stages of Change: In working with individuals living with substance use issues, a number of stages of change have been identified as useful to understanding where individuals are from pre-contemplative, contemplative, preparation, action and maintenance [45]. It is helpful for providers to both recognize and respect where clients are in relation to the stages of change in planning and implementing care. There is no expectation that clients move through the stages in a linear fashion but rather a recognition and understanding of where clients are in relation to making changing in their lives [46].

Harm Reduction: Harm reduction is a pragmatic approach to reducing the physical and psychological health harms or risks associated with substance use. Harm reduction has been an essential part of a comprehensive approach to addressing problematic substance use—both as a guiding philosophy and set of strategies—in official British Columbia provincial health policy for the last decade [2, 47-49]. Participants are not required to abstain from alcohol or other drugs and staff work consistently with participants to reduce the negative consequences of use according to principles of harm reduction as described by the International Harm Reduction Association [50]⁵. At the same time, harm reduction does not preclude clients from choosing abstinence. Harm reduction services such as needle exchange, supervised injection and others have been shown to reduce harms of drug use (e.g. transmission of blood borne diseases, overdoses), reach highly marginalized clients and connect clients to housing, health care and other social services as well as detoxification and withdrawal management services if and when clients are ready to do so [51-58].

⁵ The International Harm Reduction Association (2010) principles of harm reduction are aligned with public health and human rights commitments. These principles include targeted at risks and harms; evidence based and cost-effective, acknowledgement of incremental changes; dignity and compassion; universality and interdependence of human rights, challenges policies that target risks and harms; transparency, accountability and participation. For a full description see: www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf

Cultural Safety: While cultural competency focuses on learning about history, cultural values, and norms, cultural safety is grounded in critical reflection on history, one's own privilege, and recognizing marginalizing stereotypes and discrimination in health care system policy and practices. Health care providers recognize that there is an imbalance of power between themselves and those they are serving as well as potential differences in life experiences, resources and situations [59, 60]. While this approach originated as a way to improve care for Indigenous populations as a counter to racism, there is growing recognition that cultural safety is relevant in situations of marginalization such as problematic substance use [61] and with people who identify as LGBTQ2S⁶.

Gender and Sexuality Considerations: It is well recognized that considerations related to sex/gender and sexuality are important in the way that services are designed and delivered. As part of an equity lens, the provision of services should be sensitive to considerations related to sexual orientation (e.g., gay, lesbian, bisexual, queer, two-spirit) and sex/gender (e.g., male, female, transgendered). For example, women may not feel safe in accessing services in the same places as men and services may be lacking sensitivity to the specific needs of those who are transgendered. People who identify as lesbian, gay, bisexual, transgender or queer likely have experienced stigma and discrimination and may feel unsafe to access health or social services. They may have received inappropriate services in the past. A gender and sexuality perspective avoids heteronormative and cisgendered⁷ assumptions in the provision of care. A gender and sexuality perspective attends to, acknowledges and respects differences in sexual orientation and gender in the provision of care.

Psychosocial Rehabilitation (PSR): PSR, as developed by the World Health Organization is a model that focuses on social functioning and incorporates two broad areas of intervention: 1) improving individuals' competencies and 2) facilitating environmental changes to improved quality of life [62]. PSR is a strategy that is implemented at the interface between the person, their social network and the wider environment in which they live. It focuses on the individual in context and the social conditions in which they live. In this approach, providers acknowledge and recognize broader environmental determinants of health such as displacement, marginalization/social exclusion, racial discrimination and trauma.

6 LGBTQ2S is an acronym for lesbian, gay, bisexual, transgender, queer or two-spirit. Two-spirit is an English translation of terms in various languages of First Nations and Aboriginal cultures across North America, referring to individuals who embody both the male and female spirit. Two-spirit can include sexual orientation and/or gender identity or expression. Lesbian, gay, bisexual, queer, and heterosexual transgendered people may all refer to themselves as two-spirit (see A Path Forward, p. 48, www.health.gov.bc.ca/library/publications/year/2013/First_Nations_Aboriginal_MWSU_plan_final.pdf).

7 Cisgender refers to when one's gender identity matches the sex they were assigned at birth. A Cisgendered assumption (or cissexism) refers to the privileging of cisgendered people or the assumption that everyone is or should be cisgendered.

Purpose and Goals of ICMT

Overall Purpose of ICMT

The overall purpose of ICMT is to improve health care and outcomes for individuals and families who are impacted by problematic substance use or addiction with or without mental illness, and are experiencing functional challenges related to community living, including housing and income, through the provision of intensive community-based outreach services. Additional benefits may be realized for systems through the provision of integrated care and services.

Table 3: Specific Goals and Potential Outcomes of ICMT

What are the specific goals of ICMT?	Potential outcomes for ICMT individuals/families
<ul style="list-style-type: none">• To engage and establish therapeutic relationships with individuals who meet criteria for ICMT services• To provide client centered and strength based care that prioritizes client goals• To improve coordination of services/ enhance integration of services for individuals/families• To reduce avoidable hospitalizations• To reduce the harms of substance use for individuals/families• To increase reach to health and psychosocial services for marginalized individuals/families• To promote health of individuals and contribute to achievement of better health outcomes• To enhance the provision of housing and other community supports to assist the client to live in the community (e.g., housing stability, income supports)• To reduce involvement with the justice system, as applicable	<ul style="list-style-type: none">• Improved social functioning and improved basic life skills• Improved health status• Improved quality of life• Increased stability and housing tenure• Improved linkages to a continuum of health and social services• Improved skills in health literacy and self-management• Improved educational and employment status as deemed appropriate by the client• Reduced substance use related harms



Standards and Guidelines

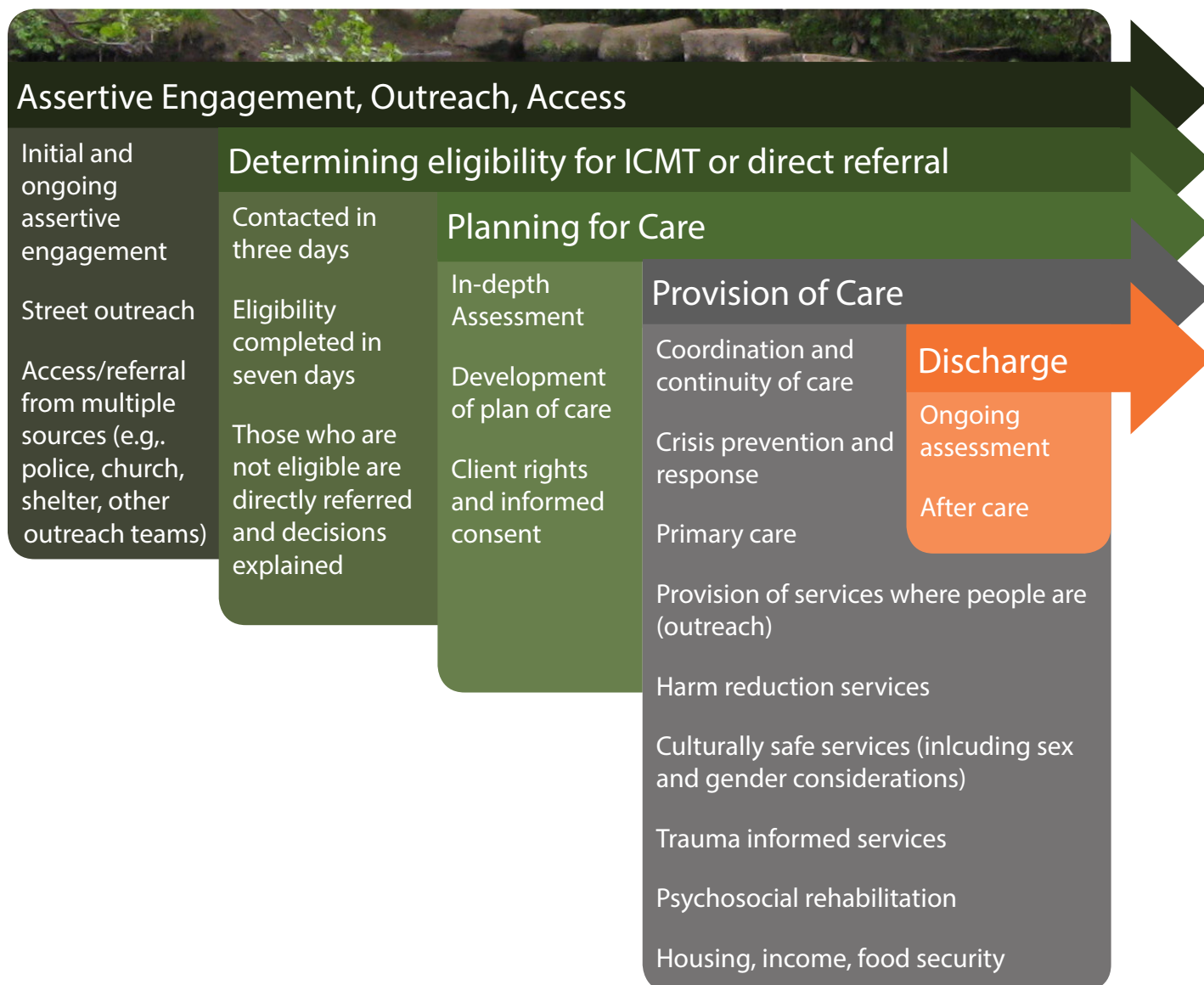
Standards refer to minimum requirements for provision of services and therefore are requirements of ICMTs. Guidelines refer to recommendations for implementation of the standards that may vary for population being served, demographics of the team/community and with supporting resources. The standards and guidelines are organized as follows:

- **Client pathway of care** including access/outreach, engagement, referral, admission, assessment and care planning (including client/family involvement), care provision (and services a client would have access to via this model of care), discharge, and aftercare/follow-up.
- **Core services** including coordination and continuity of care, crisis response, primary care, outreach, equity focused services, recovery and psychosocial rehabilitation, income, housing, food security and transition to discharge.
- **Operations** including the composition of the team, size, skill/competencies, case load, hours of operation, supervision, expectations for location of service, peer positions, processes for addressing client concerns, monitoring and evaluation are included as an appendix to guide the provision of the model.

1. Client Pathway of Care

The client pathway of care is laid out in a series of stages or steps to ensure that clients get the care that they need and that services are matched to client needs and preferences. The illustration on the next page, and the following sections outline the different stages in the pathway of care.⁸ Initial stages of the process include assertive engagement, outreach, referral and access/referral to ICMT and determining eligibility for ICMT or direct referral. This is followed by in-depth assessment, development of a care plan with specific attention to client rights and informed consent throughout the process.

Figure 2: Client Pathways of Care



⁸ Given the client centred focus of the ICMT model, it is understood that accessing and receiving services may not be a linear process, however this depiction is provided to reflect the organizational stages needing to be completed in order for a client to become registered as part of the ICMT.

1.1 Engagement/Street Outreach

Description

Client engagement may begin with an individual team member on street outreach or at the time of initial referral and determination of eligibility. If clients are deemed eligible for ICMT, engagement will continue with the entire team. Over time, engagement moves from individual care provider to the team.

Rationale

Client engagement and the development of trusting relationships are essential to assessment of the need for and delivery of ICMT services. Street outreach is a key strategy to reach potential clients and foster engagement in the early stages. In many cases, individuals may have been disengaged from the system and considerable time may be needed for engagement and building trust. The amount of time needed for engagement and establishment of a trusting relationship with a client will vary and may extend from months to several years. Street outreach and other low threshold harm reduction services can support and foster client engagement.

Intended Outcome

The engagement of clients deemed eligible for ICMT services and the development of trusting relationships between clients and ICMTs to ensure receipt of holistic care and supports that they need to live in the community.

Minimum Standards

- ◆ ICMT members create safe and respectful relationships with clients in need of ICMT services.
- ◆ If deemed eligible for ICMT, all team members will be introduced to clients, meet clients individually, and get to know clients.
- ◆ Team members will meet with clients in locations that are safe and comfortable for both client and provider.
- ◆ ICMT members will provide clients with an explanation of team care including specific expertise of team members.
- ◆ ICMT members will listen to clients' experience. Acknowledging their views and perspectives is central to care planning.

Guidelines

- ◆ ICMT staff will seek and create opportunities for the development of relationships with potential ICMT clients through street outreach services.
- ◆ Facilitating client engagement is the responsibility of individual team members who are then responsible to foster engagement and development of trust with other members of the ICMT.
- ◆ Process of engagement will be ongoing for clients who are eligible for ICMT services.
- ◆ Street outreach may be enhanced by working with harm reduction, public health, and other street outreach services.

Key Performance Indicators

- ◆ Clients are aware of the team approach to care.
- ◆ Clients express a sense of trust in their relationships with the ICMT.

1.2 Access & Referral

Description

Referral and access is characterized by:

- ◆ Processes that provide and maximize multiple avenues by which a potential client can contact, engage with, and receive services from an ICMT including street outreach.
- ◆ Minimal organizational processes that would slow down or prevent such contact.
- ◆ Teams are accessible and able to receive referrals from multiple sources of within the community.

Rationale

Clients may be experiencing homelessness, substance use and/or mental health problems so services must be easy to access and ICMT must reach out to clients. ICMT is intended to reach both those who have high needs for care but may be infrequent users of services and those who have a high need for services and frequent service use but do not meet criteria for Assertive Community Treatment.

Intended Outcome

Both clients and families who have high needs for care and may be low users of services as well as those who are frequent users of services are identified, contacted, and able to locate and access ICMTs.

Minimum Standards

- ◆ Clients who are identified or referred for ICMT services are contacted within three days and screened for eligibility for ICMT services within seven days.
- ◆ All people who are referred will be contacted and screened for eligibility for receipt of ICMT services.
- ◆ Referrals will be received from all sources. Clients may self-refer, be referred by a health or social service professional or agency, or by family or community members.

Guidelines

- ◆ Crisis response teams, harm reduction and street outreach teams may be a key source of referral and are therefore key community partners in access and provision of ICMT services.
- ◆ ICMTs should be well known within the community and the referral process is facilitated through the development of relationships between ICMTs and other community agencies.

Key Performance Indicators

- ◆ Clients are able to identify mechanisms for accessing ICMT.
- ◆ Clients are contacted within three working days for referral.
- ◆ Number of clients assessed and number of clients deemed eligible.
- ◆ Documentation of responses to those not deemed eligible.

1.3 Screening for Eligibility

Description

Eligibility screening includes identification of problematic substance use, addictions, mental illness symptoms, concurrent disorders, and homeless or at risk of homelessness, and assessment of severity. The team leader or manager must have the capacity and knowledge of assessment in substance use/addictions, mental health/mental illness, functional capacity and homelessness to conduct the eligibility screening.

Rationale

The basis on which individual clients are assessed for the program is outlined in specific eligibility criteria that focus on the potential for the individual to benefit or be best served by ICMT services. The eligibility criteria also provide clarity to referring individuals and agencies about which individuals are best served by the ICMT.

Intended Outcome

Screening for eligibility determines whether or not the ICMT can meet the needs of the referred client. A person should be matched to services and supports with intensity that is appropriate to his or her needs, strengths and preferences. Clients who are deemed eligible are accepted into the program. If not deemed eligible, the ICMT will explain to client/family/referral source reason for the decision, identify specific resources and actively link the client to appropriate resources and referrals directly. Clients who are found to be ineligible may be reassessed for eligibility in future, as circumstances change.

Minimum Standards

- ◆ Individuals and families will be deemed eligible for ICMT services if they are at least 19 years of age and experiencing:
 - Problematic to chronic dependent substance use with or without mental illness
 - Significant functional challenges associated with housing, income and health
 - Difficulties accessing health and social services and/or have not been well served by traditional models of mental health and substance use care
- ◆ Eligibility will be determined within seven days of first contact. Those who meet the eligibility criteria will have contact with ICMT services in three days and a further in-depth assessment will be initiated.

- ◆ Individuals that do not meet eligibility criteria are notified and the decision is explained either verbally or in writing.
- ◆ Individuals not deemed eligible are actively linked by the team to services that are best suited to meet their needs.

Guidelines

- ◆ Individuals previously assessed or discharged may be reassessed to determine eligibility for ICMT services. If eligibility screening is not completed within seven days, attempts to contact individual/family and referral source are made and extenuating circumstances are documented.

Key Performance Indicators

- ◆ Number of clients screened and eligibility screening completed within seven days.
- ◆ Individuals who are deemed not to benefit from ICMT services have the decision explained and are actively linked to other appropriate provider or service.

1.4 In-depth Assessment

Description

Individuals who fit the established criteria for eligibility should immediately become clients of the ICMT as caseloads and client needs permit. Following assessment of eligibility, and as trust is established, an ongoing and in depth assessment to inform care planning and delivery is conducted. This assessment is to help guide delivery of care and is done in collaboration with the client and at a pace comfortable for the client. Assessments to guide care planning are ongoing and will continue throughout the process of the relationship.

Rationale

ICMT is based on a strengths-based model of case management. Thus, in the assessment there is an emphasis on the importance of building relationships and the development of partnerships as well as a focus on the assets that clients bring to the relationship and their experience in the provision of ICMT services. Staff plays a key role in ensuring that clients have the information and resources they need in order to foster the development of trusting relationships and active and engaged partnerships for care.

Intended Outcome

- ◆ Development of a trusting relationship between provider and client is established.
- ◆ Plan of care is developed based on a comprehensive assessment of needs and priorities for care are identified in partnerships.

Minimum Standards

- ◆ All individuals that fit the eligibility criteria and wish to participate as clients are registered as clients of the ICMT.

- ◆ In-depth assessments are part of the development of the relationships with clients and set the baseline for development of client care plans so require investment of time. Time should be allocated to complete assessments as the relationship develops.
- ◆ Strengths Assessment in Life Domains [43]
 - Substance use
 - Mental illness
 - Behavior issues including aggression
 - Health service needs
 - Level of health system engagement
 - Service intensity required
 - Crisis response needs
 - Housing status & history (See Canadian Definition of Homelessness to determine housing status)⁹
 - Criminal justice involvement
 - Involvement with Ministry of Children and Families
 - Income – financial/insurance
 - Home/daily Living
 - PSR
 - Employment/Education/specialized Knowledge
 - Supportive Relationships (including family and others)
 - Wellness/Health
 - Leisure/Recreational
 - Spirituality/Culture
- ◆ Clients are reassessed at least every six months or as client needs change.

Guidelines

- ◆ ICMTs will work with a range of clients and may incorporate the use of specific assessment tools appropriate to the target population they are serving.

Key Performance Indicators

- ◆ Clients express satisfaction and trust in individual providers and team.
- ◆ Client role as partner in their care is clearly defined.
- ◆ Client assets are identified and reflected in the assessment.
- ◆ A comprehensive assessment is completed and reviewed at least every six months.

⁹ The Canadian Definition of Homelessness includes four categories 1) unsheltered, 2) emergency sheltered, 3) provisionally accommodated and 4) at risk of homelessness. For definitions of these housing situations, visit: www.homelesshub.ca/ResourceFiles/CHRNhomelessdefinition-1pager.pdf.

1.5 Care Plan

Description

An integrated and comprehensive client centered care plan reflects the services that are to be provided by the ICMT and in collaboration with community partners. An integrated plan of care provides overall direction for care provided by the ICMT and other providers who are involved in care of the individual. Care plans contain goals and objectives that are based on assessment of clients' strengths, needs, abilities and preferences as well as identified challenges and proposed solutions. The care plan is based on client goals and expected results and outlines the responsibilities of clients, ICMT members, and other agencies and organizations in the provision of care. ICMTs work with clients and their families to identify service goals and expected results in the process.

Rationale

The integrated plan of care provides a basis for integrated care that actively involves clients and their families. It is based on client assessments and outlines the activities of both the ICMT as well as services provided in collaboration with other agencies/organizations. Integrated care planning addresses strengths and needs of individuals and describes responsibilities of clients and providers in the provision of care.

Intended Outcome

Integrated care plans guide the provision of strengths-based, integrated and comprehensive care.

Minimum Standards

◆ All ICMT clients have an integrated care plan in place that at a minimum include:

- Client's strengths and assets.

- Mental and physical health needs.

- Psychosocial rehabilitation goals.¹⁰

- Provision and access to substance use services including harm reduction supplies and services, managed alcohol programs, supervised injection, opioid substitution treatment, and/or access to detoxification and treatment as appropriate.

- Primary care plan and provider.

- Spiritual needs and care provider responses.

- Informed choices and preferences identified in the assessment.

- Identified challenges, triggers and agreed to actions/solutions.

- Client goals and expected outcomes.

- Role and responsibilities of ICMT, client and families as well as other services providers/agencies or organizations.

- Identify where and how often services are delivered, timelines for initiation of services, when goals and expected results are to be achieved and for completion of services including transition or follow-up once client is discharged.

¹⁰ See Psychosocial Rehabilitation Service Framework for B.C.

- ◆ Goals and expected results are aligned with client capabilities, are achievable and measureable as well as complement goals developed by collaborating agencies.
- ◆ Care plans are documented as part of the client file.
- ◆ Integrated care plans are client-driven developed collaboratively and reassessed as client goals, strengths and needs change.
- ◆ The approaches to team-care, based on the agreed to care plan, are developed and communicated to clients and documented in the client's care plan.

Guidelines

- ◆ Care plans should address specific preferences and needs related to their care and be reflective of cultural, spiritual, sexual, gender and other preferences.
- ◆ Care plans include documentation of needs for education, emotional support, counseling, and information on health promotion, disease prevention, harm reduction and other substance use services, client self-care and responses to care.
- ◆ Care plans may be shared with other service providers in and outside of the organization who are involved in client provision of service as relevant to the care provided, as per consent standards.
- ◆ Care plans should be updated as client needs and preferences change.

Key Performance Indicators

- ◆ Number of care plans that include baseline and ongoing assessments.
- ◆ Number of care plans that are documented on the client file.
- ◆ Number of clients that indicating they were involved in the development of their care plan and are aware of their roles and responsibilities related to the plan of care.
- ◆ Percent of clients achieving goals identified in their care plans.

1.6 Client Rights and Informed Consent

Description

As part of the intake process and throughout the process of care, it is important that clients are informed of their rights and responsibilities as an ICMT client and aware of the resources, services and supports available to ICMT clients. In particular, intake is a key time to establish boundaries and emphasize the relationship of clients not just to a single provider but also to the ICMT. Throughout the process of care, informed consent from clients is obtained before services are provided. Clients are informed and able to understand the care that will be provided, who will provide the care and the implications of accepting or refusing the care offered. Consent may be implied, verbal or written as appropriate. In some cases, implied or verbal consent may be sufficient—such as clients offering of an arm for the taking of a blood pressure. In other cases, consent may be written. At times when clients may be unable to provide informed consent and a substitute decision maker, representation agreements or advanced directives should be consulted.

Rationale

Respect for individual autonomy and decision-making is fundamental to the provision of safe and ethical care that promotes well-being and empowerment. Informed consent means that individuals receive the necessary information, have the capability to understand the information and are able to make decisions free of coercion. Capabilities and capacity for decision-making may fluctuate during the provision of care. Care providers are skilled in assessing and understanding variations in client functioning and decision-making capacity.

Intended Outcome

- ◆ Clients are aware of the role of ICMT members and services provided.
- ◆ Clients are aware of their rights and responsibilities as ICMT client.
- ◆ Clients make decisions about their care.
- ◆ Advance directives, representation agreements or substitute decision makers are in place when client is unable to make decisions.

Minimum Standards

- ◆ Organizations providing ICMTs have clear policies/procedures related to client rights and informed consent in alignment with relevant legislation (e.g., Freedom of Information and Protection of Privacy Act¹¹, Health Care Consent and Care Facility Act¹² and Patient Property Act,¹³ and the Mental Health Act¹⁴).
- ◆ Clients are assessed for their ability to make decisions on their behalf using the domains of: personal safety; ability to access basic services; and ability to recognize consequences of actions and behaviours. If the client does not have the ability to make decisions on their own behalf using these elements, a full capability assessment should be considered.
- ◆ All discussions regarding client rights and consent are noted in the client file.
- ◆ Clients are provided with information as to who is providing care, what can be expected of services and their rights in the process of receiving health care.
- ◆ Information about care provision is provided at the time that clients are deemed eligible for receipt of ICMT services.
- ◆ Informed consent is obtained both at the time that care is offered and throughout the process of care provision as required. When clients are incapable of providing consent or making their own decisions, a substitute decision maker may be consulted by the team. In such cases, the roles and responsibilities of a substitute decision maker is provided. Questions, concerns and options are discussed. A substitute decision maker may be specified in legislation or may be an advocate, family member, legal guardian or caregiver.
- ◆ When a substitute decision maker gives consent, the name of the substitute decision maker, and relationship to client, and decision made is recorded in the client's file.

11 www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/96165_00

12 www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96181_01

13 www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/10_473_2003

14 www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96288_01

- ◆ Clients are provided with information about their rights to privacy and confidentiality.
- ◆ Client may appeal a service plan decision or file a complaint. They have the right to receive safe and competent services and make complaints about the quality of their care. Specific complaint processes are outlined by the organization or program.
- ◆ Informed consent of clients is required for sharing of information between teams and collaborating agencies. It is important to recognize differing professional standards related to informed consent and potential benefits and pitfalls of information sharing among teams, collaborating agencies and other supports.
- ◆ Care is offered in a respectful and assertive manner and clients have a right to refuse services or refuse to have certain people involved in their care; impacts of those rights are clearly explained to clients.
- ◆ Clients can participate in all aspects of their care and to make personal choices about their care.

Guidelines

- ◆ Clients can have a support person or advocate involved in their care.
- ◆ Depending on the particular type of care being provided, consent may be implied, verbal or written.
- ◆ Clients have the right to be aware of information in their health care records. Health authority procedures are followed to assist clients who wish to access their health care records.
- ◆ Clients who are incapable of providing consent may have advance directives and/or Ulysses Agreements in place to guide decisions. These are recorded in the client file and may be shared with service providers in and outside of the organization who need to know in order to provide care.

Key Performance Indicators

- ◆ Clients can identify who is responsible for provision of care.
- ◆ Clients are aware of their rights and responsibilities.
- ◆ Substitute decision makers or advance directives are in place and documented on the client file if applicable.

2. Core Services

2.1 Coordination and Continuity of Care

Description

ICMT is part of an integrated system of care. Coordination between community and acute care services is essential. ICMT services are provided primarily in community settings wherever clients are located. The ICMT may provide service directly or link to other services if services are not or cannot be provided by the team, or if services are better provided in the community.

Systems for regular communication and coordination between ICMTs, community agencies and acute care should be in place. ICMT services should be developed to fill in gaps and meet needs of specified target populations.

To ensure continuity of care, ICMTs continue to engage with clients regardless of setting. For example, the client would continue to be seen while in hospital or in a correctional facility. In such cases, the ICMT would participate as appropriate in the care of the client such as establishing a presence and actively engage in care planning and discharge planning activities.

Rationale

ICMTs are not stand-alone teams but rather integrated as part of a continuum of care, highlighting the importance of community collaboration and communication. The continuum of care includes health, housing, justice and social services and spans health care providers, housing service providers, police and others.

Intended Outcome

- ◆ ICMT services complement existing services.
- ◆ ICMT services are part of a continuum of services in the community.

Minimum Standards

- ◆ Mechanisms for communication between ICMT and other services are established.
- ◆ Processes for referrals are established.
- ◆ ICMTs have working protocols/memorandums of understandings established with key community organizations to ensure communication, information sharing, and joint care planning across providers and ease of access to services. Formal memorandums of understandings are established with:
 - Crisis response services and emergency departments
 - Withdrawal management programs
 - B.C. Housing and other housing providers
 - Income assistance
 - Harm reduction services
 - Community policing
 - Home health and community support services
 - Ministry of Child and Family Development
- ◆ If client is hospitalized or in correctional facilities, the ICMT will continue to be in contact with clients, participate in care and discharge planning to ensure continuity of care and seamless transitions between settings.
- ◆ Linkages exist to facilitate access to harm reduction, pharmacy, withdrawal management and treatment services.

Guidelines

- ◆ ICMTs collaborate with health, social, justice and other community services as outlined in the plan of care to meet client needs.
- ◆ Formal partnerships, cross training and liaisons with key community organizations are established.

Key Performance Indicators

- ◆ Identification of service providers for referral.
- ◆ Referrals are made to other appropriate service providers.
- ◆ Shared/integrated plans of care are established and communicated.
- ◆ Joint protocols/memorandums exist with key community organizations.

2.2 Crisis Response

Description

In the process of receiving care, clients will often experience situations of additional medical, psychological, social, legal and other stresses with increased needs for acute care. Crisis responses should be timely and available to clients when and where needed. Crisis situations are expected but cannot always be anticipated and as a result, ICMTs need to have a plan in place to provide services to clients in times of crisis. ICMTs must ensure clients have access to crisis response services 24/7 either through the ICMT itself or other services.

Rationale

ICMT clients have identified issues with moderate to severe substance use and/or mental health and it is anticipated that crisis situations will arise. Foreseeable situations may be included in the plan of care. When unplanned crises occur, a timely and appropriate response will be needed. Crisis response is separate from, but works in conjunction with emergency department services as needed.

Intended Outcome

- ◆ A crisis response plan is established to ensure services are in place and will include a network of community services as part of the response.
- ◆ Through the ICMT, clients will have access to crisis-response service coverage 24/7.
- ◆ Personal crisis response plans will be developed for each client. Crisis situations will either be anticipated or resolved as they arise.

Minimum Standards

- ◆ On-call crisis response services are available to ensure access to care 24/7.
- ◆ Protocols/memorandums are established with other community resources if the ICMT members are not available on-call 24/7.

- ◆ Care plans include strategies to minimize, reduce or prevent crises. The client chart includes documentation on agreed-to prevention strategies as well as a list of the services available on-call to address crisis situations.
- ◆ Crisis prevention and response plan is articulated and/or provided to the client and reviewed with the client and care team following every crisis incident.

Guidelines

- ◆ For clients that have been discharged from the ICMT and experience a mental health and/or substance use crisis, immediate reassessment of eligibility for ICMT services is undertaken.
- ◆ Personal crisis care plans are developed with clients and shared with community partners as appropriate.

Key Performance Indicators

- ◆ Crisis response is developed with and for ICMT clients.
- ◆ Personal crisis response plans are developed as part of care planning.
- ◆ Clients are aware of what to do/how to access services in a crisis situation.
- ◆ Crisis are prevented or resolved.
- ◆ Emergency department is used only in situations where crisis cannot be resolved by implementation of the crisis response protocol.

2.3 Primary Care

Description

ICMTs can play a key role in establishing linkages and access to primary care services. ICMTs must have a linkage to primary care providers to ensure this service is available and accessible to all clients. In B.C., there are several potential sources of primary care including physicians, nurse practitioners and community health centres.

Rationale

Having a regular source of primary care is considered standard care in British Columbia. ICMT clients may lack access and/or attachment to primary care services and may have significant, untreated health concerns. Having a regular source of primary care is important for meeting and addressing ongoing health care needs as well as being a source for health promotion and disease prevention information and activities. Primary care may or may not be a component provided directly by ICMTs. However, access and linkage to primary care is a key feature of ICMTs. The intention is that ICMTs foster connections between the client and a usual source of primary care. For example, primary care could be provided by an already established inner city health care centre where there are physicians, nurses, nurse practitioners as part of the primary care team, an independent nurse practitioner or a physician practice.

Intended Outcome

ICMT clients have access to and receive primary care. They are attached to a general practitioner, nurse practitioner or community health centre.

Minimum Standards

- ◆ All ICMT clients have access to and are attached to a primary care practitioner or clinic.¹⁵
- ◆ Clear mechanisms for communication, consultation and direct access to primary care services are developed between ICMTs and primary care providers.
- ◆ Primary care needs and treatment approaches are included in the client care plan on the client file.
- ◆ ICMTs support client's communications with and access to primary care referrals including specialist and other appointments/follow-up.
- ◆ Clients of ICMTs who are opioid dependent and interested in initiating or continuing opioid substitution treatment (OST) must have access to an authorized OST prescribing physician. In addition, ICMTs provide psychosocial supports associated with this therapy.
- ◆ ICMTs ensure clients leaving the ICMT service (moving, discharged, declining services) remain attached to a primary care provider for their ongoing care.
- ◆ To ensure responsibility and ongoing communications regarding pharmacotherapy and potential contra-indications, the most responsible physician must be noted in the client file and communicated to all other physicians involved in the client's care
- ◆ Medication reviews must be completed at least every six months by the most responsible physician.

Guidelines

ICMTs support clients to access and establish a relationship with a primary care provider or centre.

Key Performance Indicators

- ◆ Number of ICMT clients attached to a primary care provider.
- ◆ Number of ICMT clients whose chronic medical conditions are being treated.
- ◆ Appropriate substance use services are in place, including harm reduction services.
- ◆ The client file clearly articulates who is the most responsibility physician and all medications are documented on the client file and reviewed at least every six months by the most responsible physician.

¹⁵ Attachment is defined as a family physician that will provide full-service family practice services to their patients, and will continue to do so for the duration of that year, and the physician confirms that responsibility within BCMA requirements.

2.4 Outreach

Description

ICMTs use outreach to engage and support ICMT clients in their community/environment. Outreach incorporates two components. First as noted under engagement, street outreach is a strategy to reach clients in need of services and second, outreach may refer to the provision of services in the community for established ICMT clients. ICMT services are provided in the community where clients are at emotionally and physically in settings that are familiar, preferred and comfortable to them.

Rationale

Individuals who are eligible for ICMT services may have experienced difficulties in accessing and/or continuing with in services and/or have experienced stigmatizing reactions from providers--making them less willing to engage. Outreach is a strategy to actively engage potential clients and provide services to existing clients. ICMT members are able to navigate a complex system of services to streamline the client's receipt of those services. ICMTs will need to be mobile and able to move in the community both to meet clients 'where they are at' and to provide direct service and coordination.

Intended Outcome

- ◆ Outreach is a strategy to reach clients who are currently disconnected from services; to reconnect with clients in need or crisis, and; for ongoing provision of ICMT services.
- ◆ Services are provided through outreach in community settings and clients' homes.

Minimum Standards

- ◆ 80 per cent of ICMT time is spent in active engagement and provision of care with clients in the community.
- ◆ Minimal requirement is that a case manager meets with client once per week. Individuals may change their engagement or withdraw from services at any time.
- ◆ Clients receive an average of three contacts per week, based on identified client needs.
- ◆ Clients have opportunities to access ICMT in settings that are preferable for clients as well as safe/appropriate for the provision of care/supports needed. Ongoing contact may be in a variety of community settings.
- ◆ ICMTs partner with other service providers/agencies who are doing street outreach to potential clients that may require ICMT services. For example, ICMT members might accompany street outreach workers who are providing harm reduction services.

What Does Outreach Look Like?

Examples

- A member of the ICMT may accompany street outreach workers for informal check-ins with clients.
- Regularly scheduled drop-in hours at a local homeless shelter where individuals can be directly referred to an ICMT member for assessment of eligibility.
- ICMT staff accompany clients to the community pharmacy for their methadone and discuss the adjustments that will be necessary to maintain this therapy with possible employment opportunities.
- ICMT support clients to problem solve with family members.

Guidelines

- ◆ Frequency of contact is dependent on client need, and therefore will fluctuate.
- ◆ When clients are no longer requiring regular contact (i.e., weekly), options for discharge will be reviewed with the client and their family/supports.
- ◆ Assertive engagement is necessary to ensure early identification and prevention of relapse.

Key Performance Indicators

- ◆ Outreach to engage clients in the community is established. Specific outreach mechanisms and locations are identified.
- ◆ Per cent staff time providing community outreach.
- ◆ Number of clients engaged in community settings or on the street.
- ◆ ICMT clients receive an average of three contacts per week.

2.5 Equity Focused Services: Harm Reduction, Cultural Safety and Trauma Informed Practice

Description

In order to work effectively with clients, a number of clinical frameworks are employed to achieve the goals of health equity and provision of appropriate services. These include provision of harm reduction services and services that are trauma informed and culturally safe. ICMT services for clients have a primary focus on addressing harms and problems related to problematic substance use or dependency and both recognize and actively engage with clients to reduce harms of substance use. These individuals may also have previously experienced trauma, stigma and discrimination associated with poverty, homelessness substance use, gender, sexual orientation and ethnicity. The guidelines below provide specific directions for the provision of harm reduction services, culturally safe and trauma informed services.

Harm Reduction

ICMT members assess and are aware of patterns of substance use. This includes recognizing where the client is in relation to stages of changes and putting in place plans to reduce harms (not use per se). Clients who use injection drugs are able to access clean supplies either in supportive housing or through established relationships with community harm reduction services. Safer injection services, education and safer crack kits are available. Overdose prevention education and safer drinking education are available for clients assessed as at risk of problems related to overdose or problematic drinking. For those with severe chronic, relapsing alcohol dependency managed alcohol programs may be an option. Opioid substitution treatment is available for clients who are ready to take this step as well as direct access and referral to withdrawal management services on demand.

Rationale

ICMT clients may have experienced a range of harms and historical trauma as a consequence of societal policies and practices such as colonization and current drug policies. Therapeutic and trusting relationships are foundational to the provision of care, and necessary to effective work with clients. Care provided should be based on current evidence

related to establishment of therapeutic relationships including cultural safety, harm reduction, and trauma informed practice. Care should be provided to ensure that individuals are not re-traumatized when receiving services.

Intended Outcome

- ◆ Clients receive appropriate harm reduction supplies and services as needed.
- ◆ Clients feel safe and that their history, values and beliefs are respected and incorporated into the plan of care and subsequent provision of care.
- ◆ ICMTs provide care that is culturally safe and consistent with principles of harm reduction and trauma informed practice.
- ◆ Assumptions are not made about the clients' needs or preferences for care on the basis of generalizations about ethnicity, culture, trauma history or substance use. Rather, providers are aware of potential differences and discuss preferences and needs with clients.

Minimum Standards

- ◆ Client's patterns of substance use are assessed and plans put in place to reduce harms of substance use. This may include counseling, motivational interviewing, specific harm reduction services and safer use education.
- ◆ Clients are respected and treated with dignity regardless of their choices and decisions about substance use.
- ◆ ICMTs work with clients 'where they are at' in relation to their goals and plans for care and acknowledge longer term goals which although not currently feasible may be in the future.
- ◆ Harm reduction policies and procedures are in place to support ICMTs, and are consistent with provincial guidelines for best practices in the provision of harm reduction services.
- ◆ Organizational policies related to harm reduction are in place to guide provision of client specific and appropriate harm reduction supplies and services (e.g., safer injecting equipment, safer crack kits, condoms, supervised injection services, take home naloxone, managed alcohol, opioid substitution treatment).
- ◆ Harm reduction can be part of a recovery orientation including mechanisms for referral to detox and treatment services when and if clients are ready.
- ◆ ICMTs provide culturally safe care that incorporates principles of cultural safety including: recognition of history, power imbalances and cultural differences between clients and providers; providers take action that acknowledges and respects differences.
- ◆ Cultural protocols and practices are recognized and respected.
- ◆ ICMT members meet with clients in places that are welcoming and comfortable for clients.
- ◆ Trauma informed practice is incorporated into provision of ICMT services.
- ◆ ICMT team members recognize and assess potential actions, settings and activities that might re-traumatize clients.

Guidelines

- ◆ ICMT members acknowledge and recognize differences in privilege, power and social situations between providers and between providers and clients.
- ◆ ICMTs are knowledgeable regarding historical policies that have shaped harms for clients including colonization, current drug policies, and are aware of past histories of violence, abuse or trauma and consider these experiences when developing care plans.
- ◆ Clients opinions, values, and experiences are listened to, acknowledged, and inform care plans.

Key Performance Indicators

- ◆ Clients state they feel respected and valued for their views and opinions.
- ◆ Clients express feelings of being safe, welcome and comfortable in accessing care.
- ◆ ICMTs are knowledgeable regarding historical policies and factors that influence the delivery of culturally safe services and in the provision of trauma informed practice and harm reduction practices.

2.6 Recovery and Psychosocial Rehabilitation

Description

Psychosocial rehabilitation (PSR) and recovery focuses on improving quality of life, community integration and personal recovery. It is a strategy that is active, engaged, collaborative, person-centred and individualized. The World Health Organization highlights the emphasis is on strengthening individual competencies and facilitating change in environmental factors that impact one's health.¹⁶ As part of PSR and recovery, there is acknowledgment of the role that displacement, racial discrimination and trauma play in social exclusion and marginalization.

Rationale

Psychosocial rehabilitation (PSR) and recovery is a strategy for enhancing the competencies of individuals receiving care while attending to the social conditions in which they live. A wide range of services and supports in the areas of employment, education, leisure, wellness, and basic living skills need to be available to ICMT clients. The individual needs and goals in these areas are accessed, facilitated and provided for. PSR services are provided within the foundations of cultural safety, informed consent, coordination and continuity, client rights and a strengths-based approach. As a result of supporting an individual's recovery through PSR services, clients experience enhanced personal competencies, improved quality of life and community integration.

What might PSR and recovery services within ICMT look like?

- Partnership with local drop-in centre for ICMT clients to participate in cooking program
- Wellness plan includes nutritional strategies to address diabetes
- ICMT hosts a weekly walking group
- Local grocer has agreed to employ ICMT clients
- A pottery shop hosts opportunities for clients to learn art skills and sell their products
- Peer supports are available on the team to support an individual to meet their identified goal of abstinence.

¹⁶ Specific elements related to environment including housing, food and income are addressed in the next standard.

Minimum Standards

- ◆ Care plans identify client goals/needs in the PSR domains of employment, education, leisure, wellness and basic living skills development.
 - Movement towards recovery and goal attainment is reviewed and measured with clients regularly.
 - ICMTs support clients in accessing community resources that will support their recovery and development of skills within the PSR domains.
- ◆ Personal support networks are identified and sources of support including family and social relationships are mobilized.
- ◆ ICMT develop relationships/partnerships with other community providers to build capacity for opportunities for clients to engage in PSR services in the community.
- ◆ Opportunities to foster learning and growth, including employment, are facilitated.
- ◆ Volunteer and learning/education opportunities are identified and facilitated.

Guidelines

- ◆ Recognition of culture and diversity are central to recovery.
- ◆ Builds on strengths and capacity of clients.
- ◆ The ICMT builds relationships within the community to facilitate opportunities for PSR and recovery activities in the community through leisure, employment/volunteerism, education, wellness, and other life skills related learning opportunities.

Key Performance Indicators

- ◆ Clients report improvements in quality of life and capacity for self-determination and decision-making.
- ◆ Clients participate in educational, employment/ volunteer, wellness, leisure and basic skills development opportunities.
- ◆ Staff is knowledgeable about and receives professional development in PSR and recovery.
- ◆ There is evidence of PSR and recovery activities/goals in care plans.
- ◆ Partnerships/relationships are developed with local services to support PSR and recovery.



2.7 Income, Housing and Food Security

Description

Housing, income and food security are fundamental resources for health and well-being. Clients who are homeless or inadequately housed are supported to find appropriate housing options. Sources of income are assessed relevant to costs of living and client goals to ensure housing and food security. Assisting individuals to obtain housing, an adequate source of income and food security¹⁷ [63] is a foundational aspect of ICMT work and is essential to meet basic needs and build relationships.

Housing

Consistent with Canadian Mortgage and Housing Corporation guidelines for adequate housing,

- housing should not consume more than 30 per cent of income
- housing should be in good repair and meet public health standards
- housing is not overcrowded with each person having their own bedroom

Harm reduction services should be available on-demand in housing programs [62].

Rationale

Housing, income, and food are important determinants of health. They are key to addressing health and well-being; support positive health and mental wellness; and prevent harms associated with homelessness, substance use, and untreated mental illness. Fostering access to the social determinants of health is integral to psychosocial rehabilitation and prevention of harms of substance use, poor mental health, and homelessness. Harm reduction strategies can be incorporated into housing settings as means of further reducing the harms of substance use (e.g., provision of safer injecting supplies, crack kits, managed alcohol programs).

Intended Outcomes

ICMT clients will be supported to obtain an adequate income necessary to achieve housing and food security as well as other costs of living and the skills to maintain income, housing and food security.

Minimum Standards

- ◆ Client's sources of income are assessed and appropriate referrals made or facilitated.
- ◆ Client's housing status and needs are assessed.
- ◆ Planning for housing, income and food security are incorporated into care plans.
- ◆ ICMTs provide assistance with accessing appropriate sources of income (e.g., disability, employment, volunteer) and housing to ensure clients are able to cover costs of living (e.g., rent, food and other living expenses).
- ◆ Employment related goals and measures are included in the care plan if appropriate and identified by the client.
- ◆ Clients are supported to become food secure and to develop skills necessary to obtain and maintain food security.

¹⁷ Food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life. Food insecurity indicates deprivation in terms of a basic human need: access to nutritious food in sufficient quantities and of sufficient quality to maintain good health. Tarasuk, V., Mitchell, A., Dachner, N., Household Food Insecurity in Canada, 2011. 2013, PROOF.

- ◆ The ICMT develops protocols/memorandums with local income support services to facilitate the application for and receipt of support benefits in a timely manner.
- ◆ Relationships and collaborative partnerships with subsidized housing providers, landlords and BC Housing are established to support clients' access to affordable and appropriate housing.
- ◆ ICMT members provide assistance with obtaining and maintaining housing through direct support and/or ensuring clients are linked to community housing outreach workers (e.g., BC Housing).

Guidelines

- ◆ ICMTs work with BC Housing to ensure rental supplements are available to ICMT clients and families to assist clients to find market housing.
- ◆ As part of the care plan, assistance with budgeting, money management, and facilitated money management plans¹⁸ may be explored.
- ◆ Assisting clients to obtain appropriate and safe housing and food security is a priority.
- ◆ Clients are able to exercise choices in their housing options.
- ◆ The receipt of ICMT services is not contingent on maintenance of housing, but will be a component of the care plan if housing instability is an issue.
- ◆ Clients are encouraged to find or are provided with options for food security.

Key Performance Indicators

- ◆ Clients have access to a reliable and adequate source of income.
- ◆ Clients are able to meet daily food needs.
- ◆ Clients experience increased stability in housing.
- ◆ Clients have access to rental supplements and appropriate housing options.

2.8 Transition to Discharge

Description

To ensure appropriate provision of ICMT services, clients are assessed for strengths, current stability, discharge readiness and potential for relapse. Individuals with a decreasing number of contacts consistently over a period of time should be assessed for discharge. A process for routine assessment of readiness for discharge may also be implemented. Potential clients for discharge are identified and brought to attention of team leader.

¹⁸ Agreements between clients and the ICMT wherein the team holds controls over the disbursement of income through an agreed to financial plan with clients to support ensuring food and shelter needs are met. Arrangements may include establishing bank accounts with joint signing authorities, direct payments to landlords, and/or allowance disbursements.



Discharge Plans

There is no specified length of time for engagement and provision of ICMT services. A client who has decreasing frequency of contact and is assessed as stable and no longer needing ICMT services may be discharged. However, ICMT services may be re-established should the client require them in the future.

Rationale

Eligible clients need to have access to ICMT services for as long the client requires and accepts service. Discharge should be based on client functioning and level of connectedness to required community services rather than length of involvement. While ICMT is not necessarily time-limited, it is important that ICMT clients are routinely reassessed to determine their fit with existing ICMT services and needs. Readiness for discharge is assessed at regular intervals in collaboration with the client, their families/support people when appropriate, and other service providers.

Intended Outcome

Clients continue to receive ICMT services where appropriate and needed. Transitional services and supports are provided for those needing more or less supports than what can be provided by ICMTs.

Minimum Standards

- ◆ The team will reassess client progress on goals and needs for ICMT services at least every six months.
- ◆ Individuals who have not required at least weekly contacts for three consecutive months will be reassessed (in consultation with the team lead) to determine appropriateness for discharge planning.
- ◆ Individuals who are cognitively and functionally stable and able to maintain activities of daily living without the need for ongoing supports are reassessed (in consultation with the team lead) to determine appropriateness for discharge planning.
- ◆ Individuals can leave the program on their own volition at any time. ICMT will attempt to re-engage with the individual and the file will be flagged as inactive but will remain open for up to three months before the individual is deemed discharged and the file closed.
- ◆ When individuals are assessed as no longer requiring ICMT services they will be transferred to another appropriate mental health and/or substance use program or other health related service if needed.
- ◆ A clear, integrated discharge plan will be established and agreed to by the client and all service providers involved in the individual's ongoing care. The ICMT is responsible to ensure that the discharge plan clearly articulates roles/activities, and all providers understand and agree to their role post-discharge.
- ◆ Ongoing access to primary care/attachment will be maintained.
- ◆ A clear re-admission process is established for each discharged individual, should the need arise. The process will have a low administrative burden on the client and the system.

Guidelines

- ◆ Individuals should only be involuntarily discharged from the program if they present with consistently high risk to an ICMT worker that cannot be safely mitigated or, after thorough engagement, consistently refuses the services that are being offered.
- ◆ Discharge is ultimately dependent on client stability and ensuring the team's ability to re-engage in case of relapse (i.e, if the client is discharged, the team liaises with the general practitioner responsible for post-discharge and the door always remains open).
- ◆ Case files may be considered inactive, which allows opportunity for reconnection if needed.

Key Performance Indicators

- ◆ Completion of six-month assessments on all clients.
- ◆ Clients who fit eligibility criteria continue to receive ICMT services.
- ◆ Clients who require more or less services are transitioned to appropriate level of services.
- ◆ Clients experience a smooth transition process to other community resources when discharged from ICMT.
- ◆ Clients who relapse are reassessed for intake into ICMT program.

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Appendix A: Case Management Continuum in B.C.

Type of Service	Description
Harm Reduction Services	<p>A broad range of harm reduction services are provided by both public health and mental health and addiction services. This includes needle exchange services, safer crack kits and other harm reduction supplies, supervised injection services, and managed alcohol programs. Such programs are directly focused on reducing the harms associated with substance use, problematic use and chronic dependency. Some programs such as needle exchange and safer crack supplies may be accessed through existing community providers or as part of services in supportive housing. Managed alcohol programs include the provision of prescribed doses of alcohol for people who have chronic, severe and refractory alcohol dependencies. Managed alcohol programs are most often established as part of housing programs. Supervised injection services ensure safer injection through provision of safer spaces for injecting, access to clean supplies, and observation. They are provided in the community (e.g., Insite) or as part of existing health care services. Supervised injection has been specifically and repeatedly supported by B.C. provincial policy. See also BCCDC Supplies and Services for best practices in harm reduction.</p>
Case Management Services	<p>Mental health and substance use case management services including client finding, screening, assessment, treatment, psycho-social education, referral services, coordination of client’s care, self-management support, relapse prevention, crisis management, and ongoing support. Not all case management approaches encompass all these functions. The following are two common approaches to case management:</p> <p>Brokerage Case Management Services: The primary focus is on screening, assessment, referring clients to appropriate services, coordination of services and ongoing support.</p> <p>Clinical Case Management Services: Services include client finding, screening, assessment, treatment, psycho-social education, referral services, coordination of client’s care, self-management support, relapse prevention, crisis management and ongoing support.</p>
Adult Short Term Assessment and Treatment Services	<p>Assessment and short-term interventions to address acute mental health issues (e.g., episodic depression, suicidal ideation). Psychiatric assessment is conducted by a clinician and services may include: counseling services (e.g., cognitive behavioural therapy, solution-focused therapy) on an individual or group basis, psychiatric consultation, education and self-management support for the individual and his/her family, or a referral to other community services. Clinicians may be concurrently trained in both mental health and substance use issues. Includes services such as urgent short term assessment and treatment.</p>

Type of Service	Description
Intensive Case Management Team- Community Outreach Services	A formalized case management/outreach service delivery model for either urban or rural practice, that provides comprehensive services to individuals with problematic substance use, with or without mental illness and have multiple complex needs. An ICMT model has a higher level of intensity than standard case management. When compared to Assertive Community Treatment the intensity is similar but services are provided both by the team and through a collaborative approach with other community providers. Also, ICMTs have more expertise and focus on clients with primary problems related to problematic substance use and addiction with or without mental illness as well as problems associated with homelessness and poverty.
Early Psychosis Intervention (EPI)	Programs that serve young people with early psychosis, usually between the ages of 13 to 30 years, and their families. Programs provide single-entry/intake early detection of developing mental disorders, rapid assessment, bridge youth and adult mental health services, link community with hospital, and provide treatment (individual, group and family intervention) for people who have had their first episode of psychosis (e.g., schizophrenia, severe depression with psychotic symptoms). Programs also provide community education, evaluation, research, and assessment and monitoring for young people at high risk of developing psychosis. (see Standards and Guidelines for Early Psychosis Intervention (EPI) Guidelines).
Assertive Community Treatment (ACT)	A formalized service delivery model for either urban or rural practice, providing comprehensive services to individuals with mental illness and/or co-morbid severe substance use, who have multiple complex needs. ACT has a low client-to-staff ratio (one to 10 client to staff ratio), operating after hours and weekends, multidisciplinary team approach involving psychiatrist, nursing, social work, recreation therapist (RT), occupational therapist, peer support, and outreach. The ACT team provides for all the individual's needs through a client-directed delivery of care, assertive outreach and comprehensive, continuous service delivery. Services may include (but are not limited to) medication administration/monitoring, basic life-skills, primary care, accessing and providing supports to housing, money management & employment, psycho-social rehabilitation, and court liaison. (see British Columbia Program Standards for Assertive Community Treatment (ACT) Teams)

Appendix B: Program Operations

B.1 Team Composition (Minimum Urban Team)

Description

Team composition reflects the number of FTEs of professional and non-professional staff needed to make up the team. The guidelines below represent minimum requirements to be considered an ICMT. In many cases, team size may need to be larger in order to accommodate the number and complexity of potential clients who would benefit from the ICMT model of care. In smaller communities/catchment areas there may not be a large enough critical mass to warrant an ICMT.

Rationale

In order to accommodate the requirement for services 12 hours/day, seven days a week (see Standard 3.4 Hours of Operation), a minimum compliment of clinical staff and critical mass of potential clients is necessary. ICMT composition may vary and is dependent upon the specific target population being served, geographic setting and available community resources.

Intended Outcome

ICMTs are developed in relation to assessment of gaps in services and needs of target population in each community/region. Staffing consists of a multi-disciplinary team with both professional¹⁹ and non-professional staff so that skills are aligned with particular needs of clients and services provided.

Minimum Standards

- ◆ An ICMT is a minimum of 5.5 clinical staff

An urban team is appropriate for a community population of 70,000+.

Team size may be enhanced based on community/population size and complexity of client need.

Teams must have arrangements for after-hours care with crisis response teams or via on-call staff, the latter of which will require increases in staffing budget.

Components of 'team' operations as defined earlier (e.g. assessment, care planning, case consultation/reviews) must be adhered to in this approach through a combination of face-to-face and virtual team interactions.

Rural ICMTs may need to develop overtime provisions in order to fully met ICMT standards and guidelines.

- ◆ ICMTs in small urban and rural settings will cover a geographic area that may contain several communities.

The team will more likely be virtual rather than centrally located.

Team members may be located within some communities and provide outreach coverage to others.

¹⁹ Professional staff would include those that fall under a regulatory body such as a college or association with registration/licensing requirements that ensure clinical expertise to practice in that profession.

Like an urban team, a rural team is interdisciplinary and, although not necessarily co-located, would connect at least weekly through video or teleconferencing to discuss clients, share interdisciplinary perspectives, and provide mutual support. To ensure safety and coordination of care over distances, complex clients may require as much as daily conferences and involve other community providers.

Strategies for staff supervision will be critically important.

Service provision will be highly dependent on formalizing partnerships with other community providers such as home health nursing, public health, psychosocial rehabilitation and recovery programs, and existing outreach services.

Team composition includes a team leader/case manager (social worker, registered nurse, or registered psychiatric nurse), peer support, administrative data support, as well as access to or contract with an addictions medicine specialist, psychiatrist and primary care specialist (e.g., community clinic, general practitioner, nurse practitioner) (see Standard 3.2 for descriptions of core functions).

Minimum Staffing Complement

1 FTE Team Lead (0.5)/Case Manager (0.5)
5 FTE Case Managers (minimum 1 RN/RPN + 1 clinical Addiction Specialist)
1 FTE Peer Support Worker
0.5 Administrative supports/data clerk
0.5 FTE after hours on call or MOU with crisis response service for after-hours care

- ◆ Access to occupational therapists, recreation therapists, speech therapists would be beneficial resources.
- ◆ Teamleader/care manager provides direct client care at a 0.5 FTE level and must have a professional designation.
- ◆ Within the compliment of case managers, a minimum of at least one nurse (RN/RPN/MN) and one clinical addiction/substance use specialist (MA, MSW, RN/RPN/MN) is required.
- ◆ All ICMT staff must have background/training in working with addictions and/or concurrent disorders.
- ◆ Peer support workers do not hold a caseload but are a resource within the team. Therefore, peer support workers are not counted as part of the overall caseload capacity.
- ◆ Teams must ensure staffing for data entry associated with program evaluation/reporting.

Key Performance Indicators

- ◆ Minimum staffing complement is met.
- ◆ At least one peer with lived experience is a resource to team.
- ◆ Addiction medicine and psychiatric expertise is available on/to the team.
- ◆ Primary care is available to the team.

Complimentary Staffing

(may or may not be a part of the team but are built into the model of care within the community resources)

Equivalent to:

0.2 FTE addictions medicine specialist
0.2 FTE psychiatric expertise
0.2 FTE general practitioner/nurse practitioner

B.2 Team Roles and Functions

Description

ICMTs are multi-disciplinary teams composed of professional and non-professional staff who work together to provide services for people with moderate to severe substance use and/or mental health needs. The team is composed of individuals with a diverse set of skills and competencies that are complementary but based on a shared philosophy of care and knowledge of clinical frameworks and best practices in care of this sub-population. While each client will have a primary team member assigned to enhance development of therapeutic relationships, clients will have opportunities to develop relationships with the entire team²⁰ to ensure continuity and access to additional skills and knowledge.

Rationale

ICMTs work together in the provision of care to establish relationships with clients and draw on the expertise of the team in the provision of services. ICMT members will have differing expertise that can contribute to the care of all ICMT clients. Specifically, there will be expertise in substance use, addictions and harm reduction. Teams will have access to psychiatric, addiction medicine and primary care expertise.

Intended Outcome

Clients receive high quality, integrated care from a diverse team of providers based on their needs and skill/expertise within the team.

Minimum Standards

Team Leader – responsible for assessing eligibility through the intake process; reviewing (with the team) individual clients deemed appropriate for discharge; signing off on all assessments, care plans and discharge plans; provision of clinical supervision and de-briefing. The team lead is often the face of the ICMT in communities and may therefore be the primary negotiator of partnership arrangements/memorandums of understandings with other community providers.

Case Managers – Having at least one registered nurse/registered psychiatric nurse and one substance use/addictions specialist is required. All team members should be familiar with care of people with problematic substance use, addictions and concurrent disorders. Psychiatric expertise among care managers should also be available.

Case managers are responsible for completing the in-depth assessment, developing and monitoring care plans, provision of ICMT services and/or coordinating with other community resources accordingly, follow-up after crisis situations, liaison with general practitioner/psychiatrist/addiction medicine specialist/pharmacy.

²⁰ Note: this may not be achievable to the same degree in a rural ICMT and may involve other community providers.

Addictions Medicine Specialist – Expertise in addictions medicine is critical for addressing issues related to substance use management and disorders. This expertise may be either as part of the team or as a resource to the team. Access to physician specialists in substance use/addictions is a best practice. Teams should have access to a subscriber physician who is authorized as an opioid substitution treatment prescriber (e.g., methadone, suboxone).

Psychiatrist – Psychiatric expertise for full psychiatric assessments is essential either as part of the team or as a resource to the team. The psychiatrist ensures comprehensive psychiatric assessment and provision of appropriate treatment interventions, signing off on all assessments, care and discharge plans. The psychiatrist holds overall responsibility for medication management and communicates regularly with the primary care provider about any changes in medications.

Primary Care Provider – Family physician/nurse practitioner is either a part of the team or a resource to the team. As access to an opioid substitution therapy prescriber is essential, some clients may benefit from ensuring they are attached to this subspecialty as their primary care provider. The primary care provider is responsible for the overall health care needs of the ICMT client; works with the ICMT nurse and/or community nursing to ensure health maintenance needs are addressed; and is responsible to communicate with the psychiatrist about changes in medications.

Peer Support Worker – Has lived experience similar to ICMT clients being served, acts as a resource to the team, and supports clients as identified in the care plan. This position does not have a case load but provides supports across the team and are often involved in supporting psychosocial rehabilitation and recovery services that clients receive. Mechanisms are in place to ensure this position is adequately supported to maintain the peer support worker's mental and physical wellness.

Guidelines

- ◆ Where particular subpopulations are receiving care and/or teams have been established to address the needs of particular groups of individuals identified as appropriate for ICMT. Other staffing/skill compliments may need to be built into the team. For example: Aboriginal or First Nations advisors; expertise in Aboriginal health; experience working with vulnerable and/or transitioning youth and homeless populations; correctional services/policing background/training; or experience with eating disorders.
- ◆ People who have knowledge of the lived experiences specific to the population being served fill the explicit role of bringing this knowledge to the team. For example, this may include Aboriginal advisors or peers from advocacy groups representing people who use illicit substances or people living with mental illness.
- ◆ People with lived experience will either have skills to support clients and work as members of interdisciplinary teams or receive support to obtain these skills.
- ◆ Staff communication and planning: Teams meet weekly to review individual cases, update on status and discuss issues as well as planning to meet individual client needs.

To ensure safety and coordination of care, complex clients may require as much as daily conferences and involve other community providers.

Key Performance Indicators

- ◆ ICMTs are established that meet minimum staffing levels.

B.3 Staffing: Qualifications and Professional Development

Description

Staff must have the qualifications and expertise appropriate to provide high quality care to the target populations receiving services (e.g., individuals experiencing harms of substance use, women, families, people who are involved with the criminal justice system, homeless populations).

Rationale

Of particular relevance and importance are skills in cultural safety, substance use/harm reduction, trauma informed practice, mental illness and an understanding of causes of homelessness and history related to colonization, drug policies and other relevant factors impacting clients. ICMT is part of a continuum of services, so specific skills are dependent upon the kind of services provided directly by the ICMT.

Intended Outcome

ICMTs are composed of individuals with skills and expertise to provide services to the identified target populations which they are intended to serve.

Minimum Standards

- ◆ Case managers may be a combination of professional and non-professional staff, however the latter must operate under the direction of professional staff who sign-off on the individual care plans. Therefore, a team must determine the necessary compliment of professional staff needed to achieve optimum care and supervision.
- ◆ Given the nature of the work, often with disenfranchised individuals, regular staff supervision and support must be provided to ensure quality of care and staff retention.
- ◆ Staff is supported to receive professional development in accordance with requirements for ongoing education in the host organization and according to their professional discipline.
- ◆ Prior to, or upon joining the ICMT, staff must have training related to:
 - Provision of outreach and community services
 - Substance use, addictions, mental illness and concurrent disorders
 - Harm reduction philosophy, principles and practices that include understanding different perspectives on substance use
 - Strengths-based, recovery-focused care
 - Trauma-informed practice
 - Continuum of mental health and substance use care and other community resources supporting the target population
 - Psychosocial rehabilitation
 - Cultural competency and safety

Motivational interviewing

Social determinants of health and health inequities

- ◆ To support ICMT staff that do not have the minimum training competencies, the health authority/organization will ensure these staff successfully complete training within six months of commencing with the ICMT.

Guidelines

- ◆ Opportunities for debriefing, reflection and ongoing professional growth through staff supervision and training are fundamental to effective functioning of team members.
- ◆ Staff receives clinical supervision and opportunities for debriefing as part of their responsibilities both individually and as a team.
- ◆ Staff professional development includes team development, as well as individual development:
Specifically in the areas of substance use, mental health, violence, trauma, and homelessness.

Specific education related to cultural competency, cultural safety, harm reduction, trauma informed practice, and development of therapeutic relationships is part of essential knowledge and skills.

- ◆ Knowledge of health and social systems as well as community resources is essential.
- ◆ ICMT staff with expertise and knowledge may provide education to others as part of team outreach.
- ◆ Opportunities for reflective practice
- ◆ Opportunities for professional development with specific focus on stigma and discrimination.

Key Performance Indicators

- ◆ Staff has or obtains knowledge and skills in provision of trauma informed practice, cultural safety and competency, harm reduction philosophy and practices.
- ◆ Staff participates in regular debriefings with supervisors.
- ◆ Number of opportunities for staff development, team building and education.
- ◆ Hours of staff development by team/by team members.

B.4 Hours of Operation

Description

The hours of operation that an ICMT is available to provide direct care and support to clients either in office or via outreach.

Rationale

The ICMT model is more flexible and accessible to clients than traditional mental health and substance use services. Therefore, clients should have resources and supports from ICMT members during non-traditional work hours and have alternative services available as needed.

Intended Outcome

ICMT services are available to clients at a minimum of seven days a week 12 hours per day. After hours, crisis or on call services are available to clients in addition to ICMT services. Day and evening coverage is ideal so that clients and their families have access to services at varying times of day.

Minimum Standards

- ◆ ICMT services are available seven days a week, 12 hours per day.
- ◆ After-hours and crisis-response services are available either through the ICMT or through protocols/MOUs with other community agencies.
 - It is the responsibility of the ICMT for follow-up with the client and crisis service provider following each crisis incident.
 - Memorandum of understandings include communication/information sharing agreements.
- ◆ Communication structures are in place to ensure daily conversation across team members and shifts.
- ◆ The hours of ICMT services are well communicated to other community providers (e.g., mental health and substance use services, police, harm reduction services, community pharmacists, emergency department, community crisis teams, withdrawal management programs, housing providers).

Guidelines

- ◆ Access to service and coverage may be provided by a range of providers on the team or shared by teams.
- ◆ Availability and configuration of hours of ICMT services will be based on available community and regional resources. In particular, rural and urban differences in access to resources must be assessed. For example, multiple teams in rural setting with fewer resources may share coverage.

Key Performance Indicators

- ◆ Regularly scheduled team meetings to communicate, plan and coordinate care of clients occur.
- ◆ ICMT clients and families are able to access care when needed to address emergency and urgent concerns as well as having regular contact and follow up.
- ◆ Communication tools have been developed and shared with community partners, clients and their family members regarding hours of ICMT services and options for after-hours care.

B.5 Case Load Size

Description

The overall case load is based on the staff to client ratios and client capacity is determined by the size of the team.

Rationale

ICMT services are of higher intensity than standard case management services and involve not only referrals but active engagement and outreach to develop relationships with clients and provide care. Caseloads should reflect this level of intensity of service.

Intended Outcome

Staff to client caseloads will not exceed 1:20 and are based on intensity of services required by clients and fidelity to the model.

Minimum Standards

- ◆ Clinical staff-to-client ratio/caseloads will operate ideally at a 1:16 ratio and will not exceed a 1:20 ratio.
- ◆ Team members share and should be knowledgeable of all individuals and be willing to assume care of a range of individuals based on specific knowledge and expertise.
- ◆ Any clinical member of the team is able to take over the care of any individual client if needed.
- ◆ ICMT members support the overall care of clients by ensuring the appropriate mix of team skills/interventions to meet the needs of the client.

Guidelines

- ◆ In order to manage appropriate caseloads, conduct routine assessments of individual's need for ICMT services in relation to readiness for discharge or transition of care to an alternate resource/team.
- ◆ Undertake ongoing assessments to determine service intensity. Service intensity/frequency of face-to-face contacts with clients may change over the course of care provided and is documented/updated regularly in the client file.
- ◆ When caseload maximums are reached, the health authority/organization's management is made aware, and plans to address overload and wait lists are discussed.

Key Performance Indicators

- ◆ Caseloads operate between 1:16 - 1:20.
- ◆ Regular weekly contact and ongoing engagement are maintained or become less frequent as clients' transition to discharge.
- ◆ Clients seen less than weekly are re-assessed for level of intensity/discharge.
- ◆ Development of action plans to address overload and waitlists.

B.6 Evaluation

Description

ICMTs and services are important additions to the continuum of services for clients with problematic substance use/addiction and mental illness in combination with social disadvantages such as homelessness or housing instability. It is important that teams collect information about the services they provide and the impacts on clients in order to evaluate whether or not they are achieving program goals and objectives. Evaluation should be based on both overall program goals as well as specific objectives that may be unique to the development of particular ICMTs.

Rationale

Ongoing evaluation of effectiveness is essential to good program functioning and to identify areas of strength as well as areas for improvement. Program evaluation provides a regular opportunity for ICMTs to reflect on their services in terms of reach as well as diversity in clients and type of services provided. Evaluation also ensures a quality improvement process is built into the overall operations of the team and to maintain fidelity to the ICMT model.

Intended Outcome

ICMTs have a continuous quality improvement process established including collection and reporting on a provincial set of evaluation indicators as outlined in the provincial evaluation framework.

Minimum Standards

- ◆ Organizations must ensure resources to support evaluation design, data collection and regular reporting are a component of the ICMT model of care.
- ◆ ICMTs will report on key evaluation indicators as identified in the provincial evaluation framework and may include:

- Number of clients served (including case load)
- Client demographics (e.g., age, gender, ethnicity)
- Average frequency of contact with clients
- Housing status of clients
- Reduction in harms of substance use (not use per se)
- Decrease in mental illness symptoms
- Client discharges
- Incidence of crisis response
- Number of clients with identified source of primary care
- Client experiences with care

- ◆ All critical incidents are recorded and reviewed by the team.
- ◆ ICMTs have the resources (human and electronic) necessary to collect and report data related to ICMT indicators.

Guidelines

- ◆ Use of an evaluation framework to assist in planning and evaluation.
- ◆ Specific indicators are developed in collaboration with team based on identified program goals and objectives and are consistent with mental health and substance use policies.
- ◆ Support for program evaluation is provided to the team.
- ◆ Critical incidents may be shared with an ICMT community of practice for system learning and support.

Key Performance Indicators

- ◆ ICMTs have a continuous quality improvement process in place
- ◆ Evaluation indicators are reported on annually as per the provincial evaluation framework.

B.7 Community Advisory Bodies

Description

Development, implementation and operations of ICMTs are supported and guided by a regional/local community advisory body. This body may support other services but have a role to promote and enhance the quality of services provided by ICMT. Members are chosen for their specific knowledge of either ICMT or case management models; their general knowledge of mental health and substance use services; links with relevant community services; ability to represent the interests of clients ,their families and the community; and any other expertise required to support and guide the program. Members should include people who use substances and members of organizations who represent people who use substances and community stakeholders who interact with persons with serious mental health and substance use problems. This body will have linkages to other community organizations and supports such as Divisions of Family Practice, Assertive Community Treatment teams and existing harm reduction, street nurse and other outreach services.

Rationale

Advisory bodies are important in guiding the development, implementation and delivery of ICMTs. Given the broad range of expertise available in relevant areas including substance use, homelessness and health care services, they can advise on policies and directions for services, represent interests of clients and their families, referring agencies and local community. Advisory bodies have a role in developing and maintaining good communication with the community and opportunities to address emerging local issues and planning, while ensuring the program maintains fidelity to the standards. The community advisory body can promote partnerships and community awareness and understanding of substance use and mental health issues.

Intended Outcome

Prior to implementation of ICMTs, a community advisory body is developed in order to guide and inform the process of developing and implementing ICMTs. Once implemented, community advisory bodies continue to guide implementation and operations.

Minimum Standards

- ◆ Members are appointed and include: individuals with expertise and knowledge of substance use and mental health problems; members of community agencies such as non-profit service providers; advocacy organizations that represent people who use substances and people living with mental illness; Aboriginal leaders and/or Elders; Divisions of Family Practice; and other community stakeholders. Members of the advisory body should have skills in cultural competency, and ideally, reflect the diversity of the local population.
- ◆ If a member has a conflict of interest, that person should declare the conflict, abstain from discussion and voting where there is a direct conflict of interest, or remove himself/herself from the advisory body. The community advisory body shall have written terms of reference incorporating the requirements outlined in this section.
- ◆ Terms of Reference should be developed that incorporate the requirements in this section.
- ◆ Advisory bodies promote fidelity to the ICMT program standards within needs and context of the community.

Guidelines

Community advisory bodies should:

- ◆ Problem-solve and advocate to reduce system barriers to ICMT implementation.
- ◆ Provide the program with advice on timely resolutions to emerging issues.
- ◆ Represent the interests of clients and their families, referring agencies and the local community.
- ◆ Develop and maintain good communication with the community.
- ◆ Promote partnerships, awareness and understanding of substance use and mental health issues.

Key Performance Indicators

- ◆ Community advisory body is established prior to implementation.
- ◆ Membership reflects interests of clients (including advocacy groups representing people who use drugs and people living with mental illness), community agencies, community, Aboriginal peoples and other stakeholders.
- ◆ Community advisory meets at regularly established intervals to guide implementation and operations.
- ◆ Terms of reference are developed and clearly communicated.
- ◆ Community advisory bodies contribute to awareness and understanding of issues related to substance use and mental health.