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Integrated Case Management of Employment and Social Welfare Users in the Western Balkans – Guidelines and Good Practices

(Albania, Bosnia and Herzegovina, former Yugoslav Republic of
Macedonia, Kosovo*, Montenegro and Serbia)

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*This designation is without prejudice to positions on status, and is in line with UNSCR
1244/1999 and the ICJ Opinion on the Kosovo* declaration of independence.



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Table of Contents

Abstract.....	4
1. Introduction	5
2. The current status and practices of integrated case management	6
3. Examples of good practices in EU countries	7
3.1. The one-stop shop of the NAV Reform (Norway)	9
3.2. Cooperation in cases of clients with complex problems (Slovenia)	12
3.3. Digitalised case management (Denmark).....	14
3.4. Coordination Associations (Sweden).....	15
4. Steps and tools for improving cooperation and policy delivery	16
4.1. Partnership principles and Codes of Cooperation.....	22
4.2. Proposals for the joint management of interventions	25
4.3. Critical questions for analysing innovative practices	27
5. Toolkit for ICM implementation	32
5.1. ICM working definition	32
5.2. Case managers.....	33
5.3. The qualifications and experience required of case managers.....	34
5.4. The step-by-step model.....	36
5.5. Protocols for the development of individual plans	38
5.6. Code of Ethics	40
List of Tables	43
List of Boxes	43
References	44

Abstract

The Guidelines and Toolkit presented here are intended to assist Public Employment Services and Centres for Social Welfare in the Western Balkans to build up integrated case management systems. Integrated case management is understood as an innovative practice which is employed especially by these two institutions collectively to serve the most vulnerable with all available resources from both the labour market and the social assistance system, and even beyond. To enhance the inclusiveness of labour markets, the engagement of other actors is also necessary. The guidelines thus recommend the setting up of integrated case management systems that are embedded in partnership structures. The toolkit, an integrative part of this paper, furthermore offers all necessary resources to provide a quick reference resource for policymakers during the implementation of integrated case management.

1.Introduction

These ‘Guidelines for cooperation between Public Employment Services and Centres for Social Welfare in the Western Balkans regarding Integrated Case Management for Employment and Social Welfare Users in the Western Balkans’ have been developed to assist Public Employment Services (PES) and Centres for Social Welfare (CSWs) to establish integrated case management systems embedded in partnership structures. The guidelines build on the ‘Comparative Report on Integrated Case Management for Employment and Social Welfare Users in the Western Balkans’ (hereafter ‘the Comparative Report’). The guidelines should also serve to support other partners, including policymakers, the private sector and civil society organisations (CSOs) in their efforts to increase the inclusiveness of their labour markets in all Western Balkan territories, i.e. Albania, Bosnia and Herzegovina, former Yugoslav Republic of Macedonia, Kosovo*¹, Montenegro and Serbia.

The Guidelines begin with a summary of the current policy, institutional and legal frame and the practices applied in the Western Balkans followed by examples of good practices of integrated case management implemented in EU countries, selected on the basis of their successful implementation and/or their potential for transferability. The guidelines conclude by outlining the necessary steps to be taken by local/regional actors and by presenting tools for improving cooperation and policy delivery, with a template for a model contract (partnership contract), proposals for the joint management of interventions, partnership principles and codes of cooperation, as well as critical questions for analysing innovative practices. The guidelines section is followed by a comprehensive toolkit presented for the use of PES and CSWs practitioners and policymakers.

¹ References to Kosovo* shall be understood to be in the context of Security Council Resolution 1244 (1999).

2. The current status and practices of integrated case management

The status quo regarding current practices of integrated case management in the Western Balkans was analysed during the period from June to August 2017 and the findings of this analysis are presented in the Comparative Report.²

Integrated case management is understood as an innovative practice employed by the PES and CSWs in the countries collectively to serve the most vulnerable with all available resources within both the labour market and the social policy system, and even beyond (see the Comparative report on the “integrated policy frame”). The extent to which case management is practised in the Western Balkans is limited. It seems that the social policy system and the labour market system operate separately from one another. Where case management is practised it refers either to the labour market policy system or to the social policy system. There is no implementation of a *collective* and *integrated* case management system that makes best use of all available resources in helping clients throughout the entire integration and inclusion process. Essential elements of case management are found only in the Social Mentoring Programme implemented in five pilot regions in FYR Macedonia. The Comparative Report highlights the need for integrated case management on the following grounds: 1) the PES and CSWs often ‘share’ the same users; 2) the PES and CSWs could have a common rationale for collaboration, i.e. to best serve those in need with all available resources (know-how, measures, services); and 3) partnerships between the PES and CSWs are supported by legal and policy frames in most countries.

The recommendations provided in the Comparative Report emphasise the need for the building up of partnerships, i.e. practised collaboration, especially at the interface of labour market and social policy, to deliver integrated services. The Territorial Employment Pacts (TEPs) set up in some regions of the Western Balkans as part of a UNDP project are well suited to enable institutional changes at local level. For this reason, it is recommended that TEPs or other forms of local employment partnerships be established, depending on the local context. Such partnerships could assist in the implementation of integrated case management, with verified priority-setting across the countries according to the needs of vulnerable groups in the

² The Comparative Report covers all the territories of the Western Balkans except for Bosnia and Herzegovina. (Bosnia and Herzegovina was not included due to the lack of an expert interview and the unavailability of background information on this country.)

diverse local/regional/national contexts (variations include different levels of social capital available in different regions, with diverse (proactive) local actors and institutions at various locations, different legal frameworks and available sources of funding). Across the Western Balkans, these partnerships could provide an overall setting for the implementation of locally modified integrated case management actions for socially excluded clients in the various countries.

Analysis of the macro (policy level), meso (organisational level) and micro level (beneficiary level) has shown that much remains to be done for partnerships to flourish at the interface of labour market and social policies. The two systems, i.e. the PES and CSWs, should be interconnected instead of operating separately as 'policy silos'. It is necessary to increase flexibility and remove any barriers that hinder collaboration between these institutions. In addition, the workflow processes within the PES and CSWs need to be improved. Here, a need for knowledge-sharing and exchange of practices has been identified. To assist the setting up of case management systems, the implementation of a comprehensive capacity-building, training and partnership programme is recommended. Finally, there is a need to place beneficiaries at the centre of any cooperative activity.

To sum up, the Comparative Report shows there is a lack of well-established partnerships practising integrated case management in the Western Balkans and the report recommends the establishment of TEPs as a model well-suited for providing an overall setting for the implementation of locally modified integrated case management actions in the various contexts.

3. Examples of good practices in EU countries

Examples of good practices implemented in EU countries can assist in the process of setting up integrated case management in the Western Balkans. The brief descriptions of cases identified and presented in this chapter should serve as an initial orientation for improving integrated case management approaches.

The differences and lack of coordination within and between the systems of employment and social protection have long been identified as obstacles to ensure effective, client-centred support for job-seekers including career development opportunities alleviating the overreliance on social assistance. Integrated case management has been widely adopted in many EU countries over the past two decades to overcome shortcomings. However, there are diverse definitions of case management and a variety of approaches adopted in individual initiatives both between and within countries and sectors.

The vast array of experiences of case management from EU states, especially from the Western and Nordic EU member states, but also from new member states such as Slovenia, can serve as a rich resource which the Western Balkans can learn from and adapt appropriately as solutions when designing and improving PES actions and their links with CSWs. The practices identified and described below are relevant for cooperation in the Western Balkans as learning opportunities that include specific interfaces and/or target groups which have been addressed, special curricula and/or training for case managers, strategies for rolling-out or mainstreaming pilot projects, indicators for measuring success or failure, and improvements over time.

The following criteria were defined for selecting examples of good practice from the various experiences of initiatives across Europe:

- ❖ The practices need to address at least the interface between PES and agencies for social assistance clients.
- ❖ The practices need to address relevant case management issues pertinent to the Western Balkan territories.
- ❖ The practices need to have moved beyond the status of pilot projects aimed at single target groups.
- ❖ The practices need to have adopted general features of the case management cycle.
- ❖ The practices need to have a high degree of potential transferability.
- ❖ The practices need to have shown empirical evidence of their efficacy and efficiency or of improvements in efficacy and efficiency achieved through impact assessments and/or observations.

Four examples of good practice were selected. These initiatives are briefly outlined below.

3.1. The one-stop shop of the NAV Reform (Norway)

Title	NAV Reform – One-stop shops
Country	Norway (implemented across all municipalities)
Rationale <i>What were the reasons for starting this initiative? Which interfaces or gaps does the initiative address? For which target groups?</i>	In Norway the division between employment and social welfare administrations and services has been a major challenge. Norwegian policy-makers perceived the separate administration of pensions (including disability pensions) as a major obstacle to the effective implementation of strategies for activating workers rather than paying (disability) pensions or social assistance benefits. By merging three institutions – i.e. employment services and pension administration at national level, social welfare offices at local level – all service staff in one-stop shops would be able to provide a more integrated service with a larger array of solutions for individual cases.
Type/level of intervention	Multi-level governance reform based on ‘mandatory partnership agreements’
Status	Widespread practice/rolled-out practice
Stakeholders involved	The central government (responsible ministries); the Norwegian Parliament; the Association of Local and Regional Authorities; national social insurance and employment services - the Norwegian Welfare and Labour Service (NAV), with c.16,000 employees in 2011; and municipal welfare offices, with c.4,000 employees. State services are responsible for some €30 billion annually, amounting to a third of the total national budget. Altogether, NAV serves c.2.8 million people as its users or clients, amounting to roughly half the Norwegian population. Local one-stop shops have been established at municipal level. The larger organisation, the Norwegian Welfare and Labour Service (NAV), is represented at three administrative levels: national, regional and local. At national level, two central agencies for employment and pensions (i.e. the Directorate of Labour and the National Insurance Administration) have been merged to form a new Directorate for Labour and Welfare. At municipal level, the administration of social services has been included (Læg Reid & Rykkja, 2013: 7f.).
Objectives	This new type of multi-level governance aims at making services seamless for service-users at local level. The overall goals are <ul style="list-style-type: none"> • to increase the size of the working population through activation and to reduce the number of people dependent on welfare benefits; • to make services more accessible and user-friendly; and • to increase the efficiency of employment and social welfare administration.
Activities, methods and funding	In 2006 the Norwegian government implemented a reform of the Employment and Welfare Administration (NAV) by merging the national insurance and PES administrations. Although the administration of social services (social assistance) remained a local government responsibility (following intense negotiations), the reform established a one-stop shop as a joint front-line service in each municipality (Askim et al., 2014).

A written partnership agreement was signed between the municipalities and the central government. Local governments could thus choose which other municipal social services, in addition to social benefits, could be included in the 'NAV office'.

Initially, the local office had to provide - as a minimum - economic social benefits and advice in addition to state tasks (pensions and employment services). Later, housing and debt counselling were also added. Most municipalities opted to add extra services. The optional municipal functions included in the partnerships vary substantially. The most common tasks added are treatment of alcohol and drug abuse, immigration/refugees, psychiatric healthcare and child welfare. Some partnerships have also evolved their own specific aims for the local one-stop shops. Joint premises were a requirement. A minority of the one-stop shops were co-located with other local government services.

A unitary management model, in which one person is in charge of both the state and the municipal side for the partnership, was recommended but not made mandatory. Nevertheless, the unitary model has been implemented in 9 out of 10 cases. Most local offices have chosen an organisation that represents a continuation of their previous specialisation. A few offices have developed an organisational design based on integration of services, where different forms of specialisation are combined with interdisciplinarity and a matrix organisation. Most of the largest cities have chosen a dual management model.

The establishment of one-stop shops reallocated and simplified the division of labour, rearranged the hierarchy by merging organisations. New lines of control were established as general guidelines, including voluntary arrangements by the local NAV offices. The establishment of one-stop shops was however mainly based on hierarchy, with the main goals intentionally designed and controlled from the top. Guidance, control and evaluation, as well as the role of government, is mainly top-down. At the same time, the arrangement is subject to both bureaucratic and political hierarchical control.

To date, there are a total of 457 local NAV offices and 19 county offices (Lægreid & Rykkja, 2013). An important instrument in this reform has been the introduction of case work and case management offering a broader support portfolio. This entailed intensive (re-)training of staff and the development of structural solutions incl. standardized rules, IT systems and related software.

Challenges

This reform has been one of the largest in Norwegian history. It faced a wide range of challenges concerning coordination, partnership arrangements and other issues related to the complexity of merging diverse types of organizational cultures (Christensen et al., 2013), e.g. reactive approaches in providing pensions (pension agencies) as against activation approaches in PES. The establishment of one-stop shops was not only a joining-up at the base. The NAV reform also involved joining-up at the top through the establishment of a new Employment and Welfare administration under the Ministry of Labour. This led to ambiguous accountability relations, since NAVs report both to municipalities and to central government. The establishment of the NAV offices was thus largely a case of policy design from the top of a comprehensive and structural reform.

**Achievements
(Impact)**

What were the demonstrated effects on job-seekers, organisation/ inter-organisational collaboration, costs?

The reform tried to overcome existing fragmentation but could “hardly be characterized as an unqualified success” (Christensen et al., 2013, p. 15). General case management includes needs clarification, assessment of the beneficiary’s ability to work, and the construction of an activity plan. This has certainly helped support multi-service users but has probably been too broad to cater for those service users who only need one specific type of benefit or service. As a result, some decision-making has been transferred to specialized units at regional level. For the most vulnerable groups this reform has improved the possibilities of getting back into work, since it is now easier for social workers (and other case managers) to work across sectors. It still seems to be too early to assess the results of the reform, however, as many effects of the reform may only become clear over a longer period.

Transferability

National contexts play a significant role with regard to transferability. Compared to the long tradition of social insurance and welfare services that have developed separate from one another in Norway, for the Western Balkans it is important to take the concept of integration on board. Once the division of tasks has been established it will become “a challenge to create a new cultural identity based on three rather different, sector-based cultures with a long and separate previous history” (Lægreid & Rykkja, 2013, 11). It is certainly more complex and costlier to organize change by merging three long established institutions, such as the pension administration, employment services and local social welfare offices in Norway, than to design cooperation between “younger” organisations, which would provide an opportunity in the Western Balkans.

Another issue concerns the balance between the generalist role of a case-worker and the need to provide specialist knowledge with a view to productivity and effectiveness. Since both aspects are needed, appropriate pathways for different client groups are to be designed, as well as appropriate mechanisms to ‘triage’ clients according to their needs (‘support scenarios’). This could be achieved by the use of online questionnaires, though – as experiences in Norway have shown – it would be more appropriate to do so through case-workers. It remains a challenge to strike the right balance in terms of the proximity between case-workers and clients, and the use of ICT systems (including call centres) as against face-to-face meetings. Finally, it is important to remain flexible and adaptable during the reform process.

To conclude, the following features need to be considered when transferring this model to the Western Balkans:

- One-Stop-Shops are useful for specific client groups that need to be well defined and identified (standardized for clients with multifaceted requests and/or potential, face-to-face interviews, online tools).
- One-Stop-Shops at local/municipal level need to be supported by regional and national authorities.
- The staff of One-Stop-Shops need to be trained in case management and activation methods.
- The staff of One-Stop-Shops need to be able to offer a wider range of alternatives to pensions and/or benefits, e.g. training/activation, services in kind, entrepreneurial alternatives etc.

Sources, links to docs/websites
References, recommendations for further reading (literature, web links)

Askim, J., Fimreite, A.L., Moseley, A. and Holm Pedersen, L. (2011). One Stop Shops for Social Welfare: The adaptation of an organisational form in three countries. *Public Administration*, 89(4), 1451–1468.

Læg Reid, P. and Rykkja, L.H. (2013). *Coordinating Norwegian Welfare: The NAV Reform*. Bergen, University of Bergen (COCOPS Paper, www.cocops.eu).

Christensen, T., Fimreite, A.L. and Læg Reid, P. (2013). Joined-up government for welfare administration reform in Norway. *Public Organization Review*, DOI 10.1007/s11115-013-0237-8, 1–19.

Christensen, T. and Læg Reid, P. (2011). *Competing principles of agency organization – the reorganization of a reform*. Bergen, Stein Rokkan Center for Social Studies (Working Paper 8).

3.2. Cooperation in cases of clients with complex problems (Slovenia)

Title	Cooperation in cases of clients with complex problems
Country	Slovenia (implemented across all regions)
Rationale	<p>PES and the CSW staff hold regular meetings to jointly discuss cases of unemployed clients with complex problems that cannot be solved by the PES on its own (e.g. drug or alcohol abuse, mental health problems, serious social problems). They have set up committees made up of experts from the two organisations and rehabilitation specialists.</p> <p>An unemployed person who is presumed to have problems with addiction, mental health and/or other major social problems is referred to a special inter-institutional committee. The proposal for such a referral is submitted by an employment counsellor at the local Employment Office. The committee consists of at least three members: an employment counsellor, a social worker and a rehabilitation counsellor. In cases involving specific problems, experts from other fields of expertise may be involved. The committee members are appointed jointly by the head of the Employment Office where the person concerned is registered and the director of the relevant CSW. The committee meets twice a year. It assesses the unemployed person's problems, submits its opinion concerning the reasons for the person's temporary inability to work, and proposes measures and activities aimed at the quickest possible improvement in the unemployed person's employment opportunities. Prior to preparing its own opinion, the committee may if necessary obtain an opinion from a medical doctor regarding the person's health conditions. The relevant CSW and the unemployed person are then informed of the committee's opinion. If the committee is of the opinion that the unemployed person needs help/support aimed at the elimination of his/her social problems or distress prior to his/her active participation in the labour market, on the basis of the agreement recorded in the</p>

	<p>Employment Plan the person is referred to the relevant CSW. The Employment Plan also contains a deadline for the unemployed person to appear at the CSW for further treatment. Once the personal problems are solved, the CSW informs the Employment Office and instructs the unemployed person to report to the Employment Office. (Stropnik, 2015)</p>
Type/level of intervention	<p>Micro and meso level, based on national guidelines and policies at macro level.</p>
Stakeholders involved	<p>Three actors are involved: the national, regional and local offices of the PES of Slovenia, regional and local offices of the CSW, and the Slovenian Human Resources Development and Scholarship Fund. (The Fund performs activities such as life-long career orientation, on-the-job placement, job-sharing and education and training based on a contract with the respective ministry.)</p> <p>The actors cooperate at national and local level. CSWs deliver cash social assistance and provide assistance for social activation. The cooperation of the PES of Slovenia and the CSWs in the provision of labour market services and active labour market policy measures is included in both the Labour Market Regulation Act and the Social Assistance Benefits Act. There are 62 CSWs, organised according to the territorial (residence) principle, and 59 Employment Offices that are open to all persons in Slovenia. This leads to situations where a single Employment Office cooperates with several CSWs. For instance, the Ljubljana Employment Office cooperates with five CSWs in the territory of the Municipality of Ljubljana, which includes participation in 5 inter-institutional committees.</p> <p>Cooperation between the Employment Service of Slovenia (its Employment Offices) and the CSWs is facilitated by an information system. Their registers are linked and allow an effective exchange of two sets of relevant data: whether the person is included in the Register of Unemployed Persons and whether they are a beneficiary of social assistance in the form of cash. The data are refreshed at the e-Sociala portal every night.</p>
Achievements	<p>The effectiveness of cooperation between employment, social assistance and social services and the extent of individualized support is reported to be “very good”. However, a lack of vertical support and coordination on the part of the CSWs is also reported (Stropnik, 2015).</p>
Status	<p>Widespread practice/rolled-out practice</p>
Transferability	<p>This form of institutional cooperation does not require major financial investment but can contribute to knowledge exchange and thus to a more effective service offer to clients. The model is regarded as useful for further investigation of transfer to the Western Balkans, since countries in this region can build on forms of cooperation already in place (See Deliverable 1).</p>
Sources, links to docs/websites References, recommendations for further reading (literature, web links)	<p>Stropnik, N. (2015). ESPN Thematic Report on Integrated Support for the Long-Term Unemployed: Slovenia. European Commission. Link: ec.europa.eu/social/BlobServlet?docId=14283&langId=en</p> <p>Scharle, A., Csillag, M., Carta, E. and Hughes, P. (2016). Practitioner’s Toolkit to Assist the Implementation of the LTU Recommendation. European Commission. Link: ec.europa.eu/social/BlobServlet?docId=17024&langId=en</p>

3.3. Digitalised case management (Denmark)

Title	Digitalised case management
Country	Denmark (covering nearly all municipalities)
Rationale <i>What were the reasons for starting this initiative? Which interfaces or gaps does the initiative address? For which target groups?</i>	Danish multidisciplinary teams use digitalised case management that provides access to all stakeholders involved in the support of clients. Not only municipal departments but also external experts can access and edit these digital profiles, which significantly enhances the transparency of the actions taken by the stakeholders. The claimants are required to submit job applications and upload these to a job log (jobnet.dk) that is part of the file on the person. The data protection policy is an integral part of this scheme and is publicly available. The Ministry of Employment also runs an online database (jobindsats.dk) with information on social security and activation for everyone in Denmark. Anybody can assess the database. Municipalities can, for example, see how they are performing in comparison with other municipalities or the country average on any dimension of their work, such as the number of persons activated or social assistance.
Type/level of intervention	Micro and meso level
Stakeholders involved	Job centres, municipalities, the Ministry of Employment, the Agency for Labour and Recruitment, the Danish Agency for Labour Market and Recruitment (STAR), the Data Protection Agency, the Ministry for Children and Social Affairs, Ministry of Education and the Ministry for Equality, unemployment funds, training and activation providers, Statistics Denmark
Achievements <i>What were the demonstrated effects on job seekers, organisation/ inter-organisational collaboration, costs?</i>	Job centres are the single point of contact (one-stop shop) for the long-term unemployed receiving unemployment insurance benefits, temporary benefits and social assistance. There are 94 job centres in Denmark's 98 municipalities. Almost all municipalities have a job centre and some municipalities have joint job centres. Jobnet has approximately 2 million visitors a month. There is a high degree of autonomy, combined with strong performance incentives (a transparent benchmarking system).
Status	Widespread practice/rolled-out practice
Transferability	Digitalised case management could be used in other countries at different levels of integration of the PES and CSWs. It enhances coordination between stakeholders and enables the monitoring of outcomes and the quality of services.
Sources, links to docs/websites <i>References, recommendations for further reading (literature, web links)</i>	Jobnet: https://job.jobnet.dk/CV/Frontpage Kvist, J. (2015). ESPN Thematic Report on Integrated Support for the Long-term Unemployed: Denmark. European Commission. Link: ec.europa.eu/social/BlobServlet?docId=14251&langId=en Scharle, A., Csillag, M., Carta, E. and Hughes, P (2016). Practitioner's Toolkit to Assist the Implementation of the LTU Recommendation. European Commission ec.europa.eu/social/BlobServlet?docId=17024&langId=en

3.4. Coordination Associations (Sweden)

Title	CA - Coordination Associations (<i>Samordningsförbund</i>)
Country	Sweden (covering all counties and nearly all municipalities)
Rationale <i>What were the reasons for starting this initiative? Which interfaces or gaps does the initiative address? For which target groups?</i>	CA is a voluntary scheme at local level, aiming to facilitate institutional coordination between the PES, the social and health sector and municipalities. CAs are independent legal entities and are led by a local political board. CAs harmonize the goals of the participating organisations and launch joint projects (e.g. for the integration of immigrants). They maintain inter-organisational teams in the form of CA Boards that support the reintegration of the long-term unemployed.
Type/level of intervention	Micro and meso level, based on national guidelines and policies (macro)
Stakeholders involved	CA Boards are made up of representatives of the PES, the social and health sector, and political representatives of the municipality and the country council.
Achievements <i>What were the demonstrated effects on job seekers, organisation/ inter-organisational collaboration, costs?</i>	During 2010, CAs financed nearly 600 activities with approximately 34,000 participants. Most of these activities were directed at unemployed persons on sick leave and/or persons aged 16–64 with income support (Arbetsförmedlingen / Försäkringskassan, 2011). Evaluations suggest that inter-organisational cooperation on rehabilitation is perceived as promoting coherence and communication. Nevertheless, inflexible regulations on sickness insurance may be a barrier (Stahl et al., 2011). Potential tensions between actors arising from the divergent definitions of “workability” (i.e. the medical approach versus the social insurance approach) need to be addressed to facilitate effective collaboration (Stahl et al., 2009).
Status	Widespread practice/rolled-out practice. At the end of 2014, there were 85 such associations, incorporating 240 of Sweden’s 290 local municipalities and all counties (Fredriksson et al. 2015).
Transferability	A few issues of concern were raised regarding the transferability of the practice to other national contexts, e.g. the lack of employer involvement (Prins, 2006).
Sources, links to docs/websites <i>References, recommendations for further reading (literature, web links)</i>	Bengtsson, M. (2012). The National Governance of Integrated Social Cohesion Policy. National report Sweden. LOCALISE Project. Link: https://www.uni-oldenburg.de/fileadmin/user_upload/.../WP2_National_Report_s_all.pdf Fredriksson, D. S. S., and Fritzell, J. (2015). ESPN Thematic Report on Integrated Support for the Long-term Unemployed: Sweden. European Commission. Link: ec.europa.eu/social/BlobServlet?docId=14282&langId=en Prins, R. (2006). Integrated Services in Rehabilitation – on the Coordination of Organisation and Financing: Discussion Paper: European Commission. Scharle, A., Csillag, M, Carta, E and Hughes, P. (2016). Practitioner’s Toolkit to Assist the Implementation of the LTU

Recommendation. European Commission. Link:
ec.europa.eu/social/BlobServlet?docId=17024&langId=en

Ståhl, C., Svensson, T. and Ekberg, K. (2011). From Cooperation to Conflict? Swedish Rehabilitation Professionals' Experiences of Interorganizational Cooperation. *Journal of Occupational Rehabilitation*, (21), 3: 441–448.

Ståhl, C., Svensson, T., Petersson, G. and Ekberg, K. (2009). The work ability divide: holistic and reductionist approaches in Swedish interdisciplinary rehabilitation teams. *Journal of Occupational Rehabilitation*, 19(3):264–73. doi: 10.1007/s10926-009-9183-2.

4. Steps and tools for improving cooperation and policy delivery

As set out in the Comparative Report, we recommend implementing integrated case management embedded in partnership structures. Consequently, there is a need to invest in the establishment of partnerships and for investment in improvements where TEPs or similar partnerships already exist.

Partnerships can help not only to improve the workflow processes between PES and CSWs but also provide an overall structure throughout the Western Balkans for the implementation of locally modified integrated case management actions taken in these countries for hard-to-employ clients. The steps to be taken and the tools offered in this section thus mainly refer to integrated case management implemented within partnership structures. Similar steps should also be taken when integrated case management is to be implemented only within a bilateral cooperation structure of PES and CSWs. The difference refers to the signing bodies: PES and CSWs as partners of a formalised cooperation agreement and various actors as partners in a partnership. Both bilateral cooperation and partnerships apply a formalised method of cooperation³.) Although these guidelines' focus is on

³ Please refer to UNDP (2018). Comparative Report on Integrated Case Management for Employment and Social Welfare Users in the Western Balkans. for further information on the forms of relationship, distinguishing between arrangements of two partners and multi-stakeholder activities with strategic and operative orientation

collaboration between the PES and CSWs, both institutions will only succeed in delivering integrated services in the long term if they involve other partners such as NGOs and municipalities. Otherwise, they may fail due to lack of know-how and resources. Our report thus aims to help develop institutionalised cooperation amongst all relevant actors on the ground.

Partnerships apply a *formalised approach to collaboration* by signing agreements. Some disadvantages of such formalised approaches have been recorded, such as inflexibility and excessive administration (Scoppetta, 2013, in reference to the Community of Practice on Partnership in the ESF). Nevertheless, the advantages of a formal approach outweigh these drawbacks and encompass a clear framework and rules for working together, greater partner responsibility, legal power and results orientation (see Table 1).

Table 1: *Advantages and disadvantages of formal and informal approaches*

Formal approach	Informal approach
Advantages	
<ul style="list-style-type: none"> ❖ Clear framework and rules for working together ❖ Greater partner responsibility ❖ Legal power ❖ Results orientation ❖ Links to regional strategies ❖ Ability to influence policy ❖ Increased visibility ❖ Defined goals and short-term targets ❖ Improved monitoring 	<ul style="list-style-type: none"> ❖ Flexibility ❖ Greater participation ❖ Greater creativity /innovation ❖ Nearer to the real problems of citizens ❖ Local-level emphasis
Disadvantages	
<ul style="list-style-type: none"> ❖ Too much emphasis on resources ❖ Excessive administration ❖ Inflexibility 	<ul style="list-style-type: none"> ❖ Unclear focus ❖ Poor definition of roles and responsibilities

Source: Scoppetta (2013), p.15

When building up partnerships to establish integrated case management, the following three main steps are to be taken at local/regional geographical levels in the Western Balkans:

»»» STEP 1: Preparatory work

Preparatory work must be conducted to build the basis for signing partnership agreements. It may be helpful if the *primary partners of an integrated case management system*, such as the PES and CSWs (together with NGOs) first meet and

start discussing their potential collaboration, especially when starting from scratch, and especially in those cases/territories in the Western Balkans that cannot build on existing forms of cooperation. The partnership may be extended soon after these partners have reached agreement on how to work together jointly. The process of preparing the partnership work involves a series of meetings between various partners with a view to the following:

- ❖ discussing problems of social exclusion and employment, and especially specific causes of unemployment, as well as the strengths and weaknesses of the areas and regions concerned and possible ways of improving the situation and encouraging job access and creation for vulnerable groups. (It is necessary to take into account experiences of existing practices, such as the local social and employment planning processes/action planning that already applied in some Western Balkan territories);
- ❖ discussing the current collaborative situation and already-practised forms of cooperation and ways to improve these, including challenges and obstacles to cooperation, by also assessing institutional capacities such as skills, staff, resources in terms of space and internet, etc. (It is important to build on already developed collaborative approaches, as described in Deliverable 1.);
- ❖ improving methods for measuring and analysing the social and employment situation, evaluating social and employment policies and improving the know-how and technical skills of the various partners;
- ❖ identifying and analysing previous and new initiatives or pilot schemes that may have a significant impact in terms of job creation (i.e. pooling the experience of the various participants in the partnership);
- ❖ connecting with other partnerships to learn from their experiences;
- ❖ devising (new) arrangements for cooperation and consultation between the various partners;
- ❖ identifying the margins for manoeuvre and resources available to each partner; and
- ❖ seeking a consensus to develop joint solutions for the problems analysed (see also European Commission, 1999).

As regards the first steps in improving collaboration between PES and CSWs with regard to the establishment of an integrated case management system, we recommend clarifying the following issues between the two partners as the primary actors in the integrated case management system at this early stage:

- ❖ Joint assessment of the available tools that meet the various demands of individuals. (It is important to build on already established tools if they have worked out successfully.)
- ❖ Clarification of the profiles of clients to be included in the case management system.

- ❖ Joint agreement on targets, and clarification as to who is responsible and accountable for which action. (At the very beginning of collaboration, shared responsibilities are to be favoured only when tasks are clearly distinguished.)
- ❖ Clarification regarding the institutions responsible for each single action and the tasks involved in these actions, including needs assessment (individual assessment/profiling of beneficiaries) and joint individual plans (e.g. how best to combine plans in those regions where both CSWs and PES are working with this tool).
- ❖ Joint agreement on who will be responsible for the coordination of each single action (if tasks of actions are split between the partners).
- ❖ Discussing the role of each partner, as well as those of the countries' ministries of labour and social policy (and other relevant central level actors).
- ❖ Clarification on the assessment of the actions in order to ensure that the proposed measures for improvement are complementary and coherent.

■ Careful preparation is key to the success of a partnership. The PES and CSWs have a key role to play from the very beginning.

(See further subjects to be clarified and agreed between all partners in step 2 below (the partnership agreement).

During the stage of preparatory work, findings should be obtained about communication channels and structures, such as working groups, decision boards or committees. This particularly refers to processes and forms of collaboration between the PES and CSWs in implementing case management. It is also important to incorporate findings at this stage from other partners such as NGOs on what works and what does not work. These findings should inform decisions as to the partnership structure to be established.

The stage in which preparatory work is conducted may last up to six months, since various partners must be consulted to reach consensus. (Three months are expected with regard to inner collaboration cycle of PES and CSWs only).

»»» STEP 2: Signing a partnership agreement

At the end of this process, a partnership agreement will be drawn up in the form of a document setting out the views of the various partners, the detailed commitments by each participant, and practical proposals.

■ **Recommendation: The partnership agreement specifies the interventions required for integrated case management**

The *partnership agreement* includes the following information (see also section 4.4):

- ❖ the **partners** of the partnership (the PES and CSWs as primary actors in integrated case management, together with NGOs and other partners);
- ❖ brief information about the **geographical scale** of the partnership;
- ❖ brief information about the **legal** and **policy frame**;
- ❖ **analysis** of the existing **(local/regional) problems** and **context**;
- ❖ the **rationale** for the collaboration between partners;
- ❖ the **aims** and **objectives** of the partnership;
- ❖ the **legal status** of the partnership;
- ❖ the **strategy** of the partnership (short-, mid- and long-term strategy, including the common understanding of problems and ways to jointly overcome these problems);
- ❖ the **time-frame** of the agreement (2-3 annual programmes are suggested; if bi- or multi-annual partnership agreements are envisaged, include annual plans and budgets in the work programme - see below);
- ❖ the **target groups**;
- ❖ the **work programme** of the partnership, including **detailed planning of the actions** (with summary information about the integrated case management model, including milestones. More detailed planning will follow during the implementation phase (see below));
- ❖ the **roles, responsibilities, structures, budget** and **contribution of each partner** in fulfilling the work programme of the partnership;
- ❖ the overall partnership **budget** (it is important to note that a partnership budget does not always entail new costs/additional funding: the combined budgets of the various actors is already an advantage);
- ❖ **jointly defined indicators** to measure the anticipated **impact** of the partnership and its actions (e.g. on an annual basis, such as the expected number of jointly solved/proceeded cases, etc.);
- ❖ the **rules of procedure** of the partnership and its actions: details on the coordination of the partnership (steering groups, boards, coordination or partnership manager – set up either by a partner organisation or by a neutral body,⁴ chairs, meetings, allocation of personal resources put into the partnership per partner, etc.) and details on the coordination of the actions of the work programme;
- ❖ information about the **monitoring** and **evaluation** of the partnership and its work programme; and
- ❖ **additional documents** that may be partnership-specific (e.g. partnership principles and codes of cooperation; additional agreements; jointly defined tools to be used).

⁴ International experiences have shown that the nomination of partnership managers by neutral bodies helps to build trust between the partners (see Section 4.1).

Characteristics of good partnership can also be found in the 'Guide on partnerships' prepared by the OECD LEED Form on Local Partnership and Governance (2006), the 'Guide to TEPs' published by the European Commission (1999) and the 'Guide to TEPs' developed by the Austrian Co-ordination Unit of TEPs (2000). A template for a model contract is included at the end of this chapter (Section 4.4).

»»» STEP 3: Implementation

Tasks to be undertaken in the implementation phase include *sound planning and management* (including financial management) of the activities jointly agreed in the partnership work programme. All partners, but in particular PES and CSWs, are required to “*recognise partnerships as an integral part of both policy design and delivery at all governance levels, set up partnership actions that ensure innovative collaborative policy implementation and follow the course of a mental and cultural shift by their individual and organisational ways of working and develop towards learning agencies that use partnerships as a mechanism with which the inclusive society of the EU 2020 can jointly be built*” (Scoppetta, 2013: analytical paper on ‘Successful partnerships in delivering public employment services’, p.27). When planning processes and actions of integrated case management during this stage in detail, all responsible actors should be engaged. It is also necessary to ensure that the views of beneficiaries are included when designing actions.

During implementation, we recommend constant *monitoring* of each single step taken within the partnership, i.e. all the actions related to integrated case management, including the achievements made. It is also necessary to report not only on the progress made but also to conduct evaluations of the partnership and its work programme (including the actions). *Evaluation results* should be shared with all partners (and even beyond) in an open and transparent manner.

Partnership success factors include the building up of *fruitful learning environments* in which partners reflect their actions via feedback loops to enable improvements. Exchanges of practices/partnership actions from neighbouring areas and/or areas with a comparable situation should be envisaged (see Deliverable 1). In addition, knowledge may also be gained from good practices from abroad. Specific attention should be paid to promoting the exchange of experiences on integrated case management within the Western Balkans. Good practices such as those presented in Chapter 3 of these Guidelines may also be reviewed. These, however, should serve only for the purposes of initial orientation and need to be studied in more detail when aiming to adapt and transfer practices from EU countries. Exchanges of practices with other partnerships assists in broadening the partnership knowledge and skills-base for the implementation of practices.

Since the partnership and its activities should be acknowledged by the local community, *dissemination and public relation activities* should be conducted continuously. Such PR activities also help to attract new partners, whose help may serve to improve the effectiveness of interventions.

4.1. Partnership principles and Codes of Cooperation

The European Commission strengthened the implementation of the partnership principle during the current Structural Fund period by adopting the European Code of Conduct on Partnership on 7 January 2014.⁵ The partnership principle thus takes the form of a legally binding Commission Regulation (European Commission, 2014).

■ Recommendation: the European Code of Conduct on Partnership should serve as a basis for partnership agreements in the Western Balkans

The Code requires the building up of partnerships that include public authorities, economic and social partners and bodies representing civil society, including environmental partners, community-based and voluntary organisations. According to the European Code of Conduct on Partnership (European Commission, 2014, p.1): *“Specific attention should be paid to including groups who may be affected by programmes but who find it difficult to influence them, in particular the most vulnerable and marginalised communities, which are at the highest risk of discrimination or social exclusion, in particular persons with disabilities, migrants and Roma people.”* The Code also requests member states to be transparent in the selection of partners, to provide sufficient information to partners and to give them adequate time to make their voice heard in the consultation process, to ensure that partners are involved in all stages of the process from planning to evaluation, to support the capacity-building of partners and to create platforms for mutual learning and exchanges of good practices.

The European Code of Conduct on Partnership should serve as a basis for the development of partnership agreements in the Western Balkans. While building on the Code, each partnership will still need to jointly agree on the more specific individual codes of cooperation and partnership principles they want to apply (see

⁵ The European Commission is currently updating the European Code of Conduct on Partnership.

step 1). At best, these ‘golden rules’ of cooperation are to be appended to the individual partnership agreements in written form.

- **Recommendation: Draw special attention to consensus, commitment and understanding between partners and clearly define communication and interaction between them**

When developing codes of cooperation, we suggest paying specific attention to achieving consensus, commitment and understanding between the partners, as well as clearly defining communication and interaction. Since partners often have difficulty in scoping and defining what exactly is meant by “partnership”, a *common understanding* must be established (see Box 1).



Box 1: How to build consensus, commitment and understanding?

- ❖ Identify the expectations of the partners’ rights from the start
- ❖ Be mindful that partners have different and sometimes conflicting interests
- ❖ Promote compromise and flexibility
- ❖ Identify and promote the benefits of working in partnership
- ❖ Share information as regularly and openly as possible

EQUAL Managing Authorities, 2006

Partners have different degrees of political and financial power, which can significantly affect the dynamics of the partnership (EQUAL Managing Authorities, 2006). Practice shows that not all partners need to be involved in all decisions in order to be effective. The Austrian TEPs, for instance, have created various groups within each partnership, ranging from decision-making boards (with clearly defined voting systems) and topic- and/or challenge-specific working groups to (open) public fora.

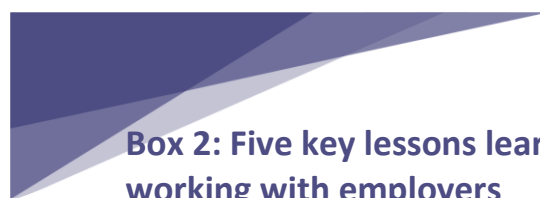
- **Recommendation: Create various groups within the partnership, such as decision-making boards (with a clearly defined voting system), topic- and/or challenge-specific groups and (open) public fora**

In addition to defining the groups of cooperation, it is recommended that *partnership managers* be nominated to coordinate the various actions. While the partners are the core of partnerships, partnership managers are often the ‘drivers’; partnership

performance rises and falls with their inputs and skills (Scoppetta, 2013). The Austrian TEP experience has shown that partnerships have been successful where full-time part coordinators were managing the TEPs. At central level, “partnership brokers” can be established to play a critical role in developing partnership arrangements tackling labour market challenges (Stott & Scoppetta, 2013).

■ **The engagement of partners depends greatly on the rationale of the partnership; there is no one-size-fits-all model that can be applied**

NGOs and the private sector have been particularly involved in working groups to implement practices (not in decision-making bodies) in the Austrian case due to potential conflicts of interest when receiving funding from the TEP budget. While private enterprises have been engaged in the Austrian partnerships to a much smaller extent than other partners, partnerships in other countries such as Ireland have managed to include private enterprises to a much greater extent (see Box 2 for the lessons learnt regarding engagement with the private sector). The engagement of private actors – alongside the involvement of other partners – strongly depends on the rationale of the partnership, and there is no one-size-fits-all model that can be applied.



Box 2: Five key lessons learnt when working with employers

- ❖ Allocate time, knowledge and resources for the engagement
- ❖ Start small and precisely (by appointing a named contact person and establishing regular long-term relationships)
- ❖ Establish win-win situations
- ❖ Pursue joint goals, pull together and reduce administrative burdens

Successful partnerships in delivering public employment services (Scoppetta, 2013)

As emphasised in the Comparative Report, it is also important to involve beneficiaries from the start, to define their roles and to ensure their voices are heard, especially when designing new measures. A partnership should allow for the joining of new partners and the opting out of partners. In addition, the level of input from partners may vary over time. Regular brainstorming and consultation sessions are recommended to foster discussion and learning between the partners.

Special attention should also be paid to ensure that the innovation created in a partnership is fed back into participating organisations. A system to create this should be in place already from the beginning, for example through the level of representation in a partnership, e.g. of the PES and CSWs in the Board/Committee (see 'Step 1 – preparatory work').

4.2. Proposals for the joint management of interventions

To support the joint management of interventions when implementing integrated case management (Step 2), it is recommended that a *Coordination Board* be set up as formalised body. (Examples of coordination boards in the Western Balkans, including the case of cooperation between the PES and CSWs in Montenegro can be found in the Comparative Report.) Coordination boards encompass all actors involved in the design, implementation and evaluation of the intervention. The board clearly defines the actions to be taken when implementing the integrated case management system.

All interventions are part of the work programme of the partnership. The partners will thus have already discussed, agreed and clearly defined their roles, functions, responsibilities, resources and budgets allocated to the intervention per partner institution (see Box 3). These findings are part of the partnership agreement.



Box 3: Checklist on Roles and Functions

- ❖ Discuss, precisely define and jointly decide on the roles and functions of each partner;
- ❖ Reflect on roles and functions regularly;
- ❖ Clarify the obligations, responsibilities and constraints on the capacity of each partnership;
- ❖ Balance interests and contributions carefully;
- ❖ Make best use of the strengths of partners;
- ❖ Establish a strong management structure;
- ❖ Consider externalising the management function;
- ❖ Ensure funding for partnership co-ordination.

OECD LEED Forum on Partnerships and Local Governance, 2006

To support streamlined implementation and to facilitate institutionalised models of interventions such the integrated case management system, it is further

recommended that *Integrated Case Management Standards* be developed for partnerships across all countries, such as practiced in Scotland/the UK (see CMSUK, 2009).

■ **Recommendation: Develop Integrated Case Management Standards across all countries**

Suggestions for standards required for case management processes comprise the definition and purpose of integrated case management (and each process and action undertaken), the needs assessment process, the selection of the case management model, the action/activity plan and its update, monitoring and evaluation of the implementation (ensuring quality assessment of the actions; see Section 3.1.), crisis intervention and, finally, case closure (see Box 4).

Regarding the selection of the case management model, which also defines the sequence of different actions/activities, we suggest leaving sufficient leeway to the local level to allow for adaptation according to needs. Nevertheless, we recommend the joint development of a pool of actions/activities from which the actors can choose appropriate practices. These may include, for instance, workability assessment, as practised in Norway (see Section 3.1), alongside some already defined key activities used for implementing case management within the project, such as needs assessment, individualised action plans and monitoring.

It is important to note that standards must be discussed, developed and *agreed upon jointly amongst all actors* to ensure ownership.



Box 4: Case Management Standards

- ❖ The definition and purpose of integrated case management (and each process and action undertaken)
- ❖ The needs assessment process
- ❖ Selection of the case management model (different actions may be chosen in various contexts)
- ❖ Action/activity plan
- ❖ Monitoring and evaluation of the implementation (including quality assessment)
- ❖ Plan update
- ❖ (Optional) Crisis intervention; and
- ❖ Case closure

4.3. Critical questions for analysing innovative practices

The following ‘critical questions’ should assist partners in analysing and reflecting upon practices already implemented in order to improve future implementation. These questions may be used for any practice but should especially serve the PES and CSWs to reflect upon the case management approach applied in the territories.

■ Recommendation: Conduct regular reflection on practices with the help of the critical questions for analysing innovative practices in the field of labour market and social policy

The questions are clustered alongside the ZSI – Centre for Social Innovation’s “4-i-processes of social innovation” (see also the European Foundation for the Improvement of Living and Working Conditions, 2013). The questions concern the phase of idea development, the phase of the intervention and involvement of actors, the implementation phase and the phase of impact generation and dissemination.

The ‘Critical questions’ for analysing innovative practices in the field of labour market and social policy are listed below:

1. IDEA - NOVELTY

1.1. Area of concern: Meeting social demand/societal challenges

- ❖ *Which social demands or societal challenges are met by the practice?*
- ❖ *Is the issue at stake thoroughly analysed (background, initial foundation/nascency, stakeholders) and understood?*
- ❖ *Are previous activities in addressing social challenges reflected in practice?*
- ❖ *Does the practice address a social problem in a new way?*
- ❖ *What is the new social approach or new solution offered by the practice?*
- ❖ *Does the practice answer complex problems?*

1.2. Area of concern: Target group

- ❖ *How was the target group involved?*
- ❖ *What is the concrete and enduring benefit of the practice for the target group?*
- ❖ *Does the practice increase the potential of the target group?*
- ❖ *Does the practice contribute to society’s esteem for the target group?*
- ❖ *Does the practice address target groups that receive little attention?*

1.3. Area of concern: Idea generation process

- ❖ *In which circumstances was the idea born?*
- ❖ *Who developed the idea? (Which individual(s), target group, organisation, cooperation, etc.?)*

- ❖ *Were different views integrated into the idea (e.g. via cooperation established between different disciplines/competencies/groups)?*
- ❖ *Which obstacles have been faced when including relevant (core) partners?*

2. INTERVENTION - INVOLVEMENT

2.1. Area of concern: Territorial and socio-economic context

- ❖ *How is the practice integrated into the local and regional environment?*
- ❖ *Are relevant social, economic and environmental circumstances incorporated into the practice?*
- ❖ *What is the strategy towards target groups: bottom-up involvement, top-down involvement, service provision?*
- ❖ *Are relevant local/regional stakeholders engaged in / informed about the practice? And if not, why not?*

2.2. Area of concern: Setting up a fruitful environment

- ❖ *Does practice realisation happen in an inventive, resourceful, creative and courageous way?*
- ❖ *Does the practice foster dialogue and cooperation with other institutions / organisations?*
- ❖ *Is information about various aspects of the practice, e.g. decision-making, finances and monitoring and evaluation, openly shared within the practice?*
- ❖ *Does the practice change with changing needs? For instance, do specific target groups call for a different approach or changes in the environment of the practice?*

2.3. Area of concern: Development process

- ❖ *Which individuals/organisations can be regarded as the “drivers” of the change?*
- ❖ *What were the success factors of the further development of the idea towards an innovation?*
- ❖ *What failures were observed? And how were they overcome?*

3. (SUCCESSFUL) IMPLEMENTATION / INSTITUTIONALISATION - EFFECTIVENESS

3.1. Area of concern: Acceptance by society

- ❖ *Has the practice put strategies in place for reducing barriers? (For example, through the promotion of: positive government policies; a supportive legal and administrative framework, good cross-sectoral relations and a culture of cooperation; connections with organisations capable of scaling up the innovation; opportunities for increasing skills and expertise)?*
- ❖ *Has the idea been supported and accepted by the society?*

3.2. Area of concern: Sustainability

- ❖ *Has the practice broadened its funding base (i.e. to non-dependency on single donors/mentors) as well as its knowledge base (i.e. know-how transfer between stakeholders)? Are connections being made to existing transnational/national/regional/local programmes, structures and strategies (e.g. relationships with Structural Funds, ERDF and others)?*

3.3. Area of concern: Mainstreaming & scaling up

- ❖ *Does the practice encourage options for continuous learning from successes and failures?*
- ❖ *Have key lessons learnt led to modifications of practice?*
- ❖ *Have other organisations, media, sponsors and politicians been made aware of and interested in the practice?*
- ❖ *Is there a structured and supportive development process which assists in mainstreaming and scaling up at both governance and practice levels?*

3.4. Area of concern: Implementation process

- ❖ *In what ways, if any, has the “ownership” of the practice changed over time (i.e. from a single ownership of an individual/organisation towards a widely supported practice)?*
- ❖ *Is the responsibility of the practice shared between stakeholders?*
- ❖ *Which crucial factors were observed when building a solid basis for the practice (stable financial funding, the skills and know-how of the persons involved, etc.)?*
- ❖ *Have any obstacles successfully been overcome (e.g. legal, financial, economic, institutional obstacles preventing the system from evolving)?*

4. IMPACT - DISSEMINATION

4.1. Area of concern: generating impact

- ❖ *Is monitoring and evaluation ensured?*
- ❖ *How can the range of impacts be determined: in terms of the size of affected groups (target groups and by dissemination and replication)?*
- ❖ *Are there any indirect effects beyond the target groups and the objectives in focus? Do these effects include unintended negative effects?*
- ❖ *What is the time-horizon of immediate and potential future impacts?*
- ❖ *Is it feasible to assess the end of the innovation's life cycle (i.e. becoming common practice) in short periods such as months or years or generations?*
- ❖ *Have the impacts been measured?*
- ❖ *How and when were the impacts measured (e.g. external evaluation or self-assessment; ex-post/ex-ante)? Which impacts were generated (e.g. ecological impacts, economic efficiency, distributional equity, etc.)?*

4.2. Area of concern: Contribution to change

- ❖ *What effects of this innovative practice can be observed? Who has been affected by the practice?*
- ❖ *Did the practice meet social demands or societal challenges as intended?*
- ❖ *Did the practice contribute to systemic change?*
- ❖ *Did the practice contribute to changing roles (of individuals, civil society organisations, corporate business, and public institutions), relations (in professional and private environments, networks, and collectives), norms (at various levels, legal requirements) and values (customs, manners, mores, and ethical/unethical behaviour)?*
- ❖ *Have societal challenges been resolved, accepted, adopted and utilized by the individuals, social groups and organisation concerned?*

Title of the partnership

- 1. General Introduction**
[Please describe the general setting, such as information on the geographical scale of the partnership, the policy and institutional frame, legal status, context, the results of the analysis of existing problems, and the rationale behind the collaboration between the partners]
- 2. Partners**
[Name the partners of the partnership. 2–20 partners may sign the agreement]
- 3. Aims and Objectives**
[Specify the aims and objectives, quantifying the aims]
- 4. Strategy of the Partnership**
[Describe the short-, mid- and long-term strategy, including the common understanding of the problems, and specify how the partnership aims to overcome these problems]
- 5. Target Groups**
[List the target groups of the partnership]
- 6. Work programme of the Partnership**
[Give details of the work programme and actions, including the contribution, roles, function and responsibilities of each partner for each action]
- 7. Partnership Budget**
[Give details of the allocation of resources put into the partnership per partner. Include the costs for actions taken by the partnership when funded by different partners]
- 8. The structure and decision-making of the partnership**
[Specify decision-making, as well as the coordination structure of the partnership (steering groups, boards, coordination manager, chairs, meetings, etc.) together with details about the coordination of the actions of the work programme]

9. **Expected Impact of the partnership and its actions**
[Give details of the envisaged impact/outputs of the partnership and its work programme]
10. **Monitoring and evaluation**
[Give details about the monitoring and evaluation of the partnership and its work programme]
11. **Additional documents**
[Add additional documents, such as Partnership Principles and Code of Cooperation (see below)]
12. **Duration, validity and termination of the partnership agreement**
[Give details of the time-frame of the agreement (validity) and how changes can be made to the partnership agreement]

[Date, place]

For [partner 1]

[Name, function]

For [partner 2]

[Name, function]

For [partner 3]

[Name, function]

For [subsequent partners]

[Name, function]

5. Toolkit for ICM implementation

The 'Toolkit for strengthening Integrated Case Management for Employment and Social Welfare Users in the Western Balkans' (Deliverable 3) aims to serve the training needs of participants in the train-the-trainer-workshop (implemented in autumn 2017). Integrated case management is hereby understood as an innovative practice employed especially by the PES and CSWs in the Western Balkans collectively to serve the most vulnerable with all available resources from both the labour market and the social policy system, and even beyond. Deliverable 3 aims to assist the PES and CSWs in the Western Balkans to establish integrated case management systems.

The toolkit builds on two reports: Deliverable 1 - 'Comparative Report on Integrated Case Management for Employment and Social Welfare Users in the Western Balkans', and Deliverable 2 - 'Guidelines for cooperation between the PES and CSWs regarding Integrated Case Management for Employment and Social Welfare Users in the Western Balkans'.

The toolkit includes the following tools: a working definition of integrated case management (ICM), a step-by-step model of needs assessment, service planning, coordination and monitoring of services provided, protocols for the development of individual plans, codes of ethics (focusing on interactions with users/clients), and the qualifications and experience required for case managers.

5.1. ICM working definition

Within the project on 'Integrated Case Management for Employment and Social Welfare Users in the Western Balkans' we suggest using the following working definition:

- **Integrated case management is understood as an innovative practice employed especially by the PES and CSWs in the countries collectively to serve the most vulnerable with all available resources, especially from the labour market and the social policy system**

The varying definitions of ICM share a common emphasis on the process itself. While ICM includes the assessment, planning, implementation, coordination, monitoring and evaluation of options in order to promote quality cost-effective outcomes in the UK (CMSUK 2009, p. 8⁶), the following steps are highlighted by experts in the United States: intake, assessment of needs, service planning, service plan implementation, service coordination, monitoring and follow-up, reassessment, case conferencing, crisis intervention and case closure (New York State Department of Health, 2006, p. 3-1, 2010 p. 4⁷). (See also our suggestions for activities within ICM in the Guidelines: Deliverable 2 - Section 4.2, p.23).

When setting up an integrated case management system in the various territories of the Western Balkans, we recommend discussing the ICM system to be applied and the definition which should build on this agreement within each partnership in the territories.

- **Discuss the ICM system to be applied between all partners involved in the partnership**

5.2. Case managers

Within the ICM model proposed by this project, case managers are core. Case managers coordinate the services for the pathway of clients throughout the entire social inclusion and integration chain. Case managers may be PES counsellors, CSW staff or other local experts trained and experienced to use the ICM method. To ease the implementation of case management, we recommend starting with case managers who are employed in either a PES or CSW. As soon as the ICM systems are set up and working smoothly, the institutions may also consider making use of other local stakeholders for assisting or providing ICM.

Case managers make use of all the locally available measures and services of the partners of the partnership, especially those of the PES and CSWs. Their goal is to assist the client progressively in the social inclusion process, including both labour

⁶ CMSUK (2009). Standards & Best Practice Guidelines, 2nd Edition. Downloadable at: <https://www.cmsuk.org/files/CMSUK%20General/000Standards%202nd%20Ed%20Nov%202009.pdf>. Access data: 30 August 2017.

⁷ New York State Department of Health, AIDS Institute (2006): Standards for HIV/AIDS Case Management. New York State Department of Health, AIDS Institute (2010): Standards for Medical Case Management. Standards for Medical Case Management Issued: September 2010. Downloadable at: https://www.health.ny.gov/diseases/aids/general/standards/casemanagement/docs/standards_medical_case_management.pdf. Access date: 30 August 2017.

market inclusion and inclusion into society. The latter refers to empowerment and the provision of social services and low-threshold offers that enable vulnerable groups to reintegrate, engage with other members of society and achieve overall well-being. This can be achieved by various means incorporated into the ICM model, such as self-confidence training, integration chains, support from social workers, drug advice and debt counselling, alongside other measures.

Case managers advocate on behalf of their clients and ensure that gaps in services are brought to the attention of higher levels of local and regional governments. Case managers are the key persons for implementing ICM and thus are responsible for the overall supply of measures and services to the client (e.g. needs assessment, individual action/activity plans, access to labour market, etc.).

Please find a description of the qualifications and experiences required in the following section and further information on Codes of Ethics in Section 2.5.

5.3. The qualifications and experience required of case managers

The qualifications and prior experience required of case managers varies in the literature according to the specific area of ICM. In general, preferred qualifications for a case manager include a Bachelor's or Master's degree in health, social work, or education services. In certain areas of ICM, one or more years of experience may be needed in case management in areas such as homelessness, addiction problems, mental illness, HIV+ persons. In certain areas, experience with families is preferred. In each specific case it must be ensured that case managers have appropriate, skills, education and competencies to deliver the services needed by clients.

The key competencies of a case manager must include the ability to create a good quality relationship with service users, as this will fundamentally influence the process and outcome of case management. Professional relationships are often based on unequal power due to the position and specialized knowledge of case managers. Appropriate use of power protects the client's vulnerability. Developing and safeguarding trust is essential, and this depends on the case manager's ability to communicate clearly and openly, avoiding misunderstanding and disappointment. Respect for the client's dignity is also a crucial element. The case manager needs to understand the service user's culture and values and not become side-tracked by any behaviour that is not relevant to the outcome. The case manager should ensure that his/her actions and communication adequately reflect positive regard in order to

sustain enduring empathy. Crucially, however, the case manager also has to be able to ensure their own safety and physical and psychological wellbeing.

The professional and personal development of case managers needs to be ensured via a set of methods, including learning opportunities, inter-professional learning and participation in professional networks and events. Case managers need to be aware of national and international practice development, share good practice with fellow case managers, and have management structures in place that provide regular supervision and feedback where relevant. The preferred qualifications for a case management supervisor include a bachelor's degree in health, social work or education services, one year of supervisory or management experience of case managers or similar professionals, and one year of case management experience with persons with a history of mental illness, homelessness or addiction problems. In some cases, experience with families is preferred.

The desirable role of a supervisor is supportive and educative, though it may also include elements of work appraisal. A positive relationship between the supervisor and the supervisee is essential to enable greater potential for learning and growth. At the same time, the supervisor needs to ensure that clients receive the best possible service, both qualitatively and quantitatively, according to the aims and objectives of the agency. According to Schulman (1982), the key factors influencing trust are rooted in a supportive atmosphere, permitting mistakes, encouraging open expression of concerns, supporting staff in discussing taboo subjects, sharing your own (supervisor's) thoughts and feelings and encouraging workers to deal openly with themes of authority (e.g. letting you know when they are upset with you) (p. 85).⁸ A supervisor needs to have good listening skills, flexibility, and the ability to empathise.

In addition to formal criteria, there are a number of additional informal criteria. The case manager needs to have a high level of personal integrity to be able to deal effectively with a variety of conflicting influences and demands and needs to behave in an ethical and professional manner at all times.

In addition to overall qualifications criteria, case managers have a duty to ensure that their skills match each case. *"When accepting a case, it is the personal responsibility of the case manager to ensure that their skills, competencies, experience, and qualifications match the requirements of the case."* (CMSUK 2009 p. 9).

⁸ Schulman, L. (1982). *Skills of Supervision and Staff Management*. Peacock Publications, Chicago, IL.

5.4. The step-by-step model

The step-by-step model outlined below serves as an initial orientation only and comprises different elements of an ICM system that should be adapted to local/regional/national needs (see Section 4.2 of the Guidelines: Deliverable 2). We recommend the development of *ICM standards across the Western Balkans* that should be applied by local/regional actors. It is important to note that the ICM model to be implemented must be discussed, developed and *agreed upon jointly between all actors* at local level to ensure ownership. Although some leeway should be given to the local/regional level, we recommend the joint development of a pool of actions/activities from which the actors can choose fitting practices.

Suggestions for implementing the ICM include the following steps:

»»» STEP 1: Joint understanding

Develop a joint understanding of the definition and purpose of ICM among all partners in a partnership at local level engaged in the ICM. This can be achieved by consulting with the various actors as well as by ensuring the involvement of the beneficiaries. (See also the section on the setting up of a partnership to deliver integrated services in Deliverable 2.) Various meetings and consultations will thus need to be held, with the following aims:

- ❖ To discuss and jointly define the working definition of ICM applied in the territory within the partnership/primary actors such as PES and CSWs.
- ❖ To discuss and jointly agree on the client's profile.
- ❖ To discuss and jointly agree on the contextualisation of the ICM model to local circumstances and needs of individuals.

»»» STEP 2: Planning

It is important to develop a clear plan of the necessary steps to be taken in a territory when implementing an ICM system. It is important to clarify the roles, functions, duties, responsibilities and funding for ICM and each action undertaken, as well as to ensure sound time-planning of the actions. Various meetings and consultations will thus need to be held, with the following aims:

- ❖ To discuss and jointly agree on the institutions providing the case managers for the territory (including agreement on the profile of the case managers (roles, responsibilities, actions, budget, etc.).
- ❖ To discuss and jointly agree on the ICM Standards to be applied.
- ❖ To discuss and jointly agree on the broader scope of the ICM, i.e. the institutions to be involved, consulted and informed on the planning, implementation and monitoring process.
- ❖ To clarify the feedback loops and actions to improve the ICM model within the partnership.

»»» STEP 3: Implementation

The implementation of each single ICM action, such as needs assessment, individual action/activity plans, workability assessment, etc., need to be coordinated and adjusted to the needs of the clients and the resources, offers and measures available in the territory. Various meetings and consultations will thus need to be held, with the following aims:

- ❖ To gather data on any challenges (obstacles) and success factors of the actions.
- ❖ To discuss intermediate results and challenges encountered.
- ❖ To discuss and jointly agree on adaptations to the actions during their implementation, e.g. the involvement of additional actors, changes in processes and work flows, etc. (See also Step 4 below.)

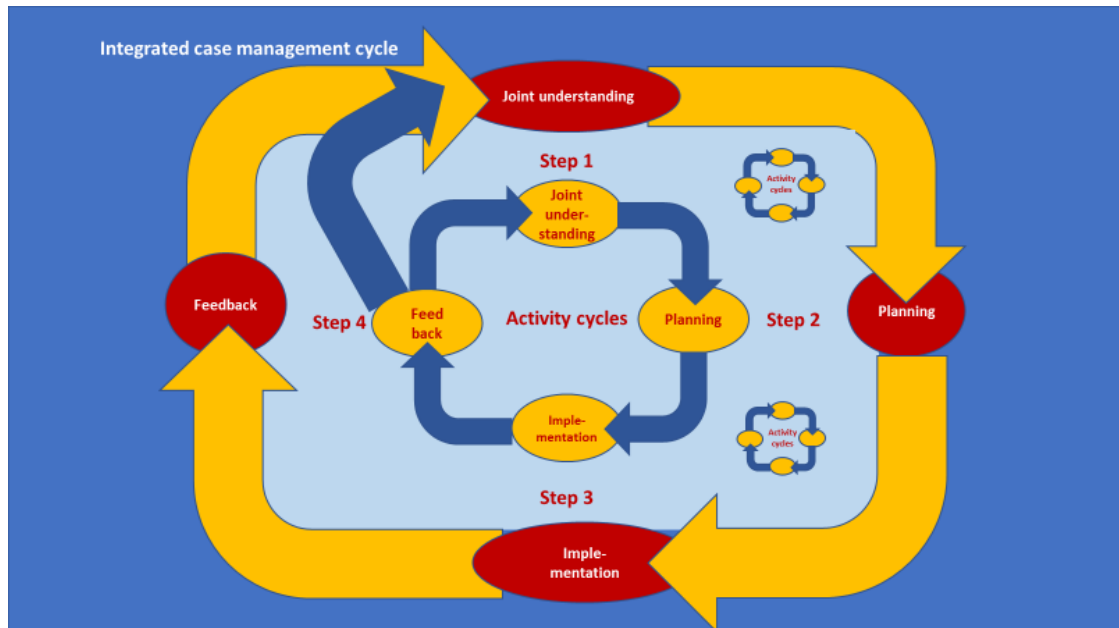
»»» STEP 4: Feedback: Quality assessment, monitoring and evaluation

Given the importance of feedback loops and of monitoring all actions, the feedback phase is particularly highlighted.

ICM, including each single action, should be monitored and evaluated constantly, including quality assessment of all actions. It is important to reflect on the actions and process and to ensure that lessons learnt are fed into the implementation of new actions of the ICM system. It is also essential to discuss and jointly agree on any adaptations that need to be made to the ICM model itself.

Figure 1 summarizes the steps to be taken during the implementation of the integrated case management system ('Integrated case management cycle') and of each activity ('Activity cycles').

Box 5: *Step-by-step model of ICM*



5.5. Protocols for the development of individual plans

In addition to needs assessments, individual plans should be made an integral part of the ICM system implemented in the Western Balkans. This activity could help both the PES and CSWs to achieve their goals. We recommend developing a *common goal*, for example helping the most vulnerable, such as long-term unemployed persons excluded from social welfare benefits during the entire integration process (see Deliverable 1 - Section 5.2, p. 26). This includes both social inclusion as well as integration into the labour market.

Individual plans should be used as the basis for joint agreement between the parties (the client and the case manager's institution) on the next steps to be taken regarding activation, profiling and matching. To implement these plans, we recommend using *implementation protocols* that describing the following issues per case:

- ❖ **Summarize key results from the needs assessment**
- ❖ **Aims of the plan**
- ❖ **Activities to achieve the aims**
- ❖ **Results to be achieved**
- ❖ **Lessons learnt (Feedback)**

A template for the implementation protocol is given below:

Table 1: *Template for the implementation protocol*

Name of client		
Name of case manager and institution		
Date, Location		
Needs assessment results	[Please specify]	
Aims	[Please specify]	
Activities	[Please specify]	
Activity 1	[Please specify]	Time-line [Please specify]
Activity 2	[Please specify]	Time-line [Please specify]
Activity 3	[Please specify]	Time-line [Please specify]
Activity 4 (and subsequent activities)	[Please specify]	Time-line [Please specify]
Results	[Please specify]	
Lessons learnt	[Please specify]	

As emphasised in the Comparative Report (Deliverable 1) and in the Guidelines (Deliverable 2), individual plans should be a joint activity of the partners (especially of the PES and CSWs). This also means that clarification between the partners is needed, especially with regard to the following issues:

- ❖ Joint discussion and agreement on the specific target group focus (which clients are covered);
- ❖ Joint discussion and agreement on how to best reach out to the most vulnerable (those that are inactive or not covered by the system/official institutions);
- ❖ Joint discussion and agreement on the joint goal to be achieved;
- ❖ Joint discussion and agreement on the process, i.e. the roles, functions, actions and tasks of each of the two partners (if individual tasks are within the action envisaged); and
- ❖ Joint discussion and agreement on the coordination, monitoring and evaluation of the actions, etc. (See Chapter 4 in Deliverable 2).

To enhance the usability of individual plans, we suggest implementing a consultation process between the institutions prior to the implementation of the plans. The outcome of these consultations should be that both institutions have a clear and joint understanding of the utilisation of the tool and have clarified roles, functions, responsibilities, the introduction of case managers, the ICM system and the activities to be undertaken, as well as the budget.

5.6. Code of Ethics

Ethical criteria need to be an inherent part of ICM in the form of an explicit 'Code of Ethics' that guides all forms of ICM activities. In our recommended principles for the Code of Ethics, we start with those elements which could be incorporated in the training of case managers.⁹ Additional principles are listed at the end of this section.

The following are key principles to be followed in the training of case managers, intended to develop an in-depth understanding and enhance practical implementation:

»»» Principle 1: Ensure privacy and confidentiality

Case managers need to assure the client's privacy and confidentiality in all phases and activities of ICM. The client's right to privacy and confidentiality needs to be assured in accordance with the law. However, where the case manager has concerns that information shared with the case manager contravenes laws or has the potential to affect the health and safety of involved parties, the case manager will need to explain to the service user that the case manager has an obligation to inform the appropriate authorities (CMSUK 2009, pp. 57–59).

The case manager needs to ensure that confidentiality is respected, for example when discussing delicate issues. The training of case managers needs to include various aspects of confidentiality, including contact with clients, other authorities and administrative procedures for practical implementation (acquiring appropriate consents from clients, keeping copies, etc.). This also includes secure data storage and destruction at the appropriate time. (For more details on this, please see CMSUK Standards (2nd Edition) November 2009.)

»»» Principle 2: Ensure dignity and respect

Case managers need to show respect for clients by respecting cultural, religious, gender, ethnic and other differences. They also need to be aware of the potential for the exploitation of power. Case managers need to support the client's right to non-discrimination, compassionate non-judgmental care and a culturally competent provider.

⁹ We hereby assume (and recommend) that training be offered to case managers from the trainers of the train-the-trainer workshop.

Respect for the dignity of the service user is fundamental to the provision of services. It is important that the case manager understands the service user's culture and values and is not sidetracked by any behaviour of the service user that is not relevant to the outcome. This respect is critical to ensure the trust of clients. Safeguarding trust requires that the case manager communicates clearly, openly, and aims to avoid misunderstanding and disappointment that can lead to the erosion of trust.

The relationship between case managers and clients is often one of unequal power due to the authority of the case manager's position, specialised knowledge, influence with other care providers or legal professionals, and access to privileged information. The appropriate use of power within the relationship protects persons against vulnerability. Empathy plays an important role here, as it enables case managers to gain greater insight into the client's needs and circumstances, and thus enables effective collaboration.

Respect for the dignity of service users also includes the client's right to refuse services. This refers to the expression of autonomy. A client saying 'no' can be unsettling to a case manager, since it is a refusal of their services when they know how beneficial case management may be to the client.

»»» Principle 3: Maintain objectivity

Case managers must maintain objectivity in their relationship with clients and should not impose their values on clients. They should not enter into any relationship with the client that interferes with objectivity, including business, personal or other relationships.

When a friend or acquaintance becomes a client, these role-related behaviours can become blurred. Confusion can reign over what one individual has a right to expect from the other. Although a case manager may have positive feelings toward certain clients, he/she should always maintain a professional distance that enables him/her to execute their job responsibilities efficiently and objectively. For example, although conversations about sensitive topics such as politics and religion may be interesting, such conversations need to be conducted in a value-neutral way with professional clients.

Healthcare professionals may face a variety of conflicts of interest. Healthcare researchers, for instance, sometimes have an equity interest in a medical drug or device on which they are conducting research. To the extent that they report favourable findings regarding the effectiveness of the drug or device, they may profit financially. Individuals in such cases are certainly conflicted.

»»» Principle 4: Inform clients adequately

Case managers must provide all necessary information to clients that enables them to make informed decisions. They must provide information to clients about ICM, including a description of the services, benefits, risks, potential costs, alternatives and the right to refuse services.

Providing a clear description of services is especially important because it allows clients/support systems to make informed decisions about case management and other services to which they have been asked to give their consent.

»»» Principle 5: Further ethical principals

The welfare of participants must be given utmost priority and any harm to participants must be prevented or minimised. Case managers need to ensure that participants are able to make decisions freely. This includes obtaining consent from participants, explaining procedures, and allowing potential participants to decline or withdraw freely without detriment.

Case managers should act with integrity and honesty in collecting, storing, analysing and interpreting data and in presenting their results. Activities to be implemented need to be conducted with impartiality and fairness. This means that case managers must have a valid reason for deciding to include or exclude any groups or service users in their research and must document this reason. Additional ethical principles may include the following:¹⁰

- ❖ Case managers abide by all laws and regulations.
- ❖ Case managers place the public interest above their own interest at all times.
- ❖ Case managers maintain their competencies at the highest level to ensure that clients receive the highest quality of service.
- ❖ Case managers act with integrity and honesty with clients and others.
- ❖ Case managers act as the client's advocate: they perform a comprehensive assessment to identify the client's needs, identify options and offer opportunities when available and appropriate.

Case managers have a professional responsibility and must practice only within the

¹⁰ Additional literature: Commission for Case Manager Certification (2015). Code of Professional Conduct for Case Managers with Standards, Rules, Procedures and Penalties. Downloadable at: https://ccmcertification.org/sites/default/files/docs/2017/code_of_professional_conduct.pdf. Case Management Society of America (2010). Standards of Practice for Case Management (Revised edition, 2010). Downloadable at: www.cmsa.org/portals/0/pdf/memberonly/StandardsOfPractice.pdf.

boundaries of their role or competence, based on their education, skills and professional experience. They must not misrepresent their role or competence to clients.

List of Tables

Table 1	Advantages and disadvantages of formal and informal approaches
Table 2	Template for the Implementation protocols

List of Boxes

Box 1	How to build consensus, commitment and understanding
Box 2	Five key lessons learnt when working with employers
Box 3	Checklist on Roles and Functions
Box 4	Case management standards
Box 5	Step-by-step model of ICM

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