Intensive Case Management Service Standards

for Mental Health Services and Supports

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Ontario

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Introduction

Intensive Case Management

Intensive case management services are a key part of the continuum of mental health services and supports for people with serious mental illness. Intensive case management promotes independence and quality of life through the coordination of appropriate services and the provision of constant and on-going support as needed by the consumer. The direct involvement of the consumer and the development of a caring, supportive relationship between the case manager and the consumer are integral components of the intensive case management process. Intensive case management is responsive to consumers' multiple and changing needs, and plays a pivotal role in coordinating required services from across the mental health system as well as other service systems (i.e., criminal justice, developmental services, addictions). Case managers fulfil a vital function for consumers by working with them to realize personal recovery goals. Case managers work to build a trusting and productive relationship with the consumer and to provide the support and resources that the consumer needs to achieve goals, stabilize his/her life and improve his/her quality of life.

Need for Intensive Case Management Service Standards

The Ontario health system is dedicated to achieving a consumer-oriented system that provides access to effective, quality health services through accountability and performance management. As well, the Ministry of Health and Long-Term Care is committed to providing a reformed mental health system that is focused on the delivery of comprehensive, coordinated and results-driven mental health services. The ministry documents *Making It Happen: Implementation Plan for Mental Health Reform*, *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports* and the *Mental Health Accountability Framework* guide the mental health reform process and direct the development of an accountable mental health system.

Intensive case management services have been provided in many settings and communities across Ontario for more than twenty years. Because programs are often developed in response to local needs, service components are not consistent across the province. As part of the commitment to achieve mental health service system responsibility and accountability, standards have been developed to ensure that intensive case management services reflect the goals and principles of province-wide mental health reform. Standards set expectations for intensive case management services so that services across the province are consistent and incorporate evidence-based best practices. Service provision, in accordance with standards, will permit development of performance measures and data collection requirements for monitoring the delivery of intensive case management services.

This document sets out the ministry standards for intensive case management. It also describes the process for developing and validating the standards and the next steps in developing mechanisms to monitor services to ensure they are being provided appropriately and effectively.

Broad Policy Context

The development of intensive case management standards is occurring within a context of broader healthcare reform which is dedicated to achieving a healthcare system that is consumer oriented and community-based and focuses on improved access to quality, accountable and evidence-based services. The provision of accountable, evidence-based, accessible intensive case management services is consistent with broad national and provincial government directions and policies for healthcare reform and provides opportunities for the integration of mental health services and supports with some of these broader healthcare initiatives.

Current healthcare initiatives in Ontario such as Local Health Integration Networks, Primary Care Reform and Family Health Teams focus on creating an integrated healthcare system that provides access to consumer-centred, comprehensive and appropriate healthcare (*Ontario Ministry of Health and Long-Term Care, 2004*). The goals of mental health reform, including intensive case management, reflect similar objectives. The current initiatives present an opportunity to expand health system capacity through the development of linkages between broader healthcare reform and mental health services.

National healthcare initiatives in recent years have specifically committed to the provision of improved community-based mental health services, including intensive case management. The Commission on the Future of Health Care in Canada's (2002) *Final Report: Building on Values: The Future of Health Care in Canada* made a number of recommendations intended to ensure the long-term sustainability of Canada's healthcare. It recommended investing in home care services, including acute mental health services, as a priority. Case management services for individuals with mental illness were identified as a key component of acute mental health services.

The First Ministers' Health Accord on Health Care Renewal (*Health Canada, 2003*) is the Federal, Provincial, and Territorial governments' commitment to improve the quality, access and sustainability of health services. Three priority areas were identified to meet these goals. One of the priorities was home care, and, as part of this, a commitment was made to invest in the provision of acute community mental health services.

The Ontario Government has also identified its commitment to addressing community mental health services. The 2004 Ontario Budget committed to expanding community mental health services to serve an additional 78,600 clients annually by 2007-08 through access to case management, assertive community treatment, crisis response and early intervention in psychosis services (*Ontario Government, 2004*).

Mental Health Policy Context

Various Ministry of Health and Long-Term Care documents emphasize the need for mental health service accountability. Accountability ensures the continuous setting of standards, monitoring of performance and reporting on outcomes to permit evaluation and improvement of the efficiency and effectiveness of programs and services and to meet system-wide goals. The development of system-wide program and service standards is a key part of this accountability.

Making It Happen

In 1999, the Ministry of Health and Long-Term Care released its implementation plan and operational framework for mental health reform. The implementation plan, *Making It Happen: Implementation Plan for Mental Health Reform*, provides the overall context for the reformed mental health system and sets out the principles and goals for mental health reform.

One of the stated principles is that mental health services will be provided in accordance with evidence-based best practices.

Among the goals for mental health reform presented in *Making It Happen: Implementation Plan for Mental Health Reform* are ensuring that mental health services and supports:

- Are provided within a comprehensive service continuum developed to meet consumer needs and based on best practices;
- Are organized and coordinated based on a "levels of need" structure, to ensure that consumers have access to the services that best meet their needs;
- Are appropriately linked to other services and supports within geographic areas;
- Achieve clear system/service responsibility and accountability through the development of explicit operational goals and performance indicators; and
- Are simplified and readily accessible, according to the consumer's needs.

Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports defines the comprehensive continuum of supports and services available in the reformed mental health system, and guides how the services should be organized and delivered. Intensive case management is considered to be part of the comprehensive continuum of supports and services. The *Operational Framework* also lays out the overall features and functions of intensive case management services and provides a framework for the development of the intensive case management service standards. (See Appendix D for Functions of Intensive Case Management Services.)

Mental Health Accountability Framework

The *Making It Happen* documents identify accountability as key to mental health system reform. In April 2003, the Ministry of Health and Long-Term Care released the *Mental Health Accountability Framework* that provides guidelines for monitoring the accountability, efficiency and effectiveness of mental health services and supports. Accountability mechanisms strive to continually evaluate and improve the mental health system through setting performance standards and measuring outcomes. The *Mental Health Accountability Framework* defines the performance domains and their accompanying indicators that inform the development of service standards and related outcome-based performance measures and data collection tools. (See Appendix A for definitions of the domains.) Multiple indicators have been developed for each performance domain, although not all indicators will be relevant to every intensive case management program. (See Appendix B for a table presenting the domains and indicators.)

Process for Developing Standards

Interjurisdictional Review

An interjurisdictional review of the status of standards development for intensive case management services in Ontario, the rest of Canada and key international jurisdictions was conducted. Within Canada, most provinces are at some stage of describing programs and services and developing standards. Nova Scotia has fully articulated program standards based on available evidence and best practices: intensive case management standards are included within the Community Supports standards (*Nova Scotia Department of Health, 2003*). Among the Nova Scotia standards are requirements for the provision of an appropriate referral process, a comprehensive assessment, an intervention plan and progress review, services based on mutually established goals/outcomes with the consumer, and linkage and coordination services (*Nova Scotia Department of Health, 2003*). Manitoba, British Columbia and Newfoundland have undertaken broad mental health system reform to set system-wide goals and define and improve the specific services, including intensive case management, which make up the mental health system (*Manitoba Department of Health, 1997; British Columbia Ministry of Health, 1998; Newfoundland Department of Health and Community Services, 2003*). The provinces are at various stages in the reform process and in the definition of standards related to intensive case management.

Work at the national level and in several states in the United States was reviewed. At the time of the review, none had fully articulated mental health services or service standards specific to intensive case management, although Ohio and California utilize program descriptions that are standards-based (*Ohio Department of Mental Health, 1999; California Mental Health Planning Council, 2001*).

In the United Kingdom and Australia, there is no specific information on direct statements of intensive case management standards. However, both countries have developed national service standards for all mental health services (*Commonwealth of Australia, 1996; National Health Service, 1999*). In Australia, the standards emphasize outcomes and the integration of services and reflect strong values based on human rights, dignity and empowerment (*Commonwealth of Australia, 1996*). In the United Kingdom, the standards related to intensive case management focus on the provision of effective services to people with severe mental illness through engagement, service planning (i.e., anticipation/prevention of crisis), written care plans, etc. (*National Health Service, 1999*). In both countries, the standards were based on the best evidence available and are intended to be used to monitor, evaluate and improve mental health services.

Stakeholder Working Group

In June 2003, the ministry consulted with a stakeholder working group of front-line providers, including consumer organizations, regarding the content for intensive case management standards. (See Appendix C for a list of participants.) Using the functions for intensive case management set out in *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports* and the Nova Scotia standards (*Nova Scotia Department of Health, 2003*) as a guide, the group developed draft standards. Each standard was linked to a performance domain and associated indicators in the *Mental Health Accountability Framework*. A sub-group of the original working group met again in November 2003 to review and refine the draft standards.

Validation of Standards

A research consultant validated the intensive case management service standards drafted by the stakeholder working group through a review of the literature in this area. Research on intensive case management and Assertive Community Treatment (ACT) published in peer-reviewed scientific journals was included in the review. A "levels of evidence" typology was adapted from a typology developed by Nova Scotia's Department of Health (*Nova Scotia Department of Health, 2003*) (See Appendix F for a description of the levels of evidence typology) to compare the proposed standards with available research evidence. Relevant literature was reviewed against the standards. Each standard was rated based on the levels of evidence typology and research supporting the standard was identified.

Intensive Case Management versus Assertive Community Treatment

The literature reviewed included research on intensive case management as well as Assertive Community Treatment (ACT). While some studies on intensive case management were located, the majority of the research focused on ACT. Although there are similarities between ACT and intensive case management models, the services are delivered differently (i.e., ACT services are provided by a team versus intensive case management services which are provided by a single case manager.) As a result, the research on ACT service standards was applied to support the intensive case management standards with caution. The intensive case management service standards will continually be reviewed and revised as additional research-based evidence and best practices specific to intensive case management service standards become available.

Intensive Case Management Standards

Features of Intensive Case Management – A Vital Component of the Service Continuum

Intensive case management is more than a brokerage function. It is an intensive service that involves building a trusting relationship with the consumer and providing on-going support to help the consumer function in the least restrictive, most natural environment and achieve an improved quality of life. The case manager maintains involvement, as consumer needs change and cross service settings.

The priority population for intensive case management services is people who meet the ministry's definition for serious mental illness and require on-going and long-term support.[1]

[1] There are three dimensions used to identify serious mental illness – disability, duration and diagnosis.

Intensive Case Management Functions

Intensive case management is a comprehensive and complex service. *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports* sets out the following specific functions of intensive case management. (See Appendix D for definition of the functions.)

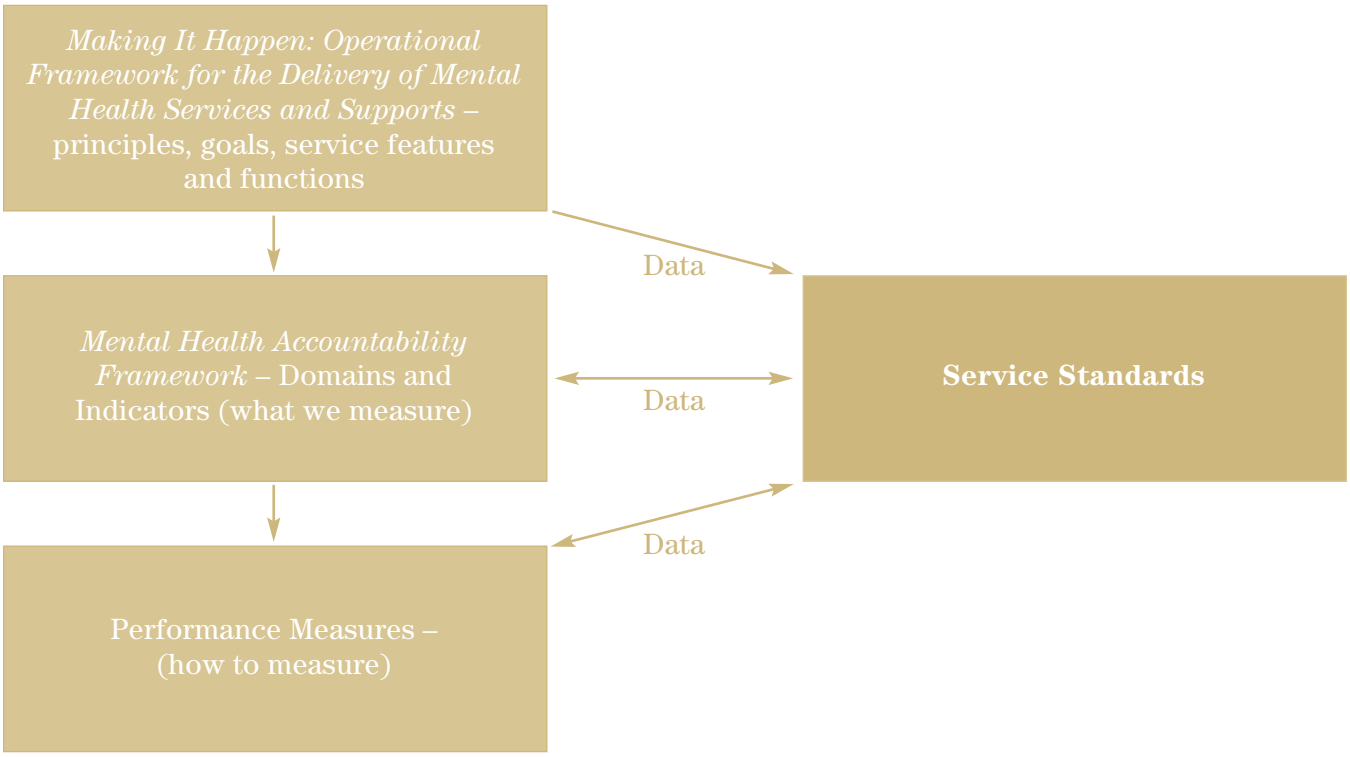
- Outreach and Consumer Identification
- Assessment and Planning
- Direct Service Provision/Intervention
- Monitoring, Evaluation and Follow-up
- Information, Liaison, Advocacy, Consultation and Collaboration

Standards were developed for each of the intensive case management functions and reflect the general features of intensive case management services.

Relationship Between Service Standards, Functions, Domains, Indicators and Performance Measures

Compliance with standards will ensure services are comprehensive, coordinated and based on consumer need and best practices. The intensive case management standards reflect the key features and functions of intensive case management laid out in *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports*, and the performance domains and indicators identified in the *Mental Health Accountability Framework*.

Figure 1: Relationship Between Service Standards, Functions, Domains, Indicators and Performance Measures



Each intensive case management service standard relates to one or more of the domains and indicators.

The next step will be the development of performance measures based on applicable domains and indicators. For this reason, every standard is associated with domain(s) and indicators and has been worded so it can be translated into measurable statements. (Refer to Appendix E for a table presenting the standards and the related domains and indicators.) Each indicator may encompass a number of measurements relevant to the service provided. For example:

- **Indicator**: Appropriateness – adherence to best practices.

  Standard: A case manager-consumer ratio of no more than 1:20 must be maintained where possible.

  Measure:
  The case management service has a case manager-consumer ratio of:
  1 to 1-5
  1 to 6-10
  1 to 11-15
  1 to 16-20
  1 to more than 20

- **Indicator**: Appropriateness – consumer/family perception of appropriateness.

  Standard: Consumers will participate in a review of their service plan at least annually. A senior staff member or supervisor should also review the plan annually.

  Measure:
  Percentage of consumers participated in a review of their service plan at least annually:
  Less than 50%
  51-60%
  61-70%
  71-80%
  81-90%
  91-100%

  Number of service plans reviewed annually by a senior staff member or supervisor:
  Less than 50%
  51-60%
  61-70%
  71-80%
  81-90%
  91-100%

Once performance measures are developed for each indicator related to an intensive case management standard, data will be collected and used to evaluate services and further refine the standards as required. Standards and services will continually be re-evaluated based on the measures and collected data to ensure the standards reflect best practices.

Intensive Case Management Standards

The standards presented in this document have been developed based on the service functions in *Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports*, the domains and indicators defined in the *Mental Health Accountability Framework* and reflect the consultation with the stakeholder working group, developments in other jurisdictions and research evidence.

The following chart presents each standard, its related service function and domain(s) and identifies the level of evidence (i.e., research evidence, expert opinion) supporting the standard. (See Appendix F for a full description of the levels of evidence.)

Table 1: Intensive Case Management Standards

Function	Standard	Domain	Levels of Evidence[2]			
			1	2	3	4
Outreach and Consumer Identification	• Where possible, assertive outreach will be offered to engage potential consumers in their place of choice, considering the safety and security of the consumer and the provider.	Accessibility		✓		✓
	• When reaching out to consumers who demonstrate identifiable and specific mental health needs for on-going support or service, services will be offered in the least intrusive manner possible.	Accessibility		✓	✓	✓
	• Services must establish alternative approaches to identify and serve consumers that reflect varied consumer needs (for example, differing life stage needs, cultural or linguistic needs). Methods of outreach and identification must be adapted to meet varying needs.	Accessibility and Acceptability		✓	✓	✓
	• All organizations must have a documented intake process including criteria to determine eligibility for service.	Accessibility		✓	✓	✓
	• The intake process must be initiated within 10 working days after initial contact.	Accessibility		✓		✓
	• Every organization must develop a plan to manage its waiting list, which must be reviewed on an annual basis.	Accessibility				✓

[2] Levels of Evidence
- Level 1 involved direct evidence of effectiveness (i.e., specific standard evaluated as independent variable in a study and shown to produce positive outcomes).
- Level 2 considered indirect evidence of effectiveness (i.e., specific standard is one of the characteristics or ingredients of a program which has been shown to be effective).
- Level 3 involved studies based on expert opinion/consensus of effectiveness or correlational evidence of standards being associated with positive consumer outcomes.
- Level 4 involved expert opinion (i.e., defined by the working group or other Canadian jurisdictions in absence of empirical support in research literature).

Table 1: *continued*

Outreach and Consumer Identification (continued)	• If referral to additional services or diversion to another service is recommended, the referral must be developed in consultation with the consumer.	Appropriateness and Accessibility				✓
Assessment and Planning	• Upon completion of the intake process, an agency standardized needs assessment for service must be initiated within 10 working days.	Accessibility				✓
	• A comprehensive, individualized service plan must be developed mutually by the case manager and the consumer and reflect the stated goals and needs of the consumer. The plan should include strategies for managing crises, and outline a timeframe for goal attainment.	Acceptability and Appropriateness		✓	✓	✓
	• The service plan must identify other services and resources if required to address the full range of a consumer's needs.	Continuity		✓	✓	✓
Direct Service Provision/ Intervention	• Service provision must be focused in the community, not the office.	Appropriateness	✓	✓	✓	✓
	• Service provision must be managed in a manner that responds to fluctuations/ variations in consumer need.	Appropriateness		✓	✓	✓
	• A case manager-consumer ratio of no more than 1:20 must be maintained where possible.	Appropriateness		✓	✓	✓
	• Intensive case management services must be available a minimum of eight hours a day, five days a week.	Accessibility		✓	✓	✓
	• Written protocols must be established for consumers to access service/ support in off-service hours, seven days a week, 24 hours a day, and should be documented in consumer service plans as part of emergency/ crisis planning.	Accessibility		✓	✓	✓

Table 1: *continued*

Direct Service Provision/ Intervention (continued)	• The agency will ensure that front line staff are trained in a variety of issues, to the best extent possible, (e.g., suicide intervention; safety standards for working in the community; non-violent intervention; anti-racism training; psycho-social rehabilitation; identifying addictions; multicultural sensitivity; family dynamics; psychiatric symptomatology and psychiatric medications) supported through professional development agreements.	Competence		✓		✓
	• To ensure consistency of service provision, services are provided by a primary case manager, to the extent possible.	Continuity		✓	✓	✓
Monitoring, Evaluation and Follow-up	• Consumers will participate in a review of their service plan at least annually. A senior staff member or supervisor should also review the plan annually.	Appropriateness and Acceptability		✓		✓
	• Consumer satisfaction (including consumers, families and outside agencies) must be surveyed regularly, and the results used to make service improvements.	Acceptability		✓		✓
	• All organizations and agencies must evaluate some aspect of their programs annually using best practices and published standards.	Appropriateness and Effectiveness		✓		✓
	• A written discharge plan must be developed upon completion of service that would include criteria for follow-up, re-entry and linkage with other services.	Effectiveness, Acceptability and Continuity				✓
	• Written protocols must be developed for a complaint process to receive and act upon the concerns of consumers, families and other organizations. Consumers must be informed of this process.	Acceptability				✓
	• An annual review of standards management must be undertaken (including implementation and compliance).	Effectiveness and Efficiency				✓

Table 1: *continued*

Information, Liaison, Advocacy, Consultation and Collaboration	• The service provider agency must develop partnership or service agreements with other agencies or community services or primary care providers to ensure continuity of service provision.	Continuity		✓		✓
	• The case manager must be knowledgeable about services that are accessible and relevant to consumer interests in order to provide up-to-date information.	Effectiveness				✓
	• The case manager must also advocate, on behalf of the consumer, for services that are accessible and relevant to the consumer's needs.	Accessibility and Appropriateness		✓	✓	✓
	• The service provider agency must develop a written plan that identifies community resources, links to be established and staff training requirements. The plan must be reviewed annually for appropriateness.	Appropriateness and Continuity				✓

Next Steps

This document describes intensive case management service standards and represents the next step in the development of accountable intensive case management services in Ontario. The ministry will be further developing the components of the *Mental Health Accountability Framework* in order to define and implement an accountability relationship and process with the mental health system.

The principles, goals and essential components of a reformed mental health system have been defined. Performance domains, indicators and standards have been developed, based on system principles and goals and program components. This represents one step in the provision of clear program direction for intensive case management services to the field. While all service providers may not be able to meet all standards immediately, significant funding is being invested in the enhancement of intensive case management services to ensure that services will be able to meet standards.

The ministry will also develop data collection requirements and outcome-based performance measures to monitor and report on the provision of intensive case management services. As these performance measures and data collection requirements are implemented, the available data will be used to measure intensive case management services and supports against the identified standards.

With these components in place, the ministry will be able to implement an accountability process to monitor how intensive case management services are being provided and answer important questions.

Are services being delivered across the province in a manner that is consistent with ministry policy and with evidence-based best practices?

Most importantly, are consumers satisfied with the service they are receiving and is the service helping them to achieve their personal goals?

This will inform the continual improvement and evaluation of the system of intensive case management services within Ontario's mental health system.

Appendix A: Performance Domains[3]

Domain	Definition
Acceptability	Services provided meet expectations of service users, community, providers and government.
Accessibility	Ability of people to obtain services at the right place and right time based on needs.
Appropriateness	Services provided are relevant to service user needs and based on established standards.
Competence	Knowledge, skills and actions of individuals providing services are appropriate to service provided.
Continuity	The system is sustainable, comprehensive, and has the capacity to provide seamless and coordinated services across programs, practitioners, organizations and levels of service in accordance with individual need.
Effectiveness	Services, intervention or actions achieve desired results.
Efficiency	Organizations/programs achieve desired results with the most cost-effective use of resources.
Safety	Organizations/programs avoid or minimize potential risks or harms to consumers, families, mental health staff and the community associated with the intervention/lack of intervention or the environment.

[3] Ontario Ministry of Health and Long-Term Care (2003). *Mental Health Accountability Framework.* p. 18

Appendix B: *Mental Health Accountability Framework* – Performance Domains and Indicators[4]

DOMAIN				
INDICATORS	**Acceptability**	**Accessibility**	**Appropriateness**	**Competence**
	Consumer/family satisfaction with service received	Service reach to persons with serious mental illness (SMI)	Existence of best practice core programs	Resources available to train staff to meet required competencies for role
	Consumer/family involvement in treatment decisions	Service reach to the homeless	Fidelity: adherence to best practices	Resources available for on-the-job development and continuous learning
	Formal complaints mechanisms in place	Access to psychiatrists and other mental health professionals	Best practices services/ supports provided to persons with SMI	Meets provincial certification/ professional standards (where applicable)
	Patient bill of rights	Identify human resource gaps	Treatment protocols for co-morbidity	
	Consumer/family involvement in service delivery and planning	Access to primary care	Hospital readmission rate*	
	Cultural sensitivity	Wait times for needed services	Involuntary committal rate*	
	Consumer/family choice of services	Availability of after hours care	Length of stay in acute care*	
		Availability of transportation	Time in community programs	
		Denial of service	Use of seclusion/ restraints	
		Early intervention	Level of service and setting appropriate to needs of individual	
		Consumer/family perception of accessibility	Needs-based funding and spending	
		Access to continuum of mental health service	Consumer/family perception of appropriateness	
		Criminal justice system involvement	Availability of community services	
			Criminal justice system involvement	
			Community/institutional balance	

[4] Ontario Ministry of Health and Long-Term Care (2003). *Mental Health Accountability Framework.* pp. 20-21

DOMAIN				
	Continuity	**Effectiveness**	**Efficiency**	**Safety**
	Continuity mechanisms	Community tenure	Mental health spending per capita	Complications associated with electro-convulsive therapy (ECT)
	Emergency room visits*	Mortality	Proportion of staff funding spent on administration and support	Medication errors
	Community follow-up after hospitalization	Criminal justice system involvement	Needs-based allocation strategy	Medication side effects
	Documented discharge plans	Clinical status	Community/institutional balance	Critical incidents
	Cases lost to follow-up	Functional status	Resource intensity planning tool	Suicides
	Clear, visible and available points of accountability	Involvement in meaningful daytime activity	Unit costs and cost per consumer	Homicides
		Housing status	Budget and tools for evaluation and performance monitoring	Involuntary committal rate
		Quality of life		Risk management practised
		Physical health status		Identify research/ practices to reduce adverse events and errors

INDICATORS

NOTE: Indicators marked with an asterisk are often used as measures. They are included here as indicators to reflect that they may signal system function or problems.

Appendix C: List of Stakeholder Working Group Participants

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Appendix D: Definitions of Intensive Case Management Functions

Making It Happen: Operational Framework for the Delivery of Mental Health Services and Supports (1999) has defined the functions of intensive case management.

- **Outreach and Consumer Identification** – reaches out to consumers who may identify or appear to have a service need to assure sufficient time and flexibility to initiate a working relationship. This function also informs family members/key supports and other service providers about the availability of and access to intensive case management services.
- **Assessment and Planning** – provides comprehensive individualized assessment to explore immediate and on-going needs. The process includes consumers to identify personal strengths and establish personal goals. This function also includes the development of a comprehensive individualized plan that incorporates the consumer's goals and values, and identifies skills, resources and service requirements. Members of a consumer's social network will be included in the assessment and planning process with consumer consent.
- **Direct Service Provision** – facilitates coordinated access to and use of wanted and needed services in areas such as assistance with daily living (housing), crisis intervention and treatment (i.e., counseling and support), health promotion and prevention, and advocating for civil and legal rights. It is important to develop partnerships with ethno-racial communities and organizations to facilitate the provision of appropriate services to members of these communities.
- **Intervention** – facilitates linkages to appropriate services, supports and resources. It provides interventions such as engagement, crisis intervention, intensive/short-term support and linkage to appropriate levels of service. This function focuses on consumer need and identifies and advocates for services that are accessible, relevant and coordinated.
- **Monitoring, Evaluation and Follow-up** – evaluates the achievement of goals (from consumer and case manager perspectives) and consumer satisfaction. It also regularly monitors service plans with consumers to ensure services are appropriate and relevant.
- **Information, Liaison, Advocacy, Consultation and Collaboration** – provides information to consumers, key supports and service providers regarding access to and type of services and supports available. This function facilitates access to a range of services, including ones in other sectors, and works collaboratively with these to facilitate the provision of resources to consumers.

Appendix E: Intensive Case Management Standards, Domains and Indicators[5]

Function	Standard
Outreach and Consumer Identification	• Where possible, assertive outreach will be offered to engage potential consumers in their place of choice, considering the safety and security of the consumer and the provider.
	• When reaching out to consumers who demonstrate identifiable and specific mental health needs for on-going support or service, services will be offered in the least intrusive manner possible.
	• Services must establish alternative approaches to identify and serve consumers that reflect varied consumer needs (for example, differing life stage needs, cultural or linguistic needs). Methods of outreach and identification must be adapted to meet varying needs.
	• All organizations must have a documented intake process including criteria to determine eligibility for service.
	• The intake process must be initiated within 10 working days after initial contact.
	• Every organization must develop a plan to manage its waiting list, which must be reviewed on an annual basis.
	• If referral to additional services or diversion to another service is recommended, the referral must be developed in consultation with the consumer.

[5] Based on the domains and indicators defined in *Mental Health Accountability Framework* (Ontario Ministry of Health and Long-Term Care, 2003).

	Domain	Indicators
	Accessibility	• Service reach to persons with serious mental illness (SMI) • Service reach to the homeless • Early intervention • Consumer/family perception of accessibility
	Accessibility	• Service reach to persons with SMI • Service reach to the homeless • Consumer/family perception of accessibility
	Accessibility Acceptability	• Service reach to persons with SMI • Service reach to the homeless • Consumer/family perception of accessibility • Denial of service • Consumer/family satisfaction with service received • Patient bill of rights • Cultural sensitivity • Consumer/family involvement in service delivery and planning
	Accessibility	• Service reach to persons with SMI • Service reach to the homeless • Denial of service • Consumer/family perception of accessibility • Wait times for needed services
	Accessibility	• Wait times for needed services • Consumer/family perception of accessibility • Denial of service
	Accessibility	• Wait times for needed services • Consumer/family perception of accessibility • Denial of service
	Accessibility Appropriateness	• Consumer/family perception of accessibility • Access to continuum of mental health service • Denial of service • Level of service and setting appropriate to needs of individual • Consumer/family perception of appropriateness • Availability of community services

Appendix E: *continued*

Function	Standard
Assessment and Planning	• Upon completion of the intake process, an agency standardized needs assessment for service must be initiated within 10 working days.
	• A comprehensive, individualized service plan must be developed mutually by the case manager and the consumer and reflect the stated goals and needs of the consumer. The plan should include strategies for managing crises, and outline a timeframe for goal attainment.
	• The service plan must identify other services and resources if required to address the full range of a consumer's needs.
Direct Service Provision/ Intervention	• Service provision must be focused in the community, not the office.
	• Service provision must be managed in a manner that responds to fluctuations/variations in consumer need.
	• A case manager-consumer ratio of no more than 1:20 must be maintained where possible.

	Domain	Indicators
	Accessibility	• Wait times for needed services • Access to psychiatrists and other mental health professionals • Consumer/family perception of accessibility
	Acceptability	• Consumer/family involvement in treatment decisions • Consumer/family involvement in service delivery and planning • Consumer/family choice of services • Consumer/family satisfaction with service received • Patient bill of rights • Cultural sensitivity
	Appropriateness	• Consumer/family perception of appropriateness • Best practices services/supports provided to persons with SMI • Level of service and setting appropriate to needs of individual • Availability of community services
	Continuity	• Continuity mechanisms
	Appropriateness	• Fidelity: adherence to best practices • Best practices services/supports provided to persons with SMI • Time in community programs • Level of service and setting appropriate to needs of individual • Availability of community services • Consumer/family perception of appropriateness
	Appropriateness	• Best practices services/supports provided to persons with SMI • Time in community programs • Level of service and setting appropriate to needs of individual • Consumer/family perception of appropriateness • Community/institutional balance • Hospital readmission rate • Length of stay in acute care • Treatment protocols for co-morbidity • Involuntary committal rate
	Appropriateness	• Fidelity: adherence to best practices • Best practices services/supports provided to persons with SMI • Level of service and setting appropriate to needs of individual

Appendix E: *continued*

Function	Standard
Direct Service Provision/ Intervention (continued)	• Intensive case management services must be available a minimum of eight hours a day, five days a week.
	• Written protocols must be established for consumers to access service/support in off-service hours, seven days a week, 24 hours a day, and should be documented in consumer service plans as part of emergency/crisis planning.
	• The agency will ensure that front line staff are trained in a variety of issues, to the best extent possible, (e.g., suicide intervention; safety standards for working in the community; non-violent intervention; anti-racism training; psycho-social rehabilitation; identifying addictions; multicultural sensitivity; family dynamics; psychiatric symptomatology and psychiatric medications) supported through professional development agreements.
	• To ensure consistency of service provision, services are provided by a primary case manager, to the extent possible.
Monitoring, Evaluation and Follow-up	• Consumers will participate in a review of their service plan at least annually. A senior staff member or supervisor should also review the plan annually.
	• Consumer satisfaction (including consumers, families and outside agencies) must be surveyed regularly, and the results used to make service improvements.

	Domain	Indicators
	Accessibility	• Wait times for needed services • Availability of after hours care • Denial of service • Availability of transportation
	Accessibility	• Access to psychiatrists and other mental health professionals • Wait times for needed services • Availability of after hours care • Early intervention • Availability of transportation • Denial of service
	Competence	• Resources available to train staff to meet required competencies for role • Resources available for on-the-job development and continuous learning • Meets provincial certification/professional standards (where applicable)
	Continuity	• Continuity mechanisms • Clear, visible and available points of accountability
	Appropriateness Acceptability	• Consumer/family perception of appropriateness • Level of service and setting appropriate to needs of individual • Consumer/family involvement in service delivery and planning • Consumer/family satisfaction with service received • Consumer/family involvement in treatment decisions • Formal complaints mechanisms in place
	Acceptability	• Consumer/family satisfaction with service received • Consumer/family involvement in service delivery and planning • Consumer/family involvement in treatment decisions • Patient bill of rights • Formal complaints mechanisms in place

Appendix E: *continued*

Function	Standard
Monitoring, Evaluation and Follow-up (continued)	• All organizations and agencies must evaluate some aspect of their programs annually using best practices and published standards.
	• A written discharge plan must be developed upon completion of service that would include criteria for follow-up, re-entry and linkage with other services.
	• Written protocols must be developed for a complaint process to receive and act upon the concerns of consumers, families and other organizations. Consumers must be informed of this process.

	Domain	Indicators
	Appropriateness	• Fidelity: adherence to best practices • Best practices for services/supports provided to persons with SMI • Consumer/family perception of appropriateness • Level of service and setting appropriate to needs of individual
	Effectiveness	• Community tenure • Mortality • Criminal justice system involvement • Clinical status • Functional status • Involvement in meaningful daytime activity • Housing status • Quality of life • Physical health status
	Effectiveness	• Community tenure • Mortality • Criminal justice system involvement • Clinical status • Functional status • Involvement in meaningful daytime activity • Housing status • Quality of life • Physical health status
	Acceptability	• Consumer/family involvement in service delivery and planning • Consumer/family choice of services • Consumer/family satisfaction with service received
	Continuity	• Documented discharge plans • Cases lost to follow-up
	Acceptability	• Formal complaints mechanism in place • Consumer/family satisfaction with service received • Consumer/family involvement in service delivery and planning • Patient bill of rights

Appendix E: *continued*

Function	Standard
Monitoring, Evaluation and Follow-up (continued)	• An annual review of standards management must be undertaken (including implementation and compliance).
Information, Liaison, Advocacy, Consultation and Collaboration	• The service provider agency must develop partnership or service agreements with other agencies or community services or primary care providers to ensure continuity of service provision.
	• The case manager must be knowledgeable about services that are accessible and relevant to consumer interests in order to provide up-to-date information.
	• The case manager must also advocate, on behalf of the consumer, for services that are accessible and relevant to the consumer's needs.
	• The service provider agency must develop a written plan that identifies community resources, links to be established and staff training requirements. The plan must be reviewed annually for appropriateness.

	Domain	Indicators
	Effectiveness	• Community tenure • Mortality • Criminal justice system involvement • Clinical status • Functional status • Involvement in meaningful daytime activity • Housing status • Quality of life • Physical health status
	Efficiency	• Budget and tools for evaluation and performance monitoring
	Continuity	• Continuity mechanisms • Cases lost to follow-up • Clear, visible and available points of accountability
	Effectiveness	• Community tenure • Mortality • Criminal justice system involvement • Clinical status • Functional status • Involvement in meaningful daytime activity • Housing status • Quality of life • Physical health status
	Accessibility	• Access to psychiatrists and other mental health professionals • Wait times for needed services • Access to continuum of mental health service • Consumer/family perception of accessibility
	Appropriateness	• Best practices services/supports provided to persons with SMI • Availability of community services • Consumer/family perception of appropriateness • Level of service and setting appropriate to needs of individual
	Appropriateness	• Availability of community services
	Continuity	• Continuity mechanisms

Appendix F: Literature Review – Summary of Key Research Findings on Intensive Case Management

Research literature on Intensive Case Management (ICM) programs and services was reviewed to inform standard development. In general, there is limited research specific to ICM. The research studies available indicate that there are no standard definitions of case management model. Most studies measured hospitalization and found that case management services decrease hospitalization.

The following presents a summary of the findings of these literature reviews.

Review of Best Practices in Mental Health Reform (1997)

The 1997 *Review of Best Practices in Mental Health Reform* (*Goering et al.*) prepared for the Federal/Provincial/Territorial Advisory Network on Mental Health found that:

- Despite widespread implementation of case management models there are no standard case management methods or definitions.
- Research tended to focus on efficacy of full support case management models or assertive community treatment (ACT), while a few included other models of case management. For example, Scott and Dixon (1995) compared ICM to generalist case management and Rapp (1996) analyzed the results of 34 case management studies and suggested elements of the programs that contribute to positive consumer outcomes.
- Most studies included some measure of hospitalization as an indicator of effectiveness. All studies found that case management reduced hospitalization and that ICM reduced inpatient utilization.
- Studies suggest case management models offer additional benefits including:
  - Cost Savings – case management models have lower direct and indirect costs, often associated with savings as a result of reduced hospital use,
  - High rates of consumer and family satisfaction,
  - Family Burden – found that use of community treatment does not increase family burden,
  - Improvements in community adjustment (social/vocational functioning, residential situation, medication compliance and quality of life), and
  - Increased use of community services in models that emphasize linkage with other community services.
- However, research suggests there is little effect on clinical status.
- Based on these findings, the following key elements of best practice for ICM were identified:
  - Use of the rehabilitation model, which focuses on improving living skills, is tailored to individual need and provides continuous interpersonal support,
  - Use of the personal strengths model, which focuses on consumer strengths and identifies or develops community resources and environments where consumers can achieve success, and
  - Provision of the following: outreach, continuous/around-the-clock service, services in the community, flexible individualized support, and involvement of consumers and key supports in all aspects of service delivery.

Inter-jurisdictional Scan

A literature review and an inter-jurisdictional scan were conducted to assess the state of intensive case management standards. Literature and documents were reviewed for service standards currently in place or being designed. The review revealed that:

- There is considerable on-going work within Canada and around the world. All Canadian jurisdictions reviewed had developed or were in the process of developing services and standards (*British Columbia Ministry of Health, 1998; Manitoba Department of Health, 1997; Nova Scotia Department of Health, 2003; Newfoundland Department of Health and Community Services, 2003*). Nova Scotia has fully developed standards for intensive case management based on available evidence and best practices (*Nova Scotia Department of Health, 2003*). Australia, the United Kingdom and the United States were at various points in developing standardized programs and services. Australia and the United Kingdom do not have standards specific to intensive case management, but have developed national standards that are applied to all mental health services (*Commonwealth of Australia, 1996; National Health Service, 1999*).
- There is growing clinical knowledge concerning key components of effective case management, although there is limited information specific to intensive case management models and there is an overall lack of firm evidence-based standards (*Baronet and Gerber, 1998; Goering et al., 1997*). However, it was found that the more intensive case management models appear to improve consumer outcomes in a number of areas, including consumer satisfaction with service, quality of life and hospitalizations and emergency room admissions (*Aubry et al., 2000; Baronet and Gerber, 1998; Bedell et al., 2000; Holloway and Carson, 1998; Rapp, 1998; Schmidt-Posner and Jerrell, 1998*).

Literature Review: Standards Validation

A research consultant conducted a literature review to validate the service standards for intensive case management. Levels of evidence were used to review the literature supporting the standards.

Levels of Evidence

- A four-level typology of evidence adapted from the typology developed by the Nova Scotia Department of Health (*Nova Scotia Department of Health, 2003*) was used to assess the literature against the proposed intensive case management service standards.
  - Level 1 involved direct evidence of effectiveness (i.e., specific standard evaluated as independent variable in a study and shown to produce positive outcomes).
  - Level 2 considered indirect evidence of effectiveness (i.e., specific standard is one of the characteristics or ingredients of a program which has been shown to be effective).
  - Level 3 involved studies based on expert opinion/consensus of effectiveness or correlational evidence of standards being associated with positive consumer outcomes.
  - Level 4 involved expert opinion (i.e., defined by the working group or other Canadian jurisdictions in absence of empirical support in research literature).

Review Findings

- The literature focused on ICM as well as ACT and found that overall there is more evidence supporting ACT services than ICM. Level 2 and 3 evidence supported most of the proposed standards, and one was supported by Level 1 evidence.

Appendix F: *continued*

Function	Standard	Evidence for Standard
Outreach and Consumer ID	• Where possible, assertive outreach will be offered to engage potential consumers in their place of choice, considering the safety and security of the consumer and the provider.	• Level 2 – one study (ACT) engaged in outreach to emergency shelter consumers with the goal of developing rapport and offering services to reluctant and suspicious consumers (*Morse et al., 1992; Calsyn et al., 1998*). • Likely that a number of programs engage in proactive outreach in the community to recruit consumers. However, this practice is not typically described in peer-reviewed articles.
	• When reaching out to consumers who demonstrate identifiable and specific mental health needs for on-going support or service, services will be offered in the least intrusive manner possible.	• Level 2 – nine studies (1 ICM, 8 ACT). In these studies, programs targeted a specific sub-population of persons with severe mental illness who had needs that were not being adequately addressed including persons with a history of homelessness (*Calsyn et al., 1998; First et al., 1990; Korr and Joseph, 1995; Lehman et al., 1997; Morse et al., 1992; Morse et al., 1997*), heavy use of mental health services (*Lafave et al., 1996*), repeated hospitalizations (*Dincin et al., 1995*), offenders who had mental health problems (*Wilson et al., 1995*), who were considered underserved (*D'Ercole et al., 1997*) or who were part of a specific diagnostic sub-group such as schizophrenia or affective disorder (*Bond et al., 1990*). • Level 3 – three studies.
	• Services must establish alternative approaches to identify and serve consumers that reflect varied consumer needs (for example, differing life stage needs, cultural or linguistic needs). Methods of outreach and identification must be adapted to meet varying needs.	• Level 2 – six studies (2 ICM, 4 ACT). • Level 3 – one study (ACT). • Studies involved programs that targeted and engaged in outreach to consumers with specific service needs, such as those requiring continuous mental healthcare in the community (*Kuno et al., 1999*), considered most difficult to treat (*Galster et al., 1994*), in need of regular

Appendix F: *continued*

Function	Standard	Evidence for Standard
Outreach and Consumer ID (continued)		home visits (*Bond et al.*, *1991a*), underserved relative to service needs (*Bond et al.*, *1990; Witheridge*, *1991*) or had high rates of re-hospitalization or difficulties in community living (*Bush et al.*, *1990*). • There was no explicit evidence in the literature that these programs were reaching out to consumers in the "least intrusive manner possible" although this was assumed given the tradition of how case management services are delivered in the community.
	• All organizations must have a documented intake process including criteria to determine eligibility for service.	• Level 2 – ten studies (2 ICM, 7 ACT, 1 similar to ICM). All programs had very specific eligibility or admission criteria. Some used standardized assessment instruments to determine if consumers met eligibility criteria (*Bond et al.*, *1991b; Calsyn et al.*, *1998; Morse et al.*, *1992*). In others, eligibility criteria included a formal diagnosis by a trained professional (*Bond et al.*, *1988; Drake et al.*, *1998; Hoult and Reynolds*, *1984*). • Level 3 – one study in which recognized experts (program managers and case managers) identified the need for ICM to have specific admission criteria (*Schaedle and Epstein*, *2000*).
	• The intake process must be initiated within 10 working days after initial contact.	• Level 2 – two studies (1 ICM, 1 ACT). In the ICM program, consumers were assessed immediately upon admission to the program (*Hoult and Reynolds*, *1984*). The other study found ACT staff assessed consumers to determine eligibility within 72 hours of hospital admission (*Dincin et al.*, *1995*).
	• Every organization must develop a plan to manage its waiting list, which must be reviewed on an annual basis.	• Level 4 – based on expert opinion.

Appendix F: *continued*

Function	Standard	Evidence for Standard
Outreach and Consumer ID (continued)	• If referral to additional services or diversion to another service is recommended, the referral must be developed in consultation with the consumer.	• Level 4 – based on expert opinion.
Assessment and Planning	• Upon completion of the intake process, an agency standardized needs assessment for service must be initiated within 10 working days.	• Level 4 – based on expert opinion.
	• A comprehensive, individualized service plan must be developed mutually by the case manager and the consumer and reflect the stated goals and needs of the consumer. The plan should include strategies for managing crises, and outline a timeframe for goal attainment.	• Level 2 – nine studies (4 ICM, 4 ACT, 1 similar to ICM). Studies emphasized the involvement of consumers in the service planning process and focusing on plans that will enhance the consumer's life in the community (e.g., *Aberg-Wistedt et al., 1995; Hoult and Reynolds, 1984; Morse et al., 1997*). • Level 3 – six studies. Identified collaboration between case managers and consumers in service planning as a critical ingredient of effective services (e.g., *Rapp, 1998; Schaedle and Epstein, 2000*).
	• The service plan must identify other services and resources if required to address the full range of a consumer's needs.	• Level 2 – 12 studies (5 ICM, 7 ACT). Identified linking consumers to services outside the case management program as an integral part of the case management role (e.g., *Hoult and Reynolds, 1984; Kuno et al., 1999; Rosenheck et al., 2003*). • Level 3 – three studies (2 ICM, 1 ACT). Experts identified coordination and liaison with other community agencies as a critical ingredient of effective case management programs (*McGrew et al., 2003; Schaedle and Epstein, 2000*).
Direct Service Provision/ Intervention	• Service provision must be focused in the community, not the office.	• Level 1 – one study showed consumers who received case management at home experienced more positive outcomes than consumers receiving services in the hospital (*Knapp et al., 1994; Muijen et al., 1992*).

Appendix F: *continued*

Function	Standard	Evidence for Standard
Direct Service Provision/ Intervention (continued)		• Level 2 – 22 studies (13 ACT, 7 ICM, 2 other). Described services as being provided in the consumer's home (*Audini et al., 1994; Bush et al., 1990; D'Ercole et al., 1997; Dincin et al., 1995; Galster et al., 1994; Lafave et al., 1996; Marks et al., 1994*), in the consumer's natural environment or *in vivo* (*Bond et al., 1990; Calsyn et al., 1998; Solomon and Draine, 1995; Stein and Test, 1980; Wolff et al., 1997*) or in the community (*Drake et al., 1998; Hoult and Reynolds, 1984; Korr and Joseph, 1995; Salkever et al., 1999*). • Level 3 – eight studies (5 ACT, 1 ICM, 2 other). Experts on case management identified *in vivo* or contact in the community as a critical ingredient (*McGrew et al., 1994; McGrew and Bond, 1995; McGrew et al., 2003; Rapp, 1998; Schaedle et al., 2002*).
	• Service provision must be managed in a manner that responds to fluctuations/ variations in consumer need.	• Level 2 – five studies (4 ICM, 1 ACT). Described programs in which service intensity varied depending on need (*Aberg-Wistedt, 1995; Dincin et al., 1995; Galster et al., 1994; Hoult and Reynolds, 1984; Hu and Jerrel, 1998*). • Level 3 – one study demonstrated that calibrating service intensity of case management based on need can produce positive outcomes (*Sherman and Ryan, 1998*).
	• A case manager-consumer ratio of no more than 1:20 must be maintained where possible.	• Included studies that used case manager-consumer ratios of 1:30 or less. • Level 2 – 17 studies (6 ICM, 11 ACT). The case manager-consumer ratio was described as between 1:10 and 1:15 (*Aberg-Wistedt et al., 1995; Bond et al., 1988; Bond et al., 1990; Bond et al., 1991a; Bond et al., 1991b; Bush et al., 1990; Dincin et al., 1995; Drake et al., 1998; Korr and Joseph, 1995; Lehman et al., 1997;*

Appendix F: *continued*

Function	Standard	Evidence for Standard
Direct Service Provision/ Intervention (continued)		*Macias et al., 1997; Morse et al., 1992*). Other studies described case management programs shown to be effective with case manager-consumer ratios between 1:15 and 1:30 (*Jerrell and Ridgley, 1995; Kuno et al., 1999; Morse et al., 1997*). • Level 3 – eight studies found a relationship between smaller caseloads and more positive outcomes (*King et al., 2000; Sherman and Ryan, 1998*) and reported expert opinions calling for small caseloads in the range of 10-12 consumers (*Rapp, 1998; Schaedle and Epstein, 2000; Schaedle et al., 2002*).
	• Intensive case management services must be available a minimum of eight hours a day, five days a week.	• Included studies where staff was available at least the minimum number of hours in a regular week (i.e., 40 hrs), although many of the programs shown to be effective in the literature provided around-the-clock services on a continuous basis (i.e., 24 hours per day and seven days per week). In these programs, it appeared that many had regular service hours (i.e., 40 hours per week) supplemented by crisis services if the need arose. There was no indication in program descriptions of the extent that service was provided during evenings and weekends in cases of non-crisis consumer need. • Level 2 – 19 studies (7 ICM, 10 ACT, 1 studied a program similar to ICM, 1 compared an ACT program to ICM program). • Level 3 – four studies (4 ACT). Studies recommended that 24 hour coverage be made available by ACT programs (*McGrew et al., 1994; McGrew et al., 2003; McGrew and Bond, 1995; Rapp, 1998*).

Appendix F: *continued*

Function	Standard	Evidence for Standard
Direct Service Provision/ Intervention (continued)	• Written protocols must be established for consumers to access service/ support in off-service hours, seven days a week, 24 hours a day, and should be documented in consumer service plans as part of emergency/crisis planning.	• Ample evidence in literature of effective programs that provide some form of service back-up in off-service hours seven days a week, 24 hours a day. In some cases, the back-up is provided by the case management program and, in other cases, back-up is arranged with another service. There is no indication in the program descriptions if they had written protocols that were documented in consumer service plans. It is likely that these programs have documented procedures in place to respond to consumer crises. • Level 2 – 16 studies (6 ICM, 10 ACT). In the studies on the ICM programs, 24 hour coverage was provided by program staff who were on-call (*Aberg-Wistedt et al., 1995; Audini et al., 1994; Bush et al., 1990; Galster et al., 1994*). • Level 3 – six studies. Reported findings of expert opinion suggesting that 24 hour coverage was a necessary service ingredient for case management to be effective (*McGrew et al., 1994; McGrew et al., 2003; McGrew and Bond, 1995; Rapp, 1998; Schaedle et al., 2002; Schaedle and Epstein, 2000*).
	• The agency will ensure that front line staff are trained in a variety of issues, to the best extent possible, (e.g., suicide intervention; safety standards for working in the community; non-violent intervention; anti-racism training; psycho-social rehabilitation; identifying addictions; multicultural sensitivity; family dynamics; psychiatric symptomatology and psychiatric medications) supported through professional development agreements.	• Level 2 – two studies. Training of case managers was not typically described in program descriptions in articles. Only two studies indicated that some form of systematic training of case managers took place in a variety of areas but not specifically those indicated above in the service standard (*D'Ercole et al., 1997; Hoult and Reynolds, 1984*).

Appendix F: *continued*

Function	Standard	Evidence for Standard
Direct Service Provision/ Intervention (continued)	• To ensure consistency of service provision, services should be provided by a primary case manager, to the extent possible.	• Level 2 – nine studies (5 ICM, 2 programs approximating ICM, 2 ACT). In the ICM studies, case managers were given primary responsibility for individual consumers and worked relatively independently with them (*Aberg-Wistedt et al, 1995; Hoult and Reynolds, 1984; Kuno et al., 1999; Macias et al., 1997; Marks et al., 1994; Muijen et al., 1992; Stanard, 1999*). • Level 3 – five studies in the form of expert opinion identified the assignment of case managers to specific consumers as a critical ingredient for ACT programs (*McGrew and Bond, 1995; Rapp, 1998*) or ICM (*Schaedle and Epstein, 2000*), or both ACT and ICM (*Schaedle et al., 2002*).
Monitoring, Evaluation and Follow-up	• Consumers will participate in a review of their service plan at least annually. A senior staff member or supervisor should also review the plan annually.	• Level 2 – one study (ICM). The ICM program described in the study, consumers met regularly with their case management team and were personally involved in the decision-making about their rehabilitation plan (*Aberg-Wistedt et al., 1995*). There was no indication if consumer received a written review of their service plan or if senior staff were involved in the review of consumer service plans.
	• Consumer satisfaction (including consumers, families and outside agencies) must be surveyed regularly, and the results used to make service improvements.	• Level 2 – three studies were found to have examined satisfaction of consumers and relatives, of which two involved ICM programs (*Aberg-Wistedt, 1995; Bond et al., 1990; Hoult and Reynolds, 1984*).
	• All organizations and agencies must evaluate some aspect of their programs annually using best practices and published standards.	• Level 2 – two studies (2 ACT). It should be noted that up until now there have not been best practices or standards identified for ICM programs. In one study, program staff reviewed each case every three months to verify changes in housing status and hospitalization (*Korr and Joseph, 1995*).

Appendix F: *continued*

Function	Standard	Evidence for Standard
Monitoring, Evaluation and Follow-up (continued)		In the other study, researchers assessed the fidelity of program implementation using the Darmouth Assertive Community Treatment scale (*Resnick et al., 2003*).
	• A written discharge plan must be developed upon completion of service that would include criteria for follow-up, re-entry and linkage with other services.	• Level 4 – based on expert opinion.
	• Written protocols must be developed for a complaint process to receive and act upon the concerns of consumers, families and other organizations. Consumers must be informed of this process.	• Level 4 – based on expert opinion.
	• An annual review of standards management must be undertaken (including implementation and compliance).	• Level 4 – based on expert opinion.
Information, Liaison, Advocacy, Consultation and Collaboration	• The service provider agency must develop partnership or service agreements with other agencies or community services or primary care providers to ensure continuity of service provision.	• Level 2 – one study included a Daily Living Program in England, (approximates ICM) that liaised with relatives, friends, neighbourhoods, social services, landlords, housing authorities, public utilities, lawyers and prison officials (*Marks et al., 1994*). It is possible other programs shown to be effective in the literature also had service agreements but these were not described in the published articles on them.
	• The case manager must be knowledgeable about services that are accessible and relevant to consumer interests in order to provide up-to-date information.	• Level 4 – based on expert opinion.

Appendix F: *continued*

Function	Standard	Evidence for Standard
Information, Liaison, Advocacy, Consultation and Collaboration (continued)	• The case manager must also advocate, on behalf of the consumer, for services that are accessible and relevant to the consumer's needs.	• Included studies on programs that engaged in advocacy on behalf of the consumer. • Level 2 – seven studies (2 ICM, 4 ACT, 1 similar to ICM) defined the role of case manager as including consumer advocacy to assist obtaining needed community resources such as housing, employment and financial resources (*Bond et al., 1990; Bush et al., 1990; Macias et al., 1997*). • Level 3 – one study provided expert opinion about critical ingredients of case management services (*Witheridge, 1991*).
	• The service provider agency must develop a written plan that identifies community resources, links to be established and staff training requirements. The plan must be reviewed annually for appropriateness.	• Level 4 – based on expert opinion.

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