Case Management (Revised)

3 Case Management in the Community Context: An Interagency Perspective

The goal of interagency case management is to connect agencies to one another to provide additional services to clients. All organizations have boundaries; case managers or "boundary spanners" move across them to facilitate interactions among agencies (Steadman, 1992). While numerous researchers have investigated the nature of these connections (Tausig, 1987; Van de Ven and Ferry, 1980; DiMaggio, 1986), a 1994 network analysis of the "cracks in service delivery system" provides especially useful insights into the function and impact of various types of community linkages (Gillespie and Murty, l994). According to Gillespie and Murty, agencies can be categorized by the connections they maintain with other community-based agencies. *Isolates*, the first category of agencies or programs, operate self-sufficiently and establish no connections to other organizations in the community. *Peripherals* establish single or limited linkages with other agencies and social providers. A third category of agencies, which the investigators leave unnamed, form effective multiple connections with other organizations.

Applying Gillespie and Murty's classification scheme to substance abuse case management yields three interorganizational models. The three models are

- The single agency
- The informal partnership
- The formal consortium

The *single agency model* is used by such traditional community-based organizations as grassroots domestic violence programs and numerous medically oriented substance abuse treatment agencies. In the single agency model, the case manager personally establishes a series of separate relationships on an as-needed basis with professional colleagues or counterparts in other agencies. The case manager retains full and autonomous control over the case and is accountable only to the parent agency.

In the *informal partnership model*, staff members from several agencies work collaboratively, but informally, as a temporary team constituted to provide multiple services for needy clients on a case-by-case basis. The partnership can involve case managers from two programs or agencies who consult with one another on problematic cases and exchange resource information. The partnership also can consist of case managers and other types of providers from two or more agencies who meet on an informal basis to integrate and coordinate services in response to clients' needs. Responsibility for a client's well-being is shared,

although accountability for the actual services provided remains with the individual agencies.

The *formal consortium model* links case managers and service providers through a formal, written contract. Agencies work together for multiple clients on an ongoing basis and are accountable to the consortium. To ensure coordination among consortium members, a single agency typically takes the lead in coordinating activities and maintains final control over selected resources and interagency processes (Cook, l977). A formal consortium can enhance the systems of care for substance abuse clients. For example, Providence, Rhode Island's Project Connect sponsors a Coordinating Committee that meets monthly on behalf of shared clients. Substance abuse treatment programs, child welfare staff, managed care providers, health care providers, and representatives from the domestic violence community come together to exchange information and coordinate services. This forum offers all participants an opportunity to get to know each other, collaborate, and advocate on behalf of substance abuse-affected families.

Characteristics of the Three Models

All three models describe arrangements for interagency case management services and methods for dispensing them. The most appropriate model for a particular agency or program hinges on its own history and mission, the needs of its clients, and the environment in which it operates. In developing a model, it is important to remember that neither organizations nor environments are static, and interagency models may evolve in complexity from the single agency to the informal partnership to the formal consortium. Although each model has advantages and disadvantages, a model's fit with its clients, the agency, and environmental conditions determines its effectiveness for a particular program (Rothman, 1992). Figure 3-1 summarizes the characteristics, advantages, and disadvantages of each organizational model.

Each model offers distinctive strengths suitable for a particular organizational environment. For example, in rural areas that depend on "one-stop shopping" social service programs, the relatively low-cost single agency focus, with its capacity to respond quickly and authoritatively, may be the optimal choice. On the other hand, the informal partnership tends to deliver more diverse services, so it is better suited to culturally diverse communities. In communities dominated by managed care, a gatekeeper must make referrals for every service, and a formal consortium may be the best choice to supply the necessary documentation.

Besides determining resource acquisition, organizational environments impinge on program decisions in other, less obvious ways. In a volatile environment, a single focus agency with its rapid startup and minimal up-front investment may provide the only sensible alternative. Where shared services can produce savings through economies of scale, the partnership arrangement may maximize scarce resources. In an environment in which program operations are routinely disrupted by political upheaval, a formal consortium with its mandated procedures may provide the stability and continuity necessary to ensure that case management services survive.

Figure 3-1
Characteristics of the Three Interagency Models

Single Agency

Characteristics

- Small grassroots agency or major provider of services for a single problem or to a single population (may be "the only game in town")
- Tends to control a niche in the social service market by default (other agencies are not interested or refuse to serve clients), history, design, or funding mandate
- Often developed in response to an "acute" situation and implemented quickly
- Less focused on organizational process than other case management models; more focused on client-related tasks
- Interagency case management services built on informal agreements
- Case manager hired by and accountable solely to the single agency

Positive Features

- Responds to crises quickly
- Tends toward more cohesive or homogeneous values than other models
- Tends to have single point of access to substance abuse treatment or other services for clients
- Agency maintains sole control over implementation and coordination of case management program
- Clients relate to a single individual concerning all problems
- Often can respond more flexibly to individual client needs
- Has the opportunity to exercise a broad range of skills
- Is self-determining and self-accountable (monitors its own services)

Negative Features

- Less control over social environment (e.g., policies and funding) and accessibility to services
- Less influence over broad policies affecting case management services
- Without a broad constituency and widespread community support, more vulnerable when funding wanes or ends
- More responsibility or burden on front-line case management staff to establish connections with other community agencies
- Case manager may feel especially burdened or taxed by having sole responsibility for client
- Can require considerable training to equip case manager to deal autonomously with the diverse needs of clients
- Limited mix of services available to clients
- Limited array of outcomes or solutions for client problems

Figure 3-1 Continued

Informal Partnership

Characteristics

- Establishes and maintains informal partnerships or networks to respond to the needs of multiple populations with multiple problems
- Initial motivation for forming partnerships may have been funding-driven as well as need-driven
- Front-line case management staff from partnership agencies meet informally as a group (and without a formal contractual obligation) to discuss client cases
- Supervisors and other staff also may become involved and form relationships to share client-related concerns
- Staffing decisions are made internally by individual agencies
- May evolve from a single agency model or be the model of choice from program inception
- Less likely to have a lead agency than a formal consortium

Positive Features

- Meets and functions only as needed
- Avoids overlap of services
- Has access to broader set of resources than single agency model
- Coordinates care better among agencies at client level
- Counters staff's feelings of isolation by sharing burden of client responsibility
- Shares information and possibly resources with partner agencies

Negative Features

- Multiple problem orientations of partnership members may conflict with one another
- More opportunity to compromise individual agency goals with respect to clients
- Not as quick to respond to emerging problems as single agency model case management
- Investment of staff and time resources greater than for single agency models (e.g., time to attend meetings)
- Possible breakdown of service coordination among multiple providers may result in service gaps and fragmented care
- Clients may find it difficult to relate to multiple providers

Formal Consortium

Characteristics

- Two or more providers linked by a formal contractual arrangement
- Represents multiple values and philosophies
- Agencies cooperate and work together for a common purpose, which is formalized in the contractual relationship
- Agencies represent or cover multiple resources (e.g., housing and employment) in a particular social service market
- Typically identifies a lead agency (often the agency that funds or obtained the funds for case management services) to coordinate the consortium's case management services
- The case manager may be supported through pooled resources from members of the consortium or by the lead agency

Figure 3-1 Continued

- The lead agency generally hires the case manager, although multiple agencies within the consortium may participate in the selection process
- Accountability is shared across agencies
- Case manager is accountable to the consortium
- Entities primarily responsible for building and supporting the consortium (e.g., United Way; State, county, or city government; National Institutes of Health; or Centers for Disease Prevention and Control) may impose conditions or constraints on the case management process (e.g., mandated community involvement)
- Takes time and effort to develop; requires substantial up-front investment
- Focuses more on organizational process than other interagency case management models
- Tends to have a longer-term or more chronic orientation than other case management models

Positive Features

- Access to more resources
- Broader structure of constituent, political, and community support when resources are limited or the economy is strained
- More control in shaping the environment in which services are provided (e.g., more input into and control over policies, funding, and the kind of case management interventions and services that are offered)
- More opportunities for coordination of care among agencies at both client and system level
- Regularized contact between agencies increases occasions for strengthening service integration
- Enhanced coordination across providers can decrease duplication of services
- Consortium participants share information regarding changes in the organizational environment, available and declining resources, and treatment information

Negative Features

- Can be slow to respond due to problems of coordination
- Must contend with multiple definitions of a problem or solution that may spark conflict among consortium members
- Time devoted to organizational process may reduce time given to client-related tasks
- Clients may find it difficult to relate to multiple providers
- Clients may need to travel to several locations for services
- Multiple agency participation per case may involve higher costs and less intense personnel/agency involvement, without added benefit to client
- Potential systemic conflict over which agency takes lead and whose philosophy prevails when differences occur

Forging the Linkages

Interagency case management arrangements are designed to help providers connect with each other to improve client services and enhance the efficiency of their respective organizations. In addition to trading useful information, agencies also may exchange services, money, clients, and client service slots. In the area of substance abuse treatment, some case managers and addiction specialists may be former users themselves and may have known one another in their former lives (Brown, l991). These ties often strengthen or facilitate interagency exchanges

and relations. Seasoned case managers tend over time to form personal working relationships with others in the field and often trade on prior contact, previous service reciprocities, and favors owed to get services for clients (Levy et al., l992). Informal "quid pro quo" arrangements are common, as are shared resources to effect economies of scale.

While this system of informal exchange or "social service bartering" is intrinsic to case management, a more formalized connection among agencies sometimes may be required. Examples include memoranda of understanding (MOUs) and interagency agreements and contracts. Each of these methods for formalizing expectations can be used in single agency models, informal partnerships, and formal consortia.

MOUs are a means to structure a relationship among agencies. When agencies rely heavily on each other's services and function primarily as brokers for their clients, MOUs are essential. They specify such crucial information as the number of service slots that agencies will make available to one another's clients and the consequences for failure to implement or comply with specified activities or procedures. Program managers, rather than case managers, typically draft MOUs and other formal agreements and contracts with staff input. They are particularly useful for

- Ensuring continuity of services during staff turnover
- Clarifying lines of authority and control over various aspects of the case management process
- Recording commitments for providing or funding case management resources (e.g., staffing, operating funds, client referrals)
- Providing a formal record of agencies' agreements and responsibilities
- Holding agencies accountable

MOUs and formal agreements have special appeal when crediting or reporting the outcome or delivery of case management services. Among agencies and service providers that are reimbursed for services on a per capita basis, MOUs can be used to specify which agency or personnel will receive credit. When services are delivered as part of a research project, MOUs can specify who has access to data and who may claim authorship when research results are published.

Some agencies also use Qualified Service Organization Agreements (QSOAs) when an agency or official outside the program provides a service to the program itself. QSOAs might be used, for example, when the program uses an outside entity for laboratory analyses or data processing. MOUs cannot be supplanted by QSOAs.

MOUs and QSOAs are not the only type of formalized agreements available to case managers. Some programs use cooperative service agreements to define what the parties deliver to and receive from each other, and to monitor the programs. A legal contract may be needed when the lead agency in a formal consortium subcontracts to other community-based case management agencies to provide specific services. Many case management agencies also enter into agreements with funding sources, including those providing Federal entitlement benefits. Although some experts question whether case managers should function as payees (that is, accept and monitor entitlement payments on their clients' behalf), a substantial number of case managers take on that role. Until agencies become familiar with such documents and procedures, obtaining counsel prior to signing may be prudent.

Identifying Potential Partners

For any case management plan to be successful, a provider must take a hard, objective look at community resources. What form do they take? What are the barriers to access? Who makes the decisions about how they are used, how are these decisions made, and how can they be obtained? If housing is a major client concern, for example, a community assessment should ascertain if housing assistance is available and how case management efforts might help clients attain it. Similarly, a client's legal status can affect both the number and kinds of services needed (e.g., client involvement in the criminal justice system or with child protective services agencies). Such legal pressures, in turn, determine the range and type of agencies with which a case management program must interact and the conditions for these relationships. Thus, depending on the legal needs of its clients, a case management program may need to identify and forge relationships with such service providers as battered women's shelters, public assistance programs, legal aid, churches, 12-Step groups, and other relevant organizations.

Not all needed services are available, of course, and at times the successful case manager must create them. In other cases, needed resources may exist but prove inaccessible or unacceptable to clients. Ideally, case management agencies or programs want to provide or facilitate the full range of services required by their clients. From a feasibility standpoint, however, most providers must confront painful realities during the assessment process and be prepared to scale back expectations.

Fortunately, most communities already have tools to assist case management programs in identifying resources, possible provider linkages, and potential gaps in services. Public Health Departments, United Way, and county governments frequently produce directories of social, welfare, health, housing, vocational, and other services offered in the community. These often include detailed information about hours, location, eligibility, service mix, and costs; some directories are computerized and regularly updated. Although the costs associated with purchasing these automated directories can be steep (and should be considered when planning the program budget), their timeliness and convenience may justify the investment. In many areas, the Yellow Pages serve as an excellent resource for obtaining initial contact information on a variety of health and social services.

Another solid source of information is *geomapping*, an automated package that assists in resource identification. Philadelphia has developed software that not only provides basic program information but also indicates whether a particular program has any openings. Traditional paper maps or maps equipped with overlays can fulfill the same function.

While directories and other service rosters provide a useful starting point in identifying potential resources and service providers, additional work is required to determine which listings will prove fruitful. There are often delays in publishing and updating such directories, so that they may be out of date even before dissemination. It is critical that they be updated on a consistent, timely basis. Directories may not list all agencies or programs, and more than one directory may be necessary because an agency's focus can shift.

Ouellet and colleagues report some limitations in using directories, encountered when they developed a case management program for HIV-infected injection drug users (Ouellet et al., 1995). Initially, during startup, staff attempted to link clients to services solely using a service directory, followed by contact with organizations expressing willingness to

provide support. Some resulting linkages were found to be "largely useless" because

- Some organizations misrepresent the number or types of services they actually offer or have available
- Many services are poorly financed and disappear quickly
- Some organizations are incompetent or too poorly managed or staffed to provide adequate services
- Some agencies are too far away for clients to use (Ouellet et al., 1995)

In addition, Ouellet noted that some organizations, such as hospitals, stigmatized and treated injection drug users so badly that clients didn't want the services at all. Also, many providers genuinely interested in service collaboration underestimated the number of people seeking help and the breadth of expressed needs, and thus were unable to handle the deluge of service requests. Other organizations had the capability to work with these clients but were unwilling to do so.

To counter such limitations, case management programs often conduct "snowball surveys" in their communities, using one interagency contact to lead to another. This technique can yield insider information about other programs and agencies, their capabilities, and experiences in service use. Identifying and documenting resources and entitlements may be best undertaken during the early phases of program startup, when caseloads are low.

Experienced case management personnel also recommend visiting the programs to which clients will most likely be referred. Onsite visits impart a wealth of information that may confirm or refute the impression conveyed in written materials. They also provide an opportunity to establish valuable contacts with agency personnel who can facilitate client services once the case management collaboration is under way.

Accurate, current information about entitlements is essential for sound interagency case management programs and often can be obtained through local governments. New York City, for example, posts menus of entitlements on electronic kiosks. Many public libraries and local government offices display updated entitlement information regularly. Federal Regional Offices of agencies such as the Administration for Children and Families are another resource for entitlement information.

As case managers compile and document resources, they should also identify gaps in services so that they and others understand what is available in the community and where advocacy efforts are needed. It is also important to publicize case management programs throughout the community. Brochures, fliers, and simple one-page fact sheets can be used to advertise or explain a program. Announcements on the Internet, in community newspapers, on bulletin boards, and in local civic and professional club newsletters are inexpensive methods for promoting new services. Apprising local police of a new program's existence and the availability of services may be particularly important as their support can prove quite helpful with clients involved in criminal justice matters.

The Agency Environment

Exploring the environment in which an agency operates is essential in determining the feasibility of mounting an interagency case management effort. Several factors influence the provider's ability to conduct case management within the community, including

- **Social service agencies'** number, type, historic responsiveness to clients with substance abuse problems, openness to case management, and relationships with each other. Communities with abundant social service resources that address a wide range

of human necessities typically are better able to meet the diverse needs of substance-abusing clients than less endowed communities. Similarly, social service infrastructures in which providers are willing to accept substance abusers as clients and to accommodate innovative approaches to addressing their problems are more likely to welcome an agency's case management initiatives than more restrictive organizational structures.

- **Community leaders' support** for or neglect of substance abuse treatment and their response to case management concepts. Advocacy may be necessary because support or pressure from community and political leaders can facilitate a substance abuse agency's efforts to institute case management. Conversely, implementation can be stalled for months and sometimes stopped entirely in communities when leadership is opposed to substance abuse treatment or case management services for substance abuse clients. Identifying proponents and adversaries is essential in planning strategies that capitalize on support or overcome/sidestep resistance to a case management program. To form a strong supportive voice within a community, provider consortiums are often formed.
- **The economic situation in the community.** The more economically stable a community, the more resources members of the civic, governmental, and corporate power structure have to bring to the table in negotiations with other power brokers on behalf of a case management program or agency.
- **Social climate.** Community acceptance of substance abuse treatment and clients can influence some agencies, particularly those with a grassroots orientation, to accept and cooperate with a case management program. Bottom-up community acceptance can exert a powerful force in gaining agency leadership cooperation, although this outcome may take time.
- **Geographic considerations** (distance, terrain, isolation of the target population from mainstream services). Availability of case management services makes little difference when clients cannot access services because of transportation and other barriers. In fact, accessibility may determine the specific agencies with which programs are able to connect on behalf of clients.
- **Legal and ethical issues affecting implementation.** Some communities have zoning laws and other legal restrictions specifying which, if any, social service programs can be established within their perimeters or near schools and other public facilities. These statutes need to be clarified before investing in program startup. In addition, clients' possible involvement in the criminal justice system can raise issues of confidentiality and other legal concerns when creating cooperative arrangements with other agencies. Special care needs to be taken when an agency works with clients who are involved with the criminal justice system or who are in any way being coerced or pressured into treatment. Issues that can affect the transfer of confidential or sensitive information need to be carefully worked out before clients are actually admitted for service. Policies and procedures should be regularly reviewed in the face of experience and adjusted accordingly.
- **Funding for program startup and program continuation**. Amount and type of available funding (e.g., multiyear grant, limited foundation support for project startup, and matching or challenge grants) directly bear on the nature and organizational complexity of an agency's case management program. Multiyear funding permits substantial advance planning prior to program

implementation. It also enables agencies to bring current and projected resources into negotiations with other community organizations. Continuing funds also allow interagency linkages to develop and improve over time. In contrast, restricted, one-year funding may argue for front-loading resources and selecting a case management model that can be implemented quickly and with immediate short-term payoff.

- **Incentives for entering into an interagency agreement.** Stakeholders who recognize the benefits to their agencies will help facilitate case management. Also, cooperative relations tend to be more stable when participating agencies have much to gain by working together.
- **Volatility of the political, economic, or social environment**, such as the recent introduction of Medicaid managed care. Support for new initiatives can be difficult to obtain in a climate in which reimbursement criteria are being altered, State and Federal funding is being redirected, or political leadership is changing and the new players are unknown. In an uncertain environment, it is critical to justify the cost of a new service with compelling evidence. When chaotic conditions prevail, introducing a case management program gradually protects valuable resources while testing feasibility before full implementation.

Agency administrators, whether they are chief executive officers, executive directors, or program directors, must develop working relationships with the other social and human services agencies with which the case managers will be interacting. To be effective, case management requires that connections be made at the administrative/director levels of agencies. Because case managers may be expected to coordinate and implement a complex service plan in an interagency environment, the case manager needs sufficient power to implement the plan. This comes from the explicit endorsement of an agency's top level administration.

An honest appraisal of the community environment equips an agency or program to make key decisions about interagency case management. Some potential cooperating agencies cannot interact effectively with the larger community or can only provide on-site services. Other agencies may be willing to cooperate, but their organizational missions differ so radically from the case management program's that collaboration is impossible (Ridgely and Willenbring, l992). Part of the environmental assessment involves identifying such providers to avoid creating linkages that will ultimately prove unworkable.

Analysis of the community environment is one in a series of ongoing assessments aimed at understanding the changes that occur among clients, within the program, and in the community. As is true of other agency activities, case management takes place within a dynamic social service environment in which agencies are in constant flux (Rothman, l992). Programs considering interagency efforts must devise coping strategies to respond to change while providing necessary continuity for the client. In addition, interagency networks are fragile and frequently develop through personal trust established between case managers. Staff turnover disrupts such relationships and threatens the case management system unless guidelines or procedures exist to facilitate a smooth transition (Levy et al., l995).

Because social environments for delivering services do change over time, flexibility and individuation are hallmarks of effective case management. When programs become rigid in their conceptualization, case management services suffer. Regular reevaluation of community resources helps ensure continued relevance.

Finally, the philosophical orientation of a program can affect the efficacy of any interagency arrangements. Understanding a program's history and philosophy helps staff members determine the type of interagency case management services they offer their clients. Compatibility in both program philosophy and organizational structure in forging interagency cooperation is essential, because services suffer when the two clash.

Potential Conflicts

The potential for conflict exists whenever two agencies or service providers work together. Tension may be present from the very onset of the collaboration. For example, existing social service agencies may view a new project as competition for scarce resources (Perl and Jacobs, l992). Or, social pressures or the need to maximize resources can force public agencies into joint ventures even if they don't mesh well or have a history of competitiveness (Alter and Hage, l993). Tensions also can develop in the course of delivering services. Interagency collaboration may result in a client having two case managers, each of whom handles a specialized problem, for example, a case manager from a treatment program and a probation officer. In such instances, manipulative clients may pit one case manager against another—a situation that can become tense for all involved.

Recognizing potential triggers for interagency conflict and antagonism is a necessary first step to dealing with it. When problems do erupt, case managers and other agency personnel can use both informal and formal communication mechanisms to clarify issues, regain perspective, and refocus the interagency case management process. The following list highlights some of the common sources of conflict that may arise as a result of interagency case management.

- Unrealistic expectations about the services and outcomes that case management linkages can produce
- Unrealistic expectations of other agencies
- Disagreements over resources
- Conflicting loyalty between agency and consortium or partnership
- Final decisionmaking and other authority over the management of a case
- Disenchantment after the "honeymoon" period ends
- Differences in values, goals, and definitions of the problem, solutions, or roles (e.g., conflict could arise when police officers working with social service personnel perceive that they are being asked to function as "social workers" and vice versa)
- Dissatisfaction with case handling or other agency's case management performance
- Clients who pit one case manager against another
- Inappropriate expectations of case managers (improper demands, "asking too much")
- Resentment over time spent on documentation, in meetings, or forging and maintaining agency relationships rather than on providing client services
- Stratification, power, and reward differentials among various agency case managers
- Differences in case manager credentials and status among agencies
- Unclear problem resolution protocols for agency personnel

The solution to interagency conflict is open, frank communication by personnel at all levels. Frequent meetings and other activities that bring people together foster such communication. In the long run, the client's welfare is a shared objective, and the difficulties that are likely to arise can be successfully resolved.

4 Evaluation and Quality Assurance of Case Management Services

Substance abuse treatment programs, including those that receive public assistance, are increasingly operating in a managed care environment. Policymaking and clinical decisionmaking in a managed care environment depend on outcome data that have traditionally described the impact of case management and substance abuse treatment interventions in terms of services used and money spent. (See Chapter 6 for more on implementing case management in a managed care setting.) An additional demand for data comes from public and private payers who want services linked to specific outcomes.

In the past, public sector substance abuse programs were not paid to collect such data and were discouraged from using funds designated for service delivery to conduct evaluations. Consequently, evaluation services often were available only through demonstration grants or through the efforts of university-based evaluators. Today, however, many providers plan, fund, and perform their own evaluations. This reflects both the mandates of funding organizations and agencies' desire to refine or improve their services. To prepare treatment programs to get involved in these efforts, this chapter first presents findings from previous evaluation efforts and then proposes a framework for facilitating quality improvement and other evaluative efforts that consider multiple stakeholders and focus on myriad outcomes and data sources.

A Brief Overview of the Research Literature

Researchers only recently have begun to assess the effectiveness of case management. Studies conducted thus far have suffered from significant methodological problems that include small sample sizes, poorly defined or implemented case management interventions, problems in evaluation design and measurement, lack of distinction between case management and comparison interventions, poor timing, and unaccounted-for contextual factors in communities where case management was studied (Orwin et al., 1994). Problems in research design are more than an academic concern—they render results that may be misleading, difficult to interpret, and unreliable for use in developing case management programs or policy.

Although problems in research design affect other kinds of addiction treatment research, case management is especially difficult to evaluate because contextual factors play a critical role in program operations. Case management programs do not function in isolation. A key

component of a successful case management intervention is the establishment of linkages to other agencies in a service network. Some researchers have suggested that the effectiveness of case management may have more to do with the environment in which it functions than with the functions of the program per se (Ridgely and Willenbring, 1992; Morlock et al., 1988). However, in spite of these difficulties, some useful findings have emerged from work in the mental health and substance abuse fields.

Much of the research on case management has been conducted in the mental health field. Reviews of its effectiveness are mixed (Bond et al., 1995; Chamberlain and Rapp, 1991; Rubin, 1992; Soloman, 1995), revealing the need to identify specific program models and expectations about which type of case management works for particular populations and at what cost (Bond et al., 1995). The Assertive Community Treatment (ACT) model currently appears to have the strongest research base for persons with initially high rates of psychiatric hospitalization, both in terms of increased retention in community based treatment programs and in reduced psychiatric in-patient days (Stein and Test, 1980). This model includes a team of case managers who work with clients in an intensive manner to address problems of daily living and who have a long-term commitment to providing services to clients as long as their needs exist (McGrew and Bond, 1995). While the model appears to be effective in reducing psychiatric hospitalization, there is little evidence that the approach results in improved quality of life or level of functioning for the client (Bond et al., 1995; McGrew and Bond, 1995; Olfson, 1990; Soloman, 1992; Test, 1992).

Evaluation of so-called administrative models in which case managers coordinate services but provide little specific clinical care is inconclusive. Some of these programs improved clients' quality of life but did not interrupt patterns of rehospitalization. However, at least one study revealed that administrative case management both increased the use of services and increased costs for clients without a concomitant measure of improvement in clients' lives (Willenbring et al., 1991).

Few studies have been undertaken on case management in the substance abuse field, and it is difficult to generalize the findings of those studies that have. One study in Canada found results similar to those in mental health studies: There are positive, measurable effects of case management, especially for clients with poor prognostic indicators at admission (such as heavy consumption of alcohol and other drugs, previous treatment failures, and lack of social support) (Lightfoot et al., 1982).

Other studies of case management in the substance abuse field have reported few or no differences for case managed clients compared to those in treatment who do not receive case management services (Inciardi et al., 1994; Falck et al., 1994; Hasson et al., 1994). The authors of those studies, however, speculate that implementation and population issues may have affected outcome. Other studies attribute some of these negative findings not to poor case management interventions, but rather to methodological problems in the evaluations (Orwin et al., 1994).

Even in light of the implementation and methodological concerns about case management research, all the studies together with the findings of other addiction research suggest that case management can be an effective enhancement to intervention in and treatment of substance abuse. This is especially true for clients with other disorders, who may not benefit from traditional substance abuse treatments, who require multiple services over extended periods of time, and who face difficulty gaining access to those services.

In addition, research suggests two reasons why case management may be effective as an

adjunct to substance abuse treatment. First, treatment may be more likely to succeed when "drug use is treated as a complex of symptom patterns involving various dimensions of the individual's life" (Inciardi et al., 1994, p. 146). Case management focuses on the whole individual and stresses comprehensive assessment, service planning, and service coordination to address multiple aspects of a client's life. Second, retention in treatment is associated with better outcomes, and a principal goal of case management is to keep clients engaged in treatment and moving toward recovery and independence (Institute of Medicine, 1990). Studies looking at treatment retention and case management posit a positive relationship between the two (Siegal, 1997; Rapp et al., in press).

Case management's ambitious scope is one of the reasons its effectiveness is difficult to measure. Ashery and others have recommended that practitioners in the field maintain reasonable expectations for case management, pay attention to the implementation of programs, and understand the enhancing or limiting factors of the particular service context in which the case management programs are implemented (Ashery, 1994). The field should consider not only how to best research case management but what to expect from it.

Evaluating Case Management Programs

In order for substance abuse programs to ascertain if case management works, the program and its various stakeholders (including funding and regulatory agencies) must specify and measure outcomes they regard as indicators of success.

This section presents options for basic evaluative methods, including documentation of the case management program's progress and measurement of system and individual client outcomes. It concludes by identifying the data needs of various stakeholders. Whether an evaluation is conducted internally by agency personnel, or by experts hired from outside, front-line case managers are the key source of information.

In documenting a case management effort, it is important to start with *benchmarks*—expectations that are made concrete as measurable statements (e.g., "case managers spend 60 percent of their time in face-to-face contact with their clients"). Some of the sources that programs can use to establish benchmarks include

- Policy and procedure manuals
- Federal, State, and local case management standards
- Agency case management program descriptions and mission statements
- Literature on program models (if the program under evaluation is a replication)
- Consultants

If no written manuals or protocols are available, or if it is clear that the program has drifted from its original design, the program managers and staff may use a consensus-development process to arrive at benchmarks.

Measuring Practice

Once the process benchmarks are defined in measurable terms, the next step is to develop and implement a method for measuring practice—to answer the question, "What are case managers doing and how does their practice conform to the benchmarks?" One approach is to maintain a simple staff log that measures case managers' activities by contact. The information should be comparable to the benchmarks and brief enough to ensure compliance and quality of data. Staff log instruments such as the one used by John Brekke and his colleagues (Brekke, 1987) have

been widely adapted and used in the mental health field. They usually record the client's name, location of the contact, duration of the contact, activity, and whether other individuals participated (e.g., staff of other agencies or family members). The brevity and frequency of case managers' contacts with clients makes this measure extremely burdensome, and as a result many programs use time-limited or sampling measures (for example, over a two-week period) to get a "snapshot" of activities.

If time and resources permit, it may be valuable to use several methods of documentation to compare their usefulness and sensitivity. Other methods and purposes include

- Reviews of case manager client records (to evaluate how service planning and referrals adhere to protocols and procedural expectations)
- Interviews or surveys of case managers or clients and their family members (to collect information on activities in which case managers engage, to gauge how clients' and case managers' views of those activities differ)
- Analysis of data from the agency's management information system (to examine patterns on type, number, and duration of case manager contacts with different target populations)

In addition to using multiple methods of documentation, it is important to review case manager activities over time because programs may drift from innovative to familiar patterns of service delivery. In addition, the timing of data collection is crucial. New programs need time to stabilize, and new staff members need a period of orientation before a true picture of program activities can be established.

The key informant survey

Evaluators can use a key informant survey to examine the operations of a program's case management activities. The survey is a fixed series of questions about the functioning of both the case management program and the system of care and is administered to a variety of stakeholders in the community. Different stakeholders are identified by each agency, depending on its particular case management model and the system of care within which it works. Appropriate stakeholders may include, but are certainly not limited to

- Agency staff
- Staff from other substance abuse and human service agencies, homeless shelters, and hospital emergency rooms
- Clients and their family members
- Criminal justice and law enforcement personnel

Survey participants might be asked about their awareness of case management services, their use of these services, types of ongoing contact with the case management program, and their perception of the impact of these services on the community. To ensure a cross section of informed opinion at various points in time, all stakeholders are asked the same questions, and the survey is repeated at several intervals. Such surveys have been used to evaluate systems change in the mental health field (Morrisey et al., 1994) and could be adapted for use in case management programs.

Client satisfaction

Knowing how clients perceive the services they receive is essential to evaluative activities. One can argue that satisfaction with service is related to treatment retention. It is also important to know whether the service provider—in this instance the case manager—and client share a common view of the services being offered and their benefits. For example, did the client feel that the case management services actually led to needed resources? Other questions might focus on client perceptions about those providing the service: Did the case manager

understand their needs and have the skills and experience necessary to help them accomplish their goals?

Such process data have direct utility for program management and development. They may help programs with defining staff training needs and assuring that the needs of the population they are working with are being addressed. Such data are also quite useful for those who have the responsibility for funding programs.

Measuring System Outcomes

Many programs in the managed care environment control access to services through what is called "case management," in which gatekeeping procedures are used to limit clients' use of expensive services such as hospitalization and residential treatment. These programs may be particularly interested in measuring *system-level* outcomes to see whether case management has a systemic effect on the delivery of substance abuse and allied services (e.g., change in patterns of service utilization or costs). Thus, a net reduction in the number of inpatient admissions for substance abuse treatment would, by itself, be defined as a positive outcome. This, of course, may not reflect the needs of all clients.

If the goal is preventing clients from "falling through the cracks" between discharge from detoxification and entry into outpatient substance abuse treatment, a system-level outcome might be measured by continuity of care. Greater continuity could be defined as fewer clients with no outpatient treatment episode after a detoxification discharge, patterns showing shorter periods of time between detoxification discharge and outpatient treatment admission, and fewer people with "revolving door" detoxification admissions. Another case management program may aim for increased access to care for certain target populations (for example, cocaine-abusing pregnant women). In this instance, it would be useful to compare the number of admissions in the target population to all admissions during a specified time period.

In order to measure most system outcomes, it is necessary to track clients within a comprehensive service agency and, if a program's mandate includes managing care across a network of agencies, to gather data on encounters and costs and analyze them. Access to a computerized management information system (MIS) is essential for complete analyses. Although these systems vary widely in their level of sophistication, for this purpose, one must be able to document more than units of service information and should be able to link encounter, claims, and cost data and produce information quickly and easily. Over a period of time, a comprehensive MIS tracks changes in patterns of service utilization and changes in costs, which gives the agency information crucial to management and planning. For example, an MIS that combines utilization and cost data could help identify high utilizers for a program that focuses on clients who use numerous or expensive services. A later section in this chapter describes how a program can evaluate and enhance its MIS system.

Measuring Client Outcomes

While most would agree that "evaluation" is generally worthwhile, there is considerably less agreement about the measurement and documentation of specific outcomes for individual clients. When trying to evaluate case management in an ongoing service agency setting, additional challenges—conceptual, methodological, and ethical—are posed. The field has seen a long-standing and often strident debate about what kinds of outcomes should be measured. Some claim a single measure such as sobriety or complete abstinence from any drug use is the only meaningful measure of treatment success. Others assert that treatment success is

most appropriately measured by a constellation of factors, including diminished alcohol and/or other drug use, improved family functioning, improved occupational functioning, less deviant and/or criminal activity, fewer contacts with the criminal justice system, and improvement on a range of psychological variables. The debate will continue. In the meantime, programs should carefully consider treatment objectives to articulate and then operationalize those outcome variables they want to measure.

Another significant complication arises when trying to evaluate case management activities and client outcomes. A program must be able to articulate the role of case management and how it meshes with other program activities. However, when "standard" client outcomes—such as reduced substance use or fewer contacts with the criminal justice system—are measured, it is very difficult to separate the effects of substance abuse treatment activities from the effects of case management activities.

Finally, conducting research in community-based treatment/service organizations presents significant challenges. Experimentation, that is, comparison and control, is at the heart of any scientific research study. One group—typically defined as the "experimental group"—receives one kind of treatment and the control group does not. The two groups are then compared, and conclusions can be reached about the efficacy of the treatment. However, in the context of community-based treatment, a potentially beneficial service like case management cannot be withheld from some clients. This makes it extremely difficult to definitively attribute specific client outcomes to case management or some other service.

Anticipating Quality Assurance Data Needs

The types of data required for an evaluation of case management, how the data are collected, and the manner in which data are put to use vary among different stakeholders. It is important to understand the types of data that various stakeholders need to evaluate the program. Structured feedback loops should be established to ensure that the data gathered are returned to various stakeholders in some meaningful way so that they have an impact on shaping future program development (and future data needs). One of the benefits of the case management approach is that it can be adapted to meet the sometimes contradictory needs of the various stakeholders.

Data needs of case managers

Although the data needs of case managers may vary from agency to agency, rapid access to data in three particular areas is critical:

- Information about clients currently on the caseload (roster management), including outcome data so case managers have feedback on their performance
- Data that allow case managers to track clients through various services
- Data that produce "flags" for follow-up letters, aftercare, and other time-sensitive functions

In addition to these elements, case managers with gatekeeping or budgeting responsibility need overall service utilization and cost figures by client in order to manage services within a budget. To evaluate process, case managers need access (preferably computerized) to referral networks, bed allocation systems, progress notes, and data related to the daily conduct of their jobs. In terms of outcome data, case managers may want rapid access to client status, especially if it would prompt additional efforts.

Data needs of program managers

Program managers must ensure that the data collected reflect the program mission and facilitate the program's management. While the case manager focuses on individual clients, the

program manager analyzes data elements to see patterns and to flag and investigate "outliers"—those who deviate drastically from the statistical norms of the population.

The initial data needs of program managers reflect concerns with concrete aspects of program operation. To program managers, case management essentially begins when the phone rings, and therefore, their data needs are filled by asking the following basic questions:

- How many inquiries are we getting about services?
- Are we getting clients?
- From what area are our clients?
- Are clients entering care once they make contact?
- Are we responsive to clients' needs from first contact forward?
- Is the type of client changing?

In addition to collecting these initial data, program managers must be able to track clients through their services so they can decide how to alter service provision. Important questions include

- Who is in what level of care at what time?
- How does the service fit with their treatment plans?
- Is the program meeting clients' different cultural needs?
- Who is dropping out, and why?
- What service not currently provided is requested most frequently?
- How much money is being spent on a particular service?

Other questions relate to the program manager's administrative functions, including

- What are the case managers doing? What are their caseloads?
- What are the results of internal monitoring?
- Are we reaching the target populations?
- Are clients retained at the appropriate level of care?

Data needs of community policymakers

Community policymakers may be local government officials, members of community coalitions, representatives of local law enforcement agencies, school board members, or other interested community-based stakeholders. Since they are not often directly associated with treatment programs, they may not have a very sophisticated understanding of program goals and may think of outcomes in terms of questions like "Is the client sober or not?" or "Is there less crime?" They tend to be less interested in improved scores on standardized measures of client functioning than in easily defined and observable outcomes that affect the community, principally

- Taxes—Reducing costs to taxpayers in the areas of incarceration, unemployment, and welfare enrollment and reducing costs of case management and substance abuse treatment by substituting a costly treatment with a less expensive one
- Safety—Reducing neighborhood crime and the number of homeless persons loitering in business districts
- Social costs—Increasing the number of substance abusers who are working and improving care for children of substance abusers

Data needs of directors of State alcohol and drug abuse agencies

Directors of State substance abuse agencies value data elements that describe the overall accessibility, quality, and cost of the substance abuse treatment system. In addition, these directors require data to track and contain the growth of Medicaid and public sector behavioral health care expenditures, to put managed care systems in place, and to evaluate the effect of managed care (including the provision of case management) on the delivery of behavioral health care services.

Key data elements that State directors often want to see in evaluation efforts include

- Patterns of service utilization and costs, including the use of public hospital and residential treatment centers
- Numbers of clients working and withdrawing from welfare and Medicaid
- Numbers of clients avoiding prison, reducing child welfare cases and costs, and reducing food stamp usage
- Numbers of appeals and grievances by clients
- Number and characteristics of substance abuse patients accessing other publicly funded social services

Increasingly, State directors of substance abuse agencies are becoming less isolated and are beginning to look for opportunities to exchange data among previously independent departments (e.g., mental health departments, Medicaid offices, and criminal justice offices). Some State agencies share access to statewide data sets. In addition, the movement toward managed behavioral health care has prompted more integration of data between State Medicaid offices and State substance abuse and mental health authorities.

Data needs of third party payers

Third party payers such as insurance companies need data that justify case management as a cost above and beyond the direct costs of treatment services (see Chapter 6). In addition, when case management is used to coordinate care, third party payers want to know whether clients are receiving the right services, at the right level of care, and in the right sequence, and to ensure that clients who are no longer in need are no longer receiving services. To that end, important data elements include

- The severity of the client's illness
- Assignment to levels of care
- Patterns of service utilization
- Use of free self-help or volunteer organization services
- Urinalysis results, use of other drugs, and scores on standardized outcome indicators
- Discharge determinations

Data needs of clients and family members

Clients and family members may serve on advisory or governing boards of local programs or may be involved in family or peer support groups within the community. They may use outcome data, especially results of client satisfaction surveys, to change programs and policies or to choose services and providers. They may be less interested in patterns of service utilization or standardized scores on outcome evaluations than in how the system functions from the user's perspective. In fact, clients might consider a program successful if it is supportive, reliable, and easily accessible, as opposed to "efficient."

Data elements important to clients and family members include

- The availability and accessibility of services
- The freedom of choice (of services and providers) that the system allows
- The use and effectiveness of the appeals and grievance process
- The influence of input from consumers and family members
- Effectiveness of treatment
- Acceptability of treatment among the targeted populations

Specifically, clients seek answers to the questions

- Am I getting the right services, in the right setting?
- Are there systems I can access myself?
- How appropriate is my care?

Management Information Systems

The management information system contains all this information and allows stakeholders to use it. Managed care has provided the behavioral health care field with an example of how to manage far-flung data on clients.

One evaluation task for local programs is determining how to use data already routinely collected by a statewide MIS or managed care company-based MIS, saving the program from duplicating primary data collection. Another important task is to develop or enhance program-level MIS that track data the program needs locally, integrate with other computer-based or paper-based systems, and supply data required by third party payer and governmental bodies. All staff members of a specific program should be stakeholders in the MIS, which increases both system accuracy and the likelihood that a broad array of staff members will use it. If an agency does not have the resources to develop a sophisticated system, it should be able to automate at least a minimum amount of client information through commercially available software.

Local programs that are part of a managed care network undoubtedly will be included in a larger MIS sponsored by the umbrella provider. Providers who are not part of these networks may need to assess their readiness to take on managed care activities by evaluating their current MIS capabilities. Today, it is critical that an MIS be designed with the data requirements of managed care organizations in mind. The following guidelines, adapted from a Federal technical assistance publication, may help a program determine whether its existing MIS is sophisticated enough to support managed care operations. A program's MIS will suffice if it does each of the following:

- Retrieves patient information online or in less than an hour
- Cross-matches client records, use of services, and financial and insurance information
- Permits individual inquiries from managed care organizations
- Produces information that is used by clinicians, supervisors, and managers
- Integrates information from other programs and sites
- Allows client and service information to be reported to all major payers
- Generates patient invoices (CSAT, 1995d)

An existing MIS that can perform all of the above functions will likely support managed care and program demands; if it cannot, the program needs to strengthen deficient areas. Changes and advancements in data collection and access to patient information must be accompanied by appropriate protections for client confidentiality.

Future Research

Research focused on case management in the substance abuse field is limited and offers many opportunities for local substance abuse programs to make significant contributions to the field. Suggested directions for future research include the following:

- Key ingredients of successful programs, especially for hard-to-reach populations
- Relative cost-effectiveness of particular case management models, including cost outcome results within systems incorporating full parity of substance abuse with other health care, outcome results when a full continuum of care is available to patients, and outcome results associated with use of standardized guidelines for placement, continued stay, and discharge for substance abuse patients
- Improved methodology to investigate research questions in "real world" settings
- Development of brief versions of valid and reliable research outcome instrumentation
- The effect of particular forms of case management on societal costs of substance abuse and its treatment

- Cost shifting among health, behavioral health, criminal justice, and other systems that can be accessed by the target population
- Creative ways to use secondary data sets (such as Medicaid and Medicare) to determine trends and patterns of care
- Research questions from broader sociological or multi-disciplinary perspectives

5 Case Management for Clients With Special Needs

Case management is an appropriate intervention for substance abusers because they generally have trouble with other aspects of their lives. This is especially true for those clients whose problems or issues can be overwhelming even for non-addicted people. Among these special treatment needs are HIV infection or AIDS, mental illness, chronic and acute health problems, poverty, homelessness, responsibility for parenting young children, social and developmental problems associated with adolescence and advanced age, involvement with illegal activities, physical disabilities, and sexual orientation.

In an ideal world, case managers would be knowledgeable about all those problems and needs. However, understanding the ramifications of even one can be a staggering task. For example, a case manager dealing with a client who has AIDS would need to be conversant in epidemiology, transmission routes, the disease's clinical progression, advances in treatment regimens, financial and legal ramifications, available social services, as well as psychotherapeutic approaches to AIDS patients' grief and fear. Given the many other special needs the case manager confronts, it is apparent that no one individual can be an expert in every area. In the absence of such comprehensive knowledge, several general attitudes and skills provide a basic foundation for the professional delivering case management services to "special needs clients." The case manager serving special needs clients should

- Make every effort to be competent in addressing the special circumstances that affect clients typically referred to a particular substance abuse treatment program
- Understand the range of clients' reactions to the challenges associated with particular special circumstances
- Remain aware of the limits of one's own knowledge and expertise
- Evaluate personal beliefs and biases about clients who have special problems
- Maintain an open attitude toward seeking and accepting assistance on behalf of a client
- Know where additional information on special problems can be accessed

While it is impossible to discuss all the special needs that case managers confront, several occur repeatedly. This information is not intended to be a comprehensive treatment of any of these areas, but rather an introduction to the issues that most directly relate to the implementation of case management.

Minority Clients

Demographic realities in the United States dictate that case managers will be called on to work with individuals of different gender, color,

ethnicity, and sexual orientation. Some will be persons of color; some will be poor, not conversant in English, disadvantaged, and over-represented in many areas of the social services system. Case managers must "respond proactively and reactively to racism, ethnocentrism, anti-Semitism, classism, and sexism . . . ageism and 'ableism'" (Rogers, 1995, p. 61).

There are five elements are associated with becoming culturally competent: (1) valuing diversity, (2) making a cultural self-assessment, (3) understanding the dynamics when cultures interact, (4) incorporating cultural knowledge, and (5) adapting practices to the address of diversity (Cross et al., 1989). According to Rogers, culturally competent case managers have the

- Ability to be self-aware
- Ability to identify differences as an issue
- Ability to accept others
- Ability to see clients as individuals and not just as members of a group
- Willingness to advocate
- Ability to understand culturally specific responses to problems (Rogers, 1995)

Case managers should either speak any foreign languages common in their locale or refer non-English speakers to someone who does. It is also crucial for the case manager to be aware of what may inhibit minorities' participation in the substance abuse treatment continuum. For example, while "accepting one's powerlessness" is a central tenet of 12-Step self-help programs, members of oppressed groups may not accept it, given their own societal powerlessness. The case manager must always be sensitive to such cultural differences and identify recovery resources that are relevant to the individual's values. Some minority group members may be inclined to seek help for a substance abuse problem from sources outside the treatment continuum, such as clergy, group elders, or members of their own social support networks. Others may prefer to be treated in a program that uses principles and treatment approaches specific to their own cultures. Case managers must advocate for culturally appropriate services for their clients.

Clients With HIV Infection and AIDS

The usual functions and activities associated with case management in substance abuse treatment—engagement, helping orient the client to treatment, goal planning, and especially resource acquisition—are made more difficult in dealing with clients who have HIV or AIDS by

- Providers' and other clients' fear of contracting HIV
- The dual stigma of being a person with both a drug abuse problem and HIV
- The progressive and debilitating nature of the disease
- The complex array of medical, especially pharmacological, interventions used to treat HIV
- The onerous financial consequences of the disease and of treatment
- The hopelessness—and lack of motivation for treatment—among the terminally ill

Case managers who provide services to this population must be prepared to work with "a base of diverse resources, enhancement or adaptation of the capabilities of existing resources, or the development of new service programs specifically designed to address [the HIV-infected individual's] needs" (Sonsel et al., 1988, p. 390). The Linkage Program in Worcester, Massachusetts, is typical of this arrangement. It engaged 19 diverse agencies—including drug treatment programs, area churches, AIDS advocacy and support agencies, the city's department of public health and a regional medical center—in a consortium of care

for substance abusers who also had HIV infection (McCarthy et al., 1992). The Worcester consortium and other linkage programs demonstrated a positive relationship between the amount of case management services provided and the receipt of drug abuse, health care, and other services (Schlenger et al., 1992).

While one person should assume primary case management responsibility for clients with HIV or AIDS, a team approach is particularly useful in combating the feelings of frustration, abandonment, grief, over-identification with the client, and anger that frequently confront professionals in this setting (Shernoff and Springer, 1992). To avoid staff burnout, providers should avoid designating the same individual as case manager for all clients with AIDS and HIV infection.

The overwhelming nature of life for a person with two life-threatening conditions—AIDS and addiction—cannot be overstated. The magnitude of even daily tasks holds significant stress for both the client and the case manager. Addicted people with AIDS or HIV need help with physical functioning, interpersonal relationships, adjustment to the treatment program, housing, and practical and psychological adjustment to the two conditions.

Part of the case manager's linking function in working with an HIV-positive client is to educate the network of service providers, including substance abuse treatment staff, to recognize the competing demands of staying sober and dealing with the social and physical sequelae of HIV disease.

Clients With Mental Illness

Almost 40 percent of people with an alcohol disorder meet criteria for a psychiatric disorder, and more than half of those with other drug disorders report symptoms of a psychiatric disorder (Regier et al., 1990). Not unexpectedly, the prevalence of coexisting disorders is significantly higher in treatment populations than in the general population, approaching 80 percent in some studies of substance abuse patients (Khantzian and Treece, 1985; Ross et al., 1988; Kosten and Kleber, 1988). Given those high comorbidity rates, substance abuse treatment staff must be prepared to address the problems of dual-diagnosis clients.

Treatment services for clients with a dual diagnosis are organized in sequential, parallel, or integrated models (CSAT, 1994b). In the integrated model, both disorders are dealt with at the same time and in the same program. Case management's primary role includes facilitating clients' transition from residential programs to the community, helping them identify and access needed resources, and providing long-term support for their functioning in the community.

In the case of sequential treatment, the case manager helps the client move from either substance abuse to mental health treatment or from mental health to substance abuse treatment. In parallel treatment, the case manager must facilitate communication and service coordination between two agencies whose treatment approaches may be based on different assumptions. Examples of the possible issues the case manager may have to address on behalf of a client in mental health treatment programs include the following:

- Bias against substance abusers affects the provision of mental health services
- Many inpatient facilities establish an arbitrary minimum number of days of sobriety for their clients
- Some service providers will not accept clients who are on medication, including methadone

Conversely, issues in substance abuse treatment programs that might be counterproductive to mental health treatment include

- Treatment approaches may rely on insight and introspection that some mental health clients are intrinsically incapable of achieving
- The approach used in substance abuse treatment may be too confrontational
- The treatment program and other clients may reject clients taking psychotropic medication

Many of the special case management issues for clients with mental illness center on the client's use of prescription drugs to stabilize mood and reduce the negative effects of the mental disorder. Some substance abuse treatment providers oppose the use of any psychotropic drugs, fearing that they will interfere with the recovery process and become a new source of chemical dependency or that the prescribing physician is not adequately aware of the client's problems with addiction. Some treatment programs unwittingly precipitate a client's relapse by requiring the client to stop taking all medications as a condition of acceptance to a treatment program. Participants in 12-Step meetings may pressure clients to be free of the "crutch" of prescription drug use.

As substance abuse treatment providers become familiar with prescribed neuroleptic drugs, they are more likely to accept the medical management of the client's illness and communicate more with the professionals providing the client's medical care. To manage client symptoms and behaviors, anticipate problems, and reinforce the medical management of the client, all staff who work with dual-diagnosis clients need some knowledge of the benefits of commonly prescribed drugs, their potential side effects, actual abuse potential, and their interactions with other drugs.

Aftercare tends to be long-term for clients with mental illness because of the continuing possibility that the client will stop taking medications when he begins to feel more stable and then take illicit drugs to cope with the re-emergent symptoms of mental illness. 12-Step programs such as Double Jeopardy, Double Trouble, and Dual Recovery Anonymous designed specifically for people with mental health and substance abuse problems can be valuable sources of support.

While case managers may not be experts in the treatment of any one of these disorders, it is vital that they know enough to work with the client in identifying her needs and be able to translate and coordinate those needs with the two types of treatment.

Homeless Clients

Alcoholism rates among the nation's homeless are estimated to be as much as two to four times the levels for individuals of the same gender in the general population. Besides alcohol, the substances most frequently used by homeless people are marijuana, cocaine, and crack cocaine (National Institute on Alcohol Abuse and Alcoholism, 1989). Crack use in particular has increased in the last 10 years, primarily among younger homeless people (Crystal, 1982). Numerous efforts at engaging homeless individuals in substance abuse treatment have been undertaken, many involving case management as a central component (Braucht et al., 1995; Conrad et al., 1993; Sosin et al., 1995; Stahler et al., 1995).

The need for case management with this population is obvious. Clients need suitable short- and long-term housing; many have mental disorders. Homeless individuals frequently suffer from significant health problems secondary to their lifestyle, including tuberculosis, HIV, and AIDS. Unemployment is high. This constellation of tangible needs can best be addressed by one individual at the interface between the streets and social service agencies.

A case manager always begins by working on issues the client feels are most pressing, and the need for stable shelter may not be at the top

of the client's list. Many homeless people feel safer and more comfortable on the streets than in a shelter because the streets are familiar to them and because they have established routines and a network of people to watch out for them. While this setting is hardly ideal, it may be one in which the client can function well enough to benefit from treatment. However, some programs may claim they cannot help homeless individuals until their other life problems are solved, requiring the case manager to advocate on the client's behalf (Sosin et al., 1994).

The case manager's rapport-building skills are critical to break through the many defensive behaviors and protective attitudes that clients develop to survive in shelters and on the streets. These behaviors—looking tough, acting with bravado, wariness of social services, maintaining a hard exterior, and letting go of social graces—make homeless clients difficult to engage and interfere with their ability to succeed in treatment or maintain stable housing. One solution to this difficulty in engaging homeless clients is through the use of *peer case managers*: homeless individuals who are in recovery themselves and are based in shelter care facilities. In one such setting, peer case managers proved to be as successful as degreed professionals or an intensive residential treatment program in assisting homeless individuals in the areas of substance use, housing stability, employment, and psychological functioning (Stahler et al., 1995). In addition, clients were more satisfied with the services provided by the peer case managers than by the degreed professional case managers. This finding may be explained by clients' beliefs that case managers who have experienced homelessness first-hand are more likely to provide needed services.

To meet their linking and advocacy responsibilities, case managers must recognize that some services generally available to substance abusers are not available to homeless people and that new services may need to be created to fill those gaps. For example, Louisville's Project Connect used case management to help homeless alcoholic and drug abusing men move from a sobering-up shelter (the pretreatment phase of the treatment continuum) through a vocational program at the exit point of treatment (Bonham et al., 1990). Another substance abuse program at the Coatesville Veterans' Affairs (VA) Medical Center picks up homeless veterans at local shelters, takes them in vans to the VA for day treatment, feeds them, and takes them back to the shelter. This has helped to keep veterans engaged in treatment as they await placement in a VA domicile or other housing arrangement. The Department of Veterans' Affairs conducts stand-downs in its homeless program, during which veterans temporarily housed in tents receive medical services and are assessed for treatment needs. They are brought into residential care for treatment as needed.

The delivery of social services is complicated by the fact that homeless clients usually are turned out of shelters from 9:00 a.m. until 4:00 p.m. The client's social network during these hours consists of other people, often not sober, who are also out of the shelter. Providers may find it useful to provide a day room with snacks and a television where clients can stay during the day or some sort of day work where clients can earn a few dollars. Case finding can be accomplished by mobile case management teams who seek out homeless substance abusers in shelters and other areas where they sleep and congregate (Rife et al., 1991).

Women With Substance Abuse Problems

Case-finding is an especially important case management activity with female substance abusers, who seem to follow a different path to

treatment than males. Because women are often referred by other service providers (Beckman and Amaro, 1986), case managers affiliated with substance abuse treatment programs must help their counterparts in other social service agencies identify women in need of treatment. Women with children are likely to be involved in numerous child-related services; women who have been victims of domestic violence present for services at battered women shelters; other women may appear at mental health centers and women's health centers. A significant number of women clients have suffered physical, verbal, psychological, or sexual mistreatment (Miller and Rollnick, 1991; Mondanaro et al., 1982), and many who present for treatment live in an unsafe environment.

Once identified, women with substance abuse problems may be difficult to engage in treatment. Society judges substance-abusing women more harshly than male substance abusers. A woman's substance abuse problem is likely to have progressed significantly before being identified, and treatment may be complicated by factors like psychological functioning, situational realities, and systemic barriers (Wildwind, 1984). Other issues such as sexual abuse, victimization, and emotional dependency are frequently associated with women who have substance abuse problems (Markoff and Cawley, 1996). Transportation is a common barrier, especially in primary outpatient and aftercare treatment.

Women substance abusers who have children confront these problems and more when considering treatment. A mother's decision to enter treatment means the case manager must either identify a program that will take both the woman and her children or assist the woman in finding appropriate child care. These mothers may avoid treatment out of guilt and shame for the activities in which they have engaged to acquire drugs and the situations in which they have placed their children. Compounding a mother's shame is the fear that authorities will take her children away from her. As a result, an assessment of such a mother's needs is complicated by the fact that she is likely to lie to the case manager about her addiction and the way her family lives.

The basic functions and tenets of case management are well suited to improving retention and outcomes for women in treatment. There is evidence that women in particular do not adequately focus on their substance use and recovery until their needs for such resources as housing, food, medical care, and personal safety are adequately addressed (Hepburn, 1990). Case managers should assist female clients in developing a safety plan setting out well-defined steps to take should she fear, or be subjected to, violence. It is imperative to determine if women are living in a safe environment. Women who have children are even more extensively involved, or need to be, with community resources, including the school system, pediatric physicians, and children's protective services if their substance use has resulted in neglect or abuse. Case managers are responsible for facilitating the acquisition of these resources as their clients more through the treatment continuum.

A woman's involvement with community resources frequently places the case manager in a position to advocate for her needs. Advocacy means securing resources not only outside the treatment program, but also within the program, especially if the program primarily treats male clients (Brindis and Theidon, 1997). Advocacy not only improves the woman's acquisition of needed resources, but also empowers her to become more assertive on her own behalf and builds a closer relationship with the case manager. Advocacy cannot, however, stop the case manager from fulfilling her legal obligation to report child abuse or neglect.

Two excellent sources of information on the role that case management plays in the

treatment of women substance abusers are *Pregnant, Substance-Using Women* (CSAT, 1993) and *Case Management in Substance Abuse Treatment: Improving Client Outcomes* (Sullivan et al., 1992).

Adolescent Substance Abusers

Substance use and dependence are significant problems among adolescents in the United States. Some substance use is due to a developmental tendency to experiment, results in few consequences, and abates with maturity. However, a number of adolescents progress to the point of substance abuse or dependence. Because of the problems associated with abuse and dependence these adolescents are frequently involved with multiple systems, including child welfare, juvenile justice, mental health, and special education (CSAT, 1993).

A case manager is in a unique position to help adolescents and their families interact with those systems. The case manager of a teenager must have a thorough understanding of the developmental issues pertinent to adolescence, an ability to establish rapport with young people, a knowledge of family dynamics, and the ability to provide support and skills training.

The case manager working with adolescents will almost inevitably provide extensive case management services to the entire family as well. Problems such as poverty, child neglect, or parental substance abuse cannot be ignored. Acquiring an entire family as clients has numerous implications for caseload size, available resources, confidentiality, and whether the client is the adolescent, the family, or both. Challenges can arise in numerous contexts, for instance when an adolescent tells the case manager she plans to have an abortion. When State or Federal laws do not provide explicit guidance, the case manager must carefully consider who is actually the client and what are the best interests of the adolescent.

One case management model describes a three-phase approach, providing services during pre-treatment/screening, residential treatment, and continuing care (Godley et al., 1994). The goal of case management services during pre-treatment/intake is to improve access to services, provide initial orientation to the treatment process, and begin skills training. Case management for clients in residential programs links the client to needed services outside the residential facility and ensures a coordinated response by multiple agencies involved in an adolescent's life. During aftercare, the professional implementing case management continues the linkage and monitoring process and provides booster relapse prevention skills training with the goal of decreasing the likelihood of relapse or interrupting a relapse episode.

Family engagement in transition and aftercare activities is paramount for the adolescent juvenile justice client. The transition work with the family needs to begin before the end of the primary treatment episode, and preferably occurs throughout the treatment episode.

Clients in Criminal Justice Settings

The number of substance abusers in the criminal justice system is staggering. The Drug Use Forecasting Project, which tested arrestees in 26 major U.S. cities for illicit drug use, found positive results ranging from 48 percent to 80 percent. In one jurisdiction, 80 percent of all women arrested tested positive for at least one illicit drug. The Bureau of Justice Statistics (U.S. Department of Justice, 1991) reported that 54 percent of State prisoners reported drug use at the time of the offense, and 52 percent reported use during the previous month.

Case management for substance abuse clients in the criminal justice system evolved in a unique fashion, bringing together two complex systems with different goals and philosophies. While the criminal justice system is interested in the rehabilitation of offenders, its main focus is on public safety, which is maintained with punishment and legal sanctions. Likewise, while the substance abuse treatment system supports public safety goals, its primary mission is to change individual behaviors. These goals are not mutually exclusive; in fact, experience has demonstrated that integrating the techniques of these two systems can have a powerful effect on reducing the drug use and criminal activity of drug-involved offenders. Because participation in substance abuse treatment and other social services is often mandated, case managers have the opportunity to engage clients over a longer period of time and may be more likely to effect successful change.

Integrating the two systems requires some effort, however. The need to establish and maintain a therapeutic relationship with clients while integrating the sanction and control obligations of the criminal justice system poses particular challenges. Ambiguities about the case manager's role in client supervision and confidentiality considerations surface frequently.

The criminal justice system is fragmented into numerous components through which offenders may be assigned. In most jurisdictions, supervision can be provided for certain pretrial offenders who have not yet gone to trial. In other jurisdictions, such offenders may be given the option of diversion, in which successful completion of certain activities will avoid a conviction. Convicted offenders may be sentenced to county jails, state prisons, or probation; probation can include halfway house supervision, intensive probation, or electronic monitoring. Released offenders may be on parole or some other sort of post-incarceration supervision; in some jurisdictions probation sentences may follow sentences of incarceration. Linkages between prison and probation, or between county jails and community-based supervision, may be weak; databases are often not connected; and entities often report to different management structures. For example, probation offices are part of the court system in some jurisdictions, the corrections department in others. Case management efforts are critical to ensuring continuity when offenders move from one supervision level to the next, or between one status or location and another. Managing offenders who are changing status within this system while they are participating in substance abuse treatment services (both inside institutions and in the community) is exponentially more complicated.

Case management with offender populations may be implemented at any point in the criminal justice continuum. Case management can assist offenders in securing resources that are not only vital to their recovery and overall well-being, but also required by their deferred sentencing or probation. Establishing appropriate housing that will facilitate sobriety and helping the offender develop job-seeking skills are but two of the specific activities that may form the basis of the case management relationship. Offenders incarcerated in State and local correctional facilities frequently need assistance in managing their lives as they reenter the larger community. Institutional life is highly regimented, presenting special problems when offenders are released. In working with paroled individuals, the case manager must recognize that prison life encourages behaviors that are not appropriate on the outside. Parolees who have been imprisoned longer than a year may require more time in a semi-structured setting (for example, a halfway house) in order to make the transition from institution to community.

The case manager should address the needs of clients released from institutions in order of importance. The first priority is immediate stability, which can be facilitated by safe housing, access to either primary substance abuse treatment or aftercare, and social networks that facilitate positive behavior. Second, the case manager should either provide or make referral to sources of skills training, since individuals who have served lengthy sentences will likely need either habilitation or rehabilitation training in the areas of job searches, interactions with non-offender social groups, and problem-solving strategies. Third, the case manager should train or find training in setting and accomplishing short- and long-term goals. Incarceration often leads offenders to believe that the locus for control of their lives lies totally with other persons or institutions. While goal-setting is important to any client group, it is particularly important to clients who have had most basic needs provided for them. Ideally, the case manager will begin providing these services several weeks or months before a scheduled release, then follow the offender into the community. Lastly, the case manager can advocate for the offender both in the treatment environment and the criminal justice system.

In order to maximize effectiveness, several configurations of case management functions have been attempted, including:

Case management provided by the justice system. Justice system case managers are assigned caseloads at specific stages of the system, such as probation or parole. An advantage of this model is that justice system officials are invested in the process because their staff members are implementing it and reporting back to them. Major disadvantages are the expense and the fact that there may be conflicts between the philosophies and goals of the substance abuse and criminal justice systems. Another issue in this model is whether the case manager has actual training in substance abuse treatment approaches and community referral techniques, as opposed to primarily correctional interventions.

Case management provided by a treatment agency. The advantage of a community-based treatment model is that the case manager has a thorough understanding of the substance abuse treatment process. The disadvantages include, again, the expense and the possibilities that the case manager may not be familiar with the criminal justice system or that the treatment agencies may not have the resources for effective case management.

Case management provided by an agency separate from the treatment and justice systems. To reduce costs, a case management coordinator may be employed, with or without a caseload, to conduct intake interviews and supervise paraprofessional staff. The disadvantages of this approach include the addition of another agency to the collaboration.

Case management provided by a coordinator from the justice system who provides consulting services and technical assistance to support existing criminal justice case management. One advantage of this model is system ownership. A coordinator, with or without a caseload, oversees the work of a paraprofessional staff. The coordinator can move the criminal justice system toward a greater awareness of treatment issues by providing technical assistance that demonstrates service coordination.

Case management provided by multidisciplinary groups in the criminal justice system for offender management. This type of group may meet regularly and during crises. This model is the most inexpensive; however, it is the most difficult to successfully operate because no one is assigned overall responsibility for the offender (CSAT, 1995b).

One of the earliest models for case management services in the criminal justice system was created in 1972, when the White

House launched a demonstration program known as Treatment Alternatives to Street Crime (TASC) to divert offenders from the criminal justice system into substance abuse treatment. (The program name has since been changed to Treatment Alternatives for Safe Communities.) TASC was initially designed to identify appropriate offenders from the criminal justice system, assess their needs for drug and alcohol treatment, refer them to treatment services, monitor their progress in treatment (including conducting regular and random urinalysis testing), and report that progress back to the criminal justice system. In order to meet its goals of ensuring continuous treatment for offender clients, increasing treatment retention, improving treatment outcomes, and reducing criminal recidivism, TASC developed a set of core functions or critical elements, including

- Organizational Elements
  - A broad base of support within the justice system with a protocol for continued and effective communication
  - A broad base of support within the treatment system with a protocol for continued and effective communication
  - An independent TASC unit with a designated administrator
  - Policies and procedures for required staff training
  - A data collection system for program management and evaluation
- Operational Elements
  - Agreed-upon offender eligibility criteria
  - Procedures for the identification of eligible offenders that stress early justice and treatment intervention
  - Documented procedures for assessment and referral
  - Documented policies and procedures for random urinalysis and other physical tests
  - Procedures for monitoring offenders, including criteria for success/failure, required frequency of contact, schedule of reporting and notification of termination to the justice system

One helpful development is that recent research has convincingly documented the success of compulsory and coerced treatment for drug involved offenders (Leukenfeld and Tims, 1988; Hubbard et al., 1989; Platt et al., 1988; DeLeon, 1988). TASC clients tend to remain in treatment longer than other criminal justice-referred clients and than voluntary clients; retention in treatment is linked to better treatment outcomes (Toborg et al., 1976).

TASC programs have been successful in identifying a large number of offenders in need of substance abuse services (Cook, 1992). The TASC evaluation conducted in 1976 stated that various programs had achieved success in identifying a large number of offenders qualified for TASC services and that self reports, urinalysis, and referrals from lawyers and judges seemed to increase client flow (Toborg, 1976).

This type of structured case management between the criminal justice and treatment systems has facilitated the traditional goals of each system. Case management benefits the criminal justice system by

- Increasing supervision through drug testing
- Reducing drug use and criminal behavior
- Broadening the range of sanctions available to the criminal justice system
- Providing systems of graduated interventions
- Offering treatment in lieu of or in combination with punishment
- Providing information to the criminal justice system
- Providing a basis for judicial decisionmaking
- Extending the power of the court to influence drug-using behavior

Case management has benefited the treatment system by

- Increasing treatment outreach
- Providing assessments and making appropriate referrals
- Utilizing resources more effectively
- Orienting clients to treatment
- Retaining clients in treatment by utilizing criminal justice leverage
- Supporting treatment compliance
- Facilitating access to additional services
- Providing a framework and structure for managing criminal justice clients (Cook, 1997)

Over the years, the TASC model has been expanded to include offenders throughout the criminal justice system, including mixed offender populations and specific populations such as women or adolescents. Depending on a TASC program's administrative and programmatic structure, the approach to delivery of services may vary. The various models include operation as a separate administrative entity within a court system or functioning as a separate nonprofit organization. Acknowledging the diversity of program design, Cook noted:

"There are clear variations in the management of TASC clients. Some TASC programs are more 'system centered' as an extension of criminal justice system control. Other TASC programs are more 'client centered,' focusing on the rehabilitation needs of the offender. A mix of both seems to produce a healthy symbiosis of criminal justice system leverage, access to treatment, and therapeutic tension" (Cook, 1997).

The TASC model has also been adapted and incorporated in recent innovations such as drug courts, which began managing drug-involved offenders in the late 1980s, and have now been implemented in more than 300 jurisdictions. Judges, prosecutors and defense attorneys, treatment professionals, case managers, and pretrial or probation departments together apply continuous oversight of participants as they undergo substance abuse treatment as part of or in lieu of a criminal sentence. Key components include

- Integration of alcohol and other drug treatment services with justice system case processing
- Prosecution's and defense counsel's promotion of public safety while protecting participants' due process rights, using a nonadversarial approach
- Eligible participants identified early and promptly placed in the program
- Access to a continuum of alcohol, drug, and other related treatment and rehabilitation services
- Frequent alcohol and other drug testing
- Coordinated strategy governing responses to participants' compliance
- Ongoing judicial interaction with each participant
- Measurement through monitoring and evaluation the achievement of program goals and gauge effectiveness; continuing interdisciplinary education promotes effective planning, implementation and operations
- Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness

See TIP 23, *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* (CSAT,1996a) for more on drug courts.

While TASC programs have been designed with the interaction of treatment and criminal justice systems in mind, case managers in non-TASC settings must be careful not to encourage or support goals or objectives that place the offender in conflict with expectations of the

criminal justice system. The roles of the criminal justice official (usually a probation officer) and the case manager should be defined in advance in agreements forged at the highest levels of both the court and the agency providing services. Typically, the case manager negotiates with the parole or probation officer for sanctions that make clinical sense. Such a relationship affords the case manager the opportunity to educate a representative of the justice system about the value of treatment and case management. An upcoming TIP, *Transition from Incarceration to Community-Based Treatment,* addresses treatment for recently released offenders. It will be available in 1998.

Clients With Physical Disabilities

Chemical dependency is a coexisting problem for many people with physical disabilities (Moore and Polsgrove, 1991). Some 15 to 30 percent of all people with disabilities have a substance abuse problem, more than twice the rate in the general population. Among disabilities, rates of substance abuse are highest among people with traumatic brain injury, spinal cord injury, mental illness, and learning disabilities (Rehabilitation Research and Training Center on Drugs and Disability, 1997). The case manager delivering services to this population must know and understand those conditions as well as blindness, deafness, and chronic disease. Other suggested areas of knowledge are

- The etiology and course of various physical disabilities
- Effective treatment options, both group and individual
- The difference between appropriate disability accommodations and enabling "handicapped" behavior
- How disability acceptance and anger affect substance abuse treatment

Because many social service professionals still assume that people with disabilities are too helpless or too removed from the world to gain access to drugs, the case manager's role may lie chiefly in education—both about physical disabilities and about substance abuse treatment. Clients with disabilities may not recognize their need for substance abuse treatment or may expect to be denied treatment. Once in treatment, they may be misunderstood, or singled out for mobility or communication problems (Rehabilitation Research and Training Center on Drugs and Disability, 1996). The Americans with Disabilities Act (ADA) provides support for treatment programs oriented to this population by mandating that facilities be physically accessible to people with disabilities and that treatment professionals have an understanding of disability issues.

Assessment includes many issues unique to physically disabled persons. The case manager should explore the relationship between the client's disability, substance abuse, and recovery potential. For example, clients who had a significant substance abuse problem before becoming disabled need different treatment approaches than those who started using to cope with a new disability. An individual with a disability that predates his substance abuse may be obsessively focused on his "disability" and not be aware of the functional limitations imposed by the chemical dependency. Others may have acquired a disability as a direct result of substance abuse, but without "sober" time for understanding the disability they may not be aware of their functional limitations and how their current functioning levels make it difficult to learn or perform certain tasks. Mentors who have disabilities or physical rehabilitation professionals can assist newly disabled individuals in understanding their disability.

Treatment programs may need to be expanded to accommodate clients' disabilities. The case manager may also need to educate

other service providers about the needs of people with disabilities. To reach those with physical disabilities, 12-Step groups must be willing to use hearing enhancement equipment (e.g., hearing loops) in meetings and to hold meetings in accessible places. The case manager should become familiar with special equipment in order to help organizations purchase or borrow appropriate resources as required under the ADA.

The person in a wheelchair who must take medication for chronic pain from an injury may prompt resistance from recovery-oriented self-help groups. Similarly, some vocational programs within a treatment setting require clients to be sober for some time before they can be placed in a training setting. As a result, vocational rehabilitation services, while appropriate, are not available to individuals receiving pharmacotherapy for opiate addiction within those programs that do not consider such people drug-free. A case manager from either the disability field or the substance abuse field should educate members of other disciplines on how to structure treatment appropriately. The Center for Substance Abuse Treatment is producing a TIP on persons with disabilities who have substance abuse problems, which will be available in late 1998.

Gay, Lesbian, Transgendered, and Bisexual Clients

Gay, lesbian, transgendered, and bisexual cultures are often associated with substance use in general and alcohol use in particular. Findings suggest that both gay men and lesbians are more likely to be involved in the use of alcohol, marijuana, and cocaine than heterosexual members of all age cohorts (McKirnan and Peterson, 1989; Skinner, 1994), with the differences particularly pronounced among younger people. Gay and lesbian clients may also find their sexual partners in areas prevalent with drugs, increasing the risk of contracting the AIDS virus. The prevalence of use, coupled with homophobia, makes the recognition and treatment of substance abuse problems more difficult.

Given the emotionally charged atmosphere that often surrounds sexuality, case managers must be especially aware of their own feelings and beliefs. The link between personal beliefs and interviewing skills is especially important in the assessment of these clients, who may be reluctant to discuss health problems or issues related to sexual practices. The case manager must know the context of the client's life and ideally, the specialized language used to describe sexual practices in the client's community. The interviewer should gather precise information regarding the nature of the individual's sexual practices and number of sexual partners, unless a client is particularly vulnerable, in crisis, or might otherwise see the inquiry as intrusive or inappropriate.

To help gay or lesbian clients gain access to services, the case manager must know more than just an agency's formal stance toward them. Some agencies that are officially accepting are in fact hostile to homosexual clients, or simply are not familiar enough with their special needs to serve them effectively. A case manager should know which 12-Step meetings, clinics, and other resources are available, knowledgeable, and accommodating to the gay and lesbian communities. As with any client, treatment planning includes helping the gay client identify and develop social opportunities that do not involve drugs and alcohol. Advocacy for gay clients includes helping clients seek treatment for injuries and infections sustained through sexual activity and seeing that clients' needs are taken seriously.

Case Management in Rural Areas

The delivery of case management services in rural areas presents unique challenges. Social services may be lacking or so geographically dispersed that effective access and coordination is difficult. In addition, case managers working in rural areas must frequently deal with a culture in which "everyone knows everyone else," from both the client's and the service provider's standpoint.

Given the scarcity of resources, agencies, and specialty services, the professional in this setting is more likely to be a generalist. Case management is more likely to provide both service and service coordination. The substance abuse case manager must be a tireless source of information and education about substance abuse problems, not just for the client, but for the community as well. Perhaps the most difficult function of the case manager in a rural setting is advocacy. In a close-knit environment, advocating for a client may mean challenging the decisions of other service providers. On the other hand, the professional's close relationships with those providers may benefit the client.

Case management in a rural setting can take one of several forms. Telecommunication and video-conferencing practice models have been used to allow clients relatively easy access to providers and to facilitate providers' communication and recordkeeping (Alemi et al., 1992). Where the client lives far away from the program, services may be provided in an intensive manner, for example, daylong sessions with a particular client. A lack of formal services can be mitigated by the use of informal helping networks such as Alcoholics Anonymous. However, in using informal networks, the case manager will have to deal with the unique challenges to confidentiality occasioned by the rural environment.

6 Funding Case Management in a Managed Care Environment

Managed care is "an organized system of care which attempts to balance access, quality, and cost effectively by using utilization management, intensive case management, provider selection, and cost-containment methods" (CSAT, 1995d). Despite the antipathy that many public sector health care providers feel toward managed care, those providers are actually striving toward the same ends using similar means as managed care organizations (MCOs). Many substance abuse treatment providers have been working within a managed care framework for decades, that is, looking at utilization data and developing a continuum of care. Substance abuse treatment providers, particularly those who use case management, have historically recognized the importance of connecting disparate services to meet the needs of clients.

Whatever treatment providers' attitudes toward managed care, they will have to learn to operate within its bounds. More than half the States are currently in the process of adopting some form of managed care to provide behavioral health care services, and more than one-third have received Federal waivers to implement Medicaid managed behavioral health programs, with other waivers planned or pending. Some experts predict that many substance abuse programs, already accustomed to scarcity of resources, will make a smooth transition to a managed care environment. However, many programs, particularly those that operate the least like businesses, may find this an extremely challenging time. The need to be accountable for outcomes, particularly in the face of a tax-conscious public, will undoubtedly increase in the managed care era.

To adapt to the world of managed care, treatment programs must assess how their services are currently delivered and identify which elements should be preserved and which should be modified. They also must have a firm grasp on how changes in Federal and State reforms will affect their current and future funding mechanisms.

Funding Case Management in a Managed Care World

Despite the promise of case management as an important adjunct to substance abuse services, it will not survive without empirical data that support its efficacy. Key decisionmakers must believe that case management is an integral component of treatment service before they will incorporate it into the funding structure. This is especially true of States choosing to offer services through managed Medicaid HMOs. It is also true for people who receive services through Medicare HMOs. (See Chapter 4 for a discussion of program evaluation and measuring outcomes.)

Controlling costs while providing care offers program administrators and case managers an opportunity to demonstrate case management's utility to a newly engaged managed care company. For example, clients with long-term or chronic conditions may be required to move from residential facilities to the community before some treatment providers believe they are ready. In this scenario, case management can prove its value by providing the clients with wraparound or supportive services to aid in a successful transition. As another example, outreach case management can help in the area of relapse prevention and aftercare and thus avert the need for high-cost services like inpatient treatment.

Managed care tools—clinical pathways, standardized assessments, and treatment protocols—can work well in a case management context. The challenge then lies in tailoring services to the unique needs of each consumer and avoiding "cookie cutter" services. Use of these tools can increase case management's attractiveness to program administrators who operate in capitated or other forms of shared-risk environments.

The true test is to develop a comprehensive case management system within a managed care framework with the inherent flexibility and resources necessary to eventually show tangible savings. Only then will an MCO be able to clearly justify case management as a reimbursable service.

Who Decides?

The decision to include case management in the array of treatment services usually rests with a primary funding source or at the program level. As many traditional public sector providers overhaul their delivery systems to participate in managed care, they must recognize the importance of case management as a key element of effective treatment and communicate that to the funding source. If the primary source of funding (usually a State agency) expects or requires specific outcomes that go beyond sobriety or cost containment, then a program administrator must develop ways to measure those outcomes.

To undertake scientifically valid outcomes studies is beyond the reach of most treatment programs. Providers can, however, increase the chances of having case management activities reimbursed if they measure everything that helps the client, such as consumer-run support groups, drop-in centers, or "Compeer" programs, in which volunteers help clients maintain sobriety and manage other aspects of their lives. Keeping good records will allow managed care companies to determine exactly what's being provided—and what constitutes case management.

Funding Models

The multiple players involved in funding public substance abuse treatment have posed complex and ongoing problems for program administrators. Each funding stream has its own eligibility rules, service conditions, and reporting requirements, which frequently differ from those of other agencies supporting a program's operations. Case management services are no exception and have traditionally been funded through a variety of sources as well. These include

- Block grants from Federal agencies
- Medicaid, which included options that allow for non-medical services (e.g., the Medicaid Rehabilitation Option)
- Medicare and Supplemental Security Income (SSI) for disabled clients
- Migrant health funds
- Private foundations and funds, such as United Way
- State and/or local tax dollars
- Private insurance

Far too often, the disparate mandates of these funders have exacerbated system and service fragmentation. Integration of funding streams has emerged as a strategy to meld services and provide continuity of care. Some States, in fact, have used Medicaid managed care initiatives as the catalyst for blending funding streams, particularly in full capitation models.

As States gain more freedom to allocate Medicaid dollars as they see fit, the prospect of increased flexibility in services offered at the program level improves. Programs that can account for funds received in terms of positive client outcomes will be better able to structure their service mix in response to clients' specific needs rather than to the dictates of funding agencies removed from the service delivery level.

Managed care is frequently used as a vehicle for integrating funding streams and for fostering collaboration among health care providers. For example, many managed care organizations establish (or will only contract with) integrated provider networks that

- Offer a full range of services
- Extend coverage over a wider geographical or population area (thus increasing the number of potential enrollees and sharing the financial risk among more providers)
- Maximize efficiencies in areas like management information systems

When providers are organized in such a manner, administrative service organizations are engaged to handle a wide range of business duties for the network.

Blended funding approaches, especially those that give providers the necessary freedom to make clinical decisions while still holding them fiscally accountable, can preserve and support the case management function as an integral facet of modern substance abuse treatment. Capitation or enrollment rates based on genuine costs associated with providing treatment and "stop-loss" clauses that cover such contingencies as reimbursement for longer or more intensive treatment than anticipated may help satisfy the providers' desire for flexibility and the payer's demand for fiscal responsibility.

Substance abuse treatment services are treated in different ways depending on which overarching health care delivery model is implemented by the State or by the managed care organization(s) contracted to provide behavioral healthcare. The two models currently prevailing are the *carve-in* model and the *carve-out* model.

Carve-in models

The *carve-in* model integrates physical (e.g., traditional medical services) and behavioral (e.g., mental health and substance abuse services) health care and is often the model chosen to manage a State's Medicaid population. Although the purchaser of services may elect a carve-in approach, frequently the MCO may elect to carve out behavioral health care by contracts with managed care organizations. This is because behavioral health care tends to be the most expensive cost center of treatment within an integrated, managed care model of treatment. The carve-in model generally appeals to providers because many individuals with mental illness and substance abuse problems also have serious physical health problems. Integrating the two also underscores the notion that since body and brain are part of the same system, mental illness and substance abuse are bona fide health problems.

However, in such a model, case management is often administrative in nature and involves clinical oversight and activities such as utilization review and prior authorization procedures. The primary care physician functions as the case manager or gatekeeper who assesses the range of services the client needs and, ideally, refers him to network providers who offer specialty services. This

happens when the physician is ill-equipped to provide the often labor-intensive, client-specific case management functions needed to successfully manage the client/member.

This model for behavioral health care has two major drawbacks. First, primary care physicians may underdiagnose substance abuse problems, especially in populations such as women (in whom depression is often diagnosed but seldom tied to substance abuse) and the elderly. Lack of knowledge or the desire to hold down costs also may lead to underutilization of services, with consumers denied access to needed care.

Second, since the course and overall treatment costs of behavioral health problems are less predictable than many physical health problems, the ability to establish firm enrollment or capitated rates is difficult. If rates are too low, the problem of inadequately treating or excluding those most in need of costly or long-term care (e.g., clients needing residential treatment) becomes a legitimate concern. When services are subcontracted, *skimming* may become a problem. In this situation, the opportunity exists to cost-shift "difficult" clients to subcontractors who receive only a percentage of the capitated rate. Not only are funds insufficient to provide proper treatment when this happens, but the subcontracting provider's resources are strained to the maximum.

Carve-out models

In *carve-out* arrangements, behavioral health care is considered distinct from other physical problems and is handled either as a separate contract or is intentionally excluded from a managed care plan. If behavioral health care is carved out and handled as a separate managed care account, it is possible to develop capitation or enrollment fees specifically tailored to this population. Carve-outs also provide States with a mechanism to monitor and control the use of substance abuse or mental health funds and some assurance that those problems are being addressed. Ideally, carve-out managed care organizations will have expertise in substance abuse services or will work jointly with providers who possess that expertise. In all cases, State officials must develop specific contract language to carefully define their responsibilities (CSAT's Technical Assistance Publication *Purchasing Managed Care Services for Alcohol and Other Drug Treatment* offers suggestions for assessing managed care approaches and structuring effective contracts for managed care services.)

Case management in a carve-out model is likely to remain a service function, particularly if the responsibility for behavioral health care is delegated to the public sector. Given the trends in behavioral health care, the public sector might be advised to learn from the example of the proprietary, more precise matching of clients and service packages through management information capabilities, some aspects of utilization review procedures, and the development of clinical pathways. These efforts also help providers use their resources wisely and ensure that appropriate and cost-effective services are available to individual consumers. Unfortunately, this method lacks integration with the physical medicine side of treatment, which can lead to ineffective case management and duplication of services by the behavioral health provider and the primary care physician.

Preparing a Program for Managed Care

To adjust their current operations to meet new demands, programs need to assess their systems, appraise their readiness to operate in a managed care environment, and position themselves and their case management services in a competitive market by identifying market niches and preparing for increased staff licensing and accreditation.

Systems Assessment

As discussed in Chapter 1, case management assumes different forms depending on its setting and organizational context. Before integrating with managed care, program directors and administrators need to understand how case management is practiced in their program. Administrators must identify potential buyers of case management services and must stay abreast of plans to integrate Medicaid with public funds and efforts to secure private vendors to manage public behavioral health care services.

Administrators also need to ascertain exactly who their program is serving, the nature and the range of clients' problems, and the gaps between what the program offers and what clients need. They must be able to articulate how these gaps are hindering the successful execution of their programs' mission.

With the blending of systems via managed Medicaid and Medicare, providers are now forced to compete directly with each other. Eventually, all services now delivered by traditional community providers will be delivered within a managed care framework. Currently, many public sector providers of services to people under Medicaid managed care guidelines (for managed care companies) are providing administrative and clinical case management services for a "fixed," "blended," or "bundled" rate. That rate is a small piece of the pie that comprises the total per-member capitation payment the provider receives and usually is not assigned a specific dollar value.

What is the program doing?

As a first step in organizational assessment, administrators must clearly define the case management model(s) being used in the program. At the agency level, community needs and available resources must be reviewed. Often case management services are subsumed under the general category of "the costs of doing business." Under managed care, it is important to know precisely what services are being offered, what they cost, and what outcomes can reasonably be expected. Case management must be scrutinized both as a stand-alone activity and as part of a total package of services potentially available to consumers. The importance of auditing the costs and revenues associated with various services cannot be over-emphasized, particularly if a system is moving toward a capitated or shared-risk paradigm. Case management, whether a direct service or administrative function, must add value and provide cost benefit to justify its inclusion in the total array of services.

Clinical case management must demonstrate direct or indirect benefits above those that consumers can expect from traditional services. The gatekeeping function in administrative-level case management limits the discretion and treatment planning authority of a substance abuse professional. Offsetting this disadvantage, ideally, are two systemwide advantages: reduced costs by denying unnecessary services and by providing support for people in the community so that they do not need more expensive residential or inpatient care, and better clinical decisionmaking. The gatekeepers' decisions are based on established clinical pathways and protocols—the goals of this standardization being improved care as well as lowered costs.

Who is paying for case management?

Reimbursement for the case management aspects of treatment may come from one or all of the following sources:

- Private managed-care organizations (MCOs)
- Fee-for-service clients
- Private payers such as corporate employee assistance programs, foundations, and grant funding
- Volunteer and local sources
- Courts and criminal justice funding
- Social service providers (e.g., child welfare)

- User taxes and State and federally appropriated funds

Providers should understand exactly how these funding streams are integrated or separated, as well as the inherent flexibility in their use. Such knowledge will help design a case management program and will also help in advocacy efforts to shape State policy on funding streams.

How does the program model fit within the system?

It is equally important for providers to understand how case management is defined in their State's managed care contract, if at all. What specific activities are considered case management and are they reimbursable? If they are reimbursable, are there limits on the number of billable units per consumer? Is there a finite pool of funds available on a fee-for-service basis? Given the melding of clinical and fiscal functions at the provider level, it is also critical to consider who benefits from case management and who does not. What is a reasonable length of time to offer services to a consumer? It is imperative that program staff grapple with these questions to best allocate available resources.

Readiness Review

In some cases, conversion to managed care must be accomplished in as little as six months after the enactment of legislation or by corporate decree, so providers must assess their readiness to make this transition rapidly and effectively.

Tools and surveys can help administrators do a readiness review by providing a clear picture of what models they are using and how they fit in the changing environment. One such tool is the *Managed Healthcare Organizational Readiness Guide and Checklist* reproduced in Appendix C. This and similar tools can help agencies evaluate their current operations within each of the following areas

- Program services and structure
- MIS capacities
- Fiscal/financial structures
- Utilization review capabilities
- Program evaluation and quality management
- Staff development and training needs
- Board and management structure
- Marketing
- Licensure and accreditation (CSAT, 1995d)

Identifying Market Niches

In the managed care environment, programs will have to function as businesses and therefore must position themselves and their case management services in a competitive market (Brokowski and Eaddy, 1994). By focusing on the establishment of a market niche like the treatment of special populations (e.g., drug users, criminal justice clients, older adults, clients with HIV and AIDS), an agency can be a player in the transition to managed care. In addition, issues such as staffing, pricing, and salaries can be revisited within the market framework.

Despite its inefficiencies, the public system of behavioral health has more experience and expertise than private programs do in caring for the most seriously disabled populations and in providing services that focus on their everyday life problems, such as employment and housing. Since this chronically needy clientele is least likely to be covered by private employer health plans, it offers a natural market niche for public-sector service providers.

Providers who serve Medicaid and Medicare recipients will see an increase in commercial business as a result of managed care contracts but will primarily be paid indirectly. MCOs will become the main source of revenue for the providers, as opposed to the local or state government. Medicaid and Medicare revenues will flow from the government to the managed care company to the service provider. High-volume providers, who are successful at delivering high-quality, cost-effective services

may even find themselves acquired by the managed care company.

State and Federal governments, in anticipation of the changing public sector system, have been disseminating resources to help publicly funded treatment providers survive and compete in a marketplace dominated by managed care organizations. The Federal Government is also currently designing programs and projects via the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP). The National Leadership Institute Coordinating Center (NLICC) will provide resources, technical assistance, and materials to assist public sector providers in making the internal changes necessary to compete.

Licensing and Accreditation

One of the most controversial aspects of case management is the issue of licensing. Many believe that case managers should have earned at least a master's degree. Others argue that some of the best addictions counselors have received their education through overcoming their own substance abuse.

While both viewpoints—and the many in between—are valid, managed care will increasingly require higher levels of education as case management becomes a common ingredient in its mix of services. Case management functions were performed by paraprofessionals in the 1980s and early 1990s. Today, however, credentialing standards of managed care organizations and other providers require that case management be performed by people with master's degrees in social work or education. All case managers may need to earn advanced degrees to perform reimbursable case management in the near future.

Provider profiling and performance reviews of individual practitioners are commonplace in managed care systems. Because data drive so many managed care decisions, any outlier, whether the cost of one consumer's care or the performance level of an organization or professional, is likely to prompt a closer look. It seems likely that, as managed care organizations gain greater influence in the substance abuse world, there will be an increased demand for more professionally trained treatment personnel and for provider organizations to gain accreditation from national organizations such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Rehabilitation Accreditation Commission (CARF), Community Mental Health Services (CMHS), SAMHSA, or the National Committee for Quality Assurance (NCQA).

Future Directions

The profound changes in reimbursement patterns have sent shock waves through the substance abuse treatment field. And change clearly will persist. Payers and those who allocate resources will continue to demand that the efficacy of services be demonstrated. On the programmatic level this will necessitate evaluating each service component and determining how it contributes to overall objectives. Programs must articulate their service expectations and decide what kinds of training and experience a practitioner must have to successfully deliver them.

What is needed now is more research on case management. Several promising lines of research, presented in Chapter 4, suggest that certain forms of case management activities improved client outcomes, resulting in fewer employment problems, increased income, longer treatment retention, and diminished drug use. Other studies focusing on a criminal justice population suggest far-ranging benefits. However, the applicability of those studies to the population outside prison and jail has yet to be established.

This research should be undertaken in a variety of settings and should address issues that demonstrate the efficacy of case management activities. What approaches work best for what populations in which kind of setting? While such questions are typically investigated by university researchers through demonstration projects, the research community must work with community-based programs in this case. It will require hands-on experience to fully understand how case management functions, what benefits it achieves for program clients, and how much it costs to provide this service. Case managers must be able to follow their clients from pretreatment to aftercare to determine if treatment and services have succeeded. Quantifying its benefits is the most compelling argument for case management.

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