

The ICM Approach - Making a Difference with Families in Christchurch

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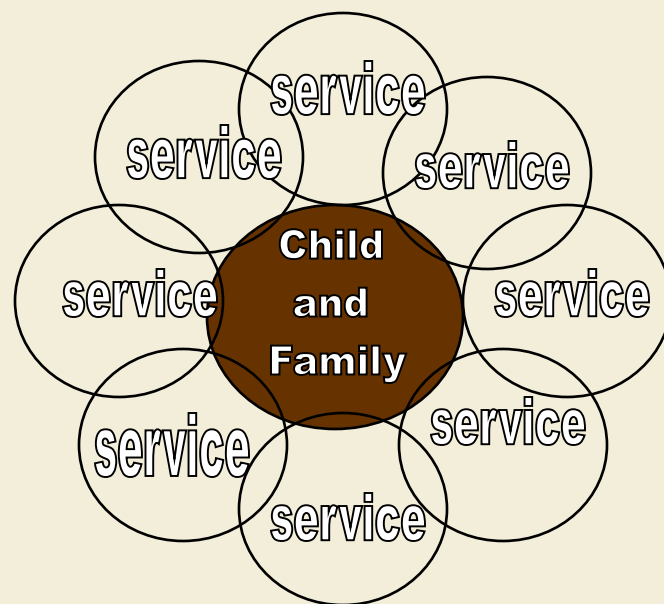
Canterbury
District Health Board
Te Poari Hauora o Waitaha

Intensive Case Management
(ICM) team



Systems of Care *(Stroul & Friedman 1986)*

- Child centered and family focused
- Community based
- Culturally competent





Wraparound *(Burnes & Goldman 1998)*

- Community-based
- Individualized and Strengths based
- Culturally competent
- Family voice and choice
- Team driven
- Flexible resources
- Natural supports
- Persistence/
continuation of care
- Collaboration
- Outcome based



Our Philosophy

to create a system of care that will utilise

- Intensive interventions
- Needs focused individual interventions
- Holistic approach
- Eclectic methods of interventions
- Flexible interventions



— Intensive Case Management Team Operation Manual
— (Canterbury District Health Board, 2001)



Our Service

- **Small** well resourced team with low case loads
 - 3 Case Managers, Consultant Psychiatrist, Researcher, Administrator and Family Rep
 - 15 to 30 clients at any time
- **Hours** Monday to Friday 8:30 - 5:00, flexible
- **Based** at TPMH with community service delivery
- **Supported** by Welfare and Health joint funding, Cross Sector Reference Group, Service Delivery Unit Meetings (Senior Management level), Mem. Of Understanding, Service-user Leadership



Our Referrals

- Active client of CYF and CAF Mental Health Service
- Complex needs that require multi-agency involvement and the current level of inter-agency collaboration is unable to meet those needs
- **Moderate to Severe Mental Health Diagnosis**
(excluding conduct related disorders, substance use disorders and personality disorders as the main diagnosis).
- **Strengthening Families process results in a recommended referral to ICM**
- **The family and young person consent to ICM involvement**



Our Clients

- Enthusiastic, good sense of humour, many hobbies, interests and individual strengths
- Number of significant supports in their lives
- But... affected by trauma, multiple caregivers or numerous residential and educational placements
- Most have severe problems with emotional symptoms, peer and/or family relationships
- Most have severe functional impairment in school, at home, and/or behaviour toward others
- On average 7 different agencies involved – some with competing demands and conflicting advice



Principals of Intervention Process

- Compassionate
- Individualised
- Family Centred
- Strengths Based
- Needs Driven
- Culturally Competent
- Outcomes Focused
- Flexible
- Community based



Intensive Case Management Team Operation Manual
(Canterbury District Health Board, 2001)



GOALS ICM System of Care

- To create an individualised system of care that is strengths based/needs focused
- Work with the family, supports and services involved to facilitates and co-ordinates a single individualised plan that will sustain the system of care around the young person, his or her family/whanau/caregivers and key supports without ICM



Engagement and Team Preparation

(nee Assessment)

- Engagement with client, family, formal and informal supports including peers and key community partners
- Preparation for ICM process and exploring expectations of all parties
- Comprehensive psycho-social understanding of historical and current information developed
- Mental Health, Welfare, Education, Family, and Systemic domains
- Identification of strengths, needs and goals



Initial ICM Plan Development

- A single plan built on strengths
 - Addresses needs identified
 - Uses creative solutions
 - Aims for sustainable change
 - Goal driven NOT time limited
- Individualised Inter-Agency Team (IIAT)
 - Actions ICM Care plan - one **SINGLE** document
 - Supported by a Memorandum of Understanding between agencies and a number of collaborative initiatives





Plan Implementation

- IIAT Meetings
 - Team meets approx six weekly to review progress
 - Communicates regularly to ensure timelines are met
 - Transforms Collaboration into an Integrated System
- Flexible Funding
 - Supports treatment goals where no other funding is available
 - Aims to enable sustainable change and to empower
 - *E.g. increase therapeutic input, provide opportunities for new learning experiences, academic tuition, budgeting, social skill enhancement, parental psychotherapy*



Transition - Discharge from ICM

- The system of care is sustainable without ICM
 - The client and/or family is the lead agent of their system of care team, or they have appointed someone else
- The young person and family no longer want ICM involved
- And/Or, the young person is no longer a client of both Welfare (CYF) and Child and Adolescent Mental Health (CAF) services



ICM Outcomes

- Strengths

- ❖ Increased caregiver satisfaction with service delivery

- ❖ Fewer agencies involved

 - 75% referred to GP for mental health*

 - 60% no longer CYF clients*

- ❖ Increased caregiver rated strengths (BERS)

- ❖ Reduced symptoms and impairment

 - Significantly reduced CBCL, YSR, and HoNOSCA*

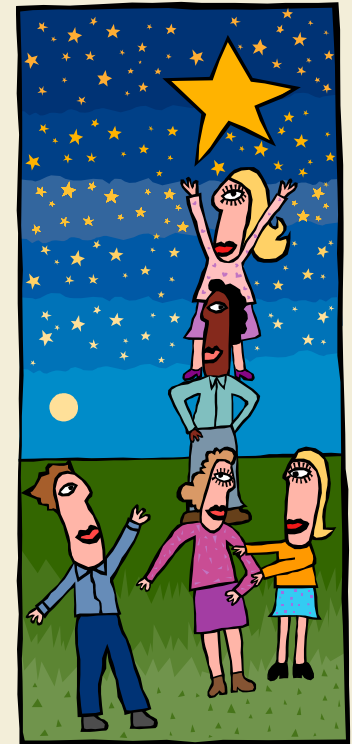
 - Fewer diagnoses including primary diagnoses*

 - Fewer on medication 53% compared to 75%*

- ❖ Increased functioning in life domains (CAFAS)

- Needs/Goals

- ❖ education/vocation and residential stability





Many thanks for your interest

QUESTIONS