# ACCESS TO RECOVERY:

# A CASE-MANAGEMENT GUIDE

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## Introduction

During the summer of 2007, the Center for Substance Abuse Treatment in the Substance Abuse and Mental Health Services Administration, (SAMHSA/CSAT) tasked its Access to Recovery (ATR) technical assistance contract, the Performance Management Technical Assistance Coordinating Center (PM TACC), to develop a set of resource materials for incoming second-round ATR grantees. The PM TACC prime contractor, the American Institutes for Research (AIR), and their subcontractor, JBS International, Inc., brought to this product-development task the experiential knowledge rooted in service to CSAT and the ATR Round 1 grantees throughout all phases of the first-round grants-- from the pre-application roll-out of the Presidential initiative, to early implementation and sustained operation of the grant programs, to their eventual close-out. SAMHSA/CSAT's selected topics for the resource materials target key issues, barriers, challenges, and decision points that faced the first-round grantees during each of these phases. They are written from the PM TACC contract's experiences with the 15 grantees that broke new ground for the substance abuse field by demonstrating the feasibility of using a voucher model for providing publicly-funded treatment and recovery services.

Some of the newly developed resource materials modify, update, and consolidate technical assistance (TA) reports emanating from the Round 1 grantees' TA experiences. Other products provide syntheses of the Round 1 grantees' experiences related to various topics central to effective and efficient planning, implementation and management of an ATR grant. CSAT has requested that these reports be made available to Round 2 ATR grantees so that the new cohort may benefit from the experience and work accomplished by the initial ATR grant recipients. Below are lists of the available reports.

### SYNTHESES

- Access to Recovery Report: Lessons Learned from Round 1 Grantees' Implementation Experiences
- Administrative Management Models: Compilation of Approaches by Initial Access to Recovery Grantees
- Planning and Implementing a Voucher System for Substance Abuse Treatment and Recovery Support Services: *A Start-Up Guide*
- Setting Up a System for Client Follow-Up
- Recovery Support Services
- Case Management
- Summary and Analysis of Grantee Fraud, Waste, and Abuse Activities

### TA CONSOLIDATED REPORTS

- Basics of Forecasting and Managing Access to Recovery Program Expenditures
- Compilation of Technical Assistance Reports on Rate Setting Procedures
- Development of a Paper-based Backup Voucher System
- Financial Management Tools and Options for Managing Expenditures in a Voucher-Based System: Round 1 Grantee Experiences
- Motivational Interviewing: A Counseling Approach for Enhancing Client Engagement, Motivation, and Change

- Outreach to Faith-Based Organizations: Strategic Planning and Implementation
- Strategies for Marketing Access to Recovery to Faith-Based Organizations
- Targeted Populations: Technical Assistance Examples

## About this TA Report

This document, *A Case-Management Guide*, provides a literature review of case management practices for substance abuse services and serves as a guide for grantees and service providers on the provision of case management services that allow clients and case managers to make more informed decisions when selecting services. The guide is being developed by talking with each grantee about their experiences designing and providing case management services to ATR clients.

The document begins with review of recent research findings on the efficacy of case management in the broader substance abuse services context. The noteworthy finding from this review is the evidence for "differential effectiveness" of case management practices on outcomes of care. Research findings are presented that emphasize not merely *if* case management "works"—but when, and for whom, it works best. These findings hold important implications for ATR grantees that choose to incorporate case management into their programs.

In addition to the literature review defining "effective" case management practices, contexts, and influence on client outcomes, we also provide results from semi-structured interviews with ATR Round I (ATR I) grantees on their experiences with case management in ATR I, and their refinement of these practices/systems for ATR Round II (ATR II). We review and define various case management models that were adopted in ATR I and suggest that a SAMHSA "best practice", the *strengths-based case-management model*, is also a best practice for implementing case management in the ATR-specific context, so long as three caveats are met by the ATR program:

- Define standardized rates for case management services;
- Separate the case-management role from the provider role; and
- "Triage" clients, if necessary, to identify those who most need a case manager.

Finally, we discuss the implications of ATR's tenet of client choice on the case manager role, including information case managers use to help clients make informed decisions.

The Case Management Guide presented here defines case management, describes the case management approaches/models utilized in ATR's Round 1 grants and synthesizes recent research findings relevant to implementing case management in the ATR context. The availability of accurate information for consumer choice is a prime requisite of the Access to Recovery (ATR) model. In appreciation of this key element, the following manual integrates the theory and practice of "case management" with ATR's emphasis on providing client information and ensuring choice. Consistent with SAMHSA's *Treatment Improvement Protocol (TIP) Series 27* (1998), entitled "Comprehensive Case Management for Substance Abuse Treatment," we define case management as a set of *functions* through which an ATR program helps clients gain access to the services they need for sustained recovery. Our goal is to suggest ways that previous

research, as well as the experience of Round I ATR grantees (ATR I), might guide Round II ATR grantees (ATR II) in implementing case management effectively.

Our discussion is organized into four sections. Section 1 provides an overview of case management, both as traditionally conceptualized and in the context of ATR. Section 2 presents empirical results that—especially since 2004 when ATR began—have supported or challenged the positive effect of case management on patient outcomes in venues other than ATR. Section 3 relates ATR I grantees' experiences and recommendations regarding the use of case management in an ATR setting. Finally, Section 4 suggests future research directions that might enhance the utility of ATR case management.

## About the ATR Program

ATR is a competitive discretionary grant program funded by SAMHSA that provides vouchers to clients for purchase of substance abuse clinical treatment and Recovery Support Services (RSS). ATR program goals include expanding capacity, supporting client choice, and increasing the array of faith-based and community-based providers for clinical treatment and recovery support services. Key among ATR's goals is providing clients with a choice among qualified providers of clinical treatment and RSS. Under the ATR program, treatment and RSS can be provided by both nonsectarian and faith-based organizations (FBOs).

## Section 1: An Overview of Case Management

Whether applied to the traditional milieu of physical health services generally, to the more specific field of substance-abuse treatment, or to the particular structure of ATR programs, a case manager advises and guides individuals in choosing treatment modalities and providers. Thus, regardless of the setting, a case manager is an *information intermediary*.

### Case-Management Principles

The *TIP Series 27* (1998) notes that, in the 30 years preceding its own publication, the social services literature had referenced "case management" more than 600 times. The use of the term, then and now, has ranged from organizing the flow of cases through a criminal-justice system to coordinating a hospitalized patient's treatment across departments and providers. Nevertheless, case management still refers, most commonly, to arranging for (or to providing) in-patient or out-patient medical services.

Further, Carr (2007) emphasizes that, given the current concern with ensuring the safety of hospitalized patients, the in-patient case manager serves as both a care facilitator and a patient advocate. Similarly, the *TIP Series 27* (1998) underscores the substance-abuse case manager's responsibility to promote the welfare of his or her clients by advocating clients' interests with their families, the judiciary, diverse service agencies, and even legislative bodies.

In contrast, case management in an ATR environment focuses on guaranteeing that, for each vouchered treatment or recovery support service (RSS), clients have more than one appropriate provider from which to choose. The case manager's "advocacy" function is limited to arranging for provider services and coordinating care among multiple providers, if necessary.

Despite advocacy's limited role in ATR, other principles that define constructive case management are equally relevant to virtually any system of care:

- Case managers' prime motivation is to foster client self-determination and meet client needs. (Their challenge, however, is to obtain and provide the data that clients require to make informed decisions; we address this issue more fully in Section 4.)
- Case managers give clients a single point of contact with service providers.
- Case managers are community-oriented. (This principle is especially salient to the ATR mission of building self-sustaining networks of faith-based and other community organizations [FBCOs] that will continue to provide services after ATR ends.)
- Case managers are realistic; they start where the client *is*.
- Case managers both anticipate likely concerns before they arise and adjust quickly to unexpected events.
- Case managers are culturally sensitive (*TIP Series 27*, 1998).

These principles reflect the basic standards by which clients and service providers alike assess case-manager performance. For example, to document the client perspective, Kopelman, Huber, Kopelman, Sarrazin, and Hall (2006) evaluated clients' satisfaction with a strengths-based model of case management,[1] provided as part of a rural substance- abuse treatment program. The results of this study, the Iowa Case Management Project (ICMP), indicated that the case-management characteristics clients value most are *convenience*, *privacy*, *comfort*, and *accessibility*.

Moreover, from a programmatic perspective, Simpson (2007) has identified *structural* factors that facilitate effective case management when the case manager is part of a team. Specifically, a study of seven United Kingdom community mental-health teams revealed, perhaps unsurprisingly, that respectful team interactions facilitated coordination of care. Less expected, however, was the finding that formal team structures and formal policies also exerted a beneficial influence on case management. Given that the members of ATR program staffs form a discrete organization, defining and implementing a formal team that includes the case manager—and that defines roles, responsibilities, and procedures for sharing information—might be a worthwhile strategy for enhancing service coordination. Finally, Hesse, Vanderplasschen, Rapp, Broekaert, and Fridell (2007) reinforce the importance of structure by suggesting that codifying a program's case-management protocol in a formal document can accentuate the degree to which case management facilitates patients' connection to other services.

Last, the *TIP Series 27* (1998) asserts that, because case managers' qualifications must reflect the principles defined above, their training in case management *per se* is more important than their university or post-graduate background. In support of this position, Aliotta, Boling, Commander, Day, Greenberg, Lattimer, Marshall, and Rogers (2007) endorse the Case Management Society of America's (CMSA) evidence-based Case Management Adherence Guidelines (CMAG), developed to help case managers increase patients' understanding of and adherence to medication schedules. The CMSA trains case managers to apply CMAG tools and approaches. A follow-up survey administered one year after the first training program found that—although 39 percent of the respondents experienced no change in themselves or in their patients—42 percent reported that their new skills had increased their overall effectiveness, and 43 percent reported an improvement in patient adherence. More particularly, 66 percent of respondents reported using motivational interviewing (Aliotta et al., 2007), a technique that many ATR I grantees included in their training programs for faith-based and other providers.

**Case-Management Models**

Although the principles underlying general case management also apply to ATR, traditional case-management models appear to be less *directly* relevant. For example, the *TIP Series 27* (1998) describes three basic, medical case-management models: the single-agency model, the informal-partnership model, and the formal consortium model. Each model addresses initiating

[1] Strengths-based interventions, derived from social work, help clients gain self-efficacy by building on their strengths and successes (Brun & Rapp, 2001).

and maintaining cooperation among agencies that provide services to clients, thus reflecting an ATR perspective.

However, none of the situations for which each model is most appropriate captures the singular character of an ATR program. For instance, in its emphasis on grassroots organizations the *single-agency model* is comparable to ATR. However, the "single agency" for which the model is named does not reflect ATR's "intermediary" role. Rather, as described in the *TIP Series 27* (1998) describes, the agency provides clients with services—often extensive "one-stop-shopping" services. As a result, the single-agency model is particularly useful in rural settings or in other environments where service providers are scarce. In addition, this model's case manager is accountable only to the agency. Although he or she establishes as-needed relationships with colleagues in other organizations, the purpose of these relationships is not to build a lasting, independent network of community-based service providers (*TIP Series 27*, 1998), like the networks ATR envisions.

Second, in an *informal-partnership model*, case managers from several agencies temporarily collaborate as an informal team, to provide various services to clients. Informal partnerships represent a particularly appropriate model for managing cases in culturally diverse communities offering a wide range of services (*TIP Series 27*, 1998). Perhaps the primary difference between this model and ATR is that the case managers who comprise the informal-partnership team share the responsibility for the client's overall welfare, whereas the individual agencies remain accountable for the services they provide. In contrast, because ATR recruits providers and provider agencies—as well as issuing *vouchers* for the services clients need—ATR case managers can exercise formal authority over providers and are ultimately responsible for clients' receiving appropriate support for treatment and recovery.

Third, the *formal-consortium model* creates an association of case managers and service providers who are bound by a written contract. The service agencies are accountable to the consortium and collaborate in treating multiple clients. Typically, a single agency serving as the leader coordinates consortium activities and allocates resources. Formal consortia are especially practical for communities in which a "gatekeeper" must issue a separate referral for each service provided (*TIP Series 27*, 1998). While the informal-partnership model lacks sufficient power to exercise ATR responsibilities, the formal-consortium model lacks sufficient flexibility. First, federal guidelines prohibit formal contracts between an ATR program and local providers; instead, ATRs arrange provider agreements through less formal vehicles like "memoranda of understanding" (MOUs). Second, ATR providers are linked to the ATR program that enlisted them, but do not necessary have formal or informal relationships with other agencies.

In short, just as ATR represents a new vision of substance-abuse care, it offers a unique opportunity to implement new models of case management. Nonetheless, the extent to which case management has actually improved patient outcomes remains a matter of debate. We address this issue in Section 2.

## Section 2: The Efficacy of Case Management

The case-management literature notes that healthcare often involves transferring patients across services, across levels of care, or across providers. These transitions represent risk points at which patients are likely to be adversely affected by poor coordination and missed communication—points at which implementing case management is particularly critical (Carr, 2007). Therefore, it would seem intuitively obvious that, by ensuring smooth transitions, case management improves the final result of patients' treatment; however, empirical research has often failed to support this conviction.

### Ambiguous Findings

***Single-study results.*** For example, a 1999 study conducted by McLellan, Hagan, Levine, Meyers, Gould, Bencivengo, Durell, and Jaffe examined whether assigning clinical case managers (CCMs) improved the outcome of substance-abuse treatment, defining the desired outcome as clients' increased access to and use of community-based social services. The no-case-management (NoCM) sample received twice weekly, abstinence-oriented, outpatient drug-abuse counseling on a group basis. In contrast, each individual in the clinical-case-manager (CCM) sample, in addition to receiving the same counseling, was also assigned a CCM, who provided access to *pre-contracted* services, like drug-free housing, medical care, legal referrals, and parenting classes from community agencies. Furthermore, the CCM group received more alcohol-related, medical, employment, and legal services *during* their drug treatment than did the than NoCM group. At the six-month follow-up, the CCMs fared significantly better than the NoCMs, with respect to improved medical, employment, and legal status; reduced alcohol consumption; and improved family relations. Thus, on the face of the matter, the results supported CCM's effectiveness in improving outcomes for substance-abuse clients enrolled in community treatment programs.

Nevertheless, McLellan et al. (1999) stressed that CCM cannot be effectively implemented unless case managers and service providers are trained to collaborate; moreover, the authors insisted that all services participating in a CCM program must be *pre-contracted*, to ensure their availability. These conditions complement Simpson's (2007) later finding, discussed in Section 1, that formal team structures and formal policies facilitate successful case management. But at their inception ATR programs have not yet identified a roster of provider agencies, much less contracted for their services; in fact, it must be remembered that ATR is proscribed from issuing formal contracts per se. Consequently, the McLellan et al. (1999) results cannot be directly generalized to ATR programs. (One might also question the extent to which the supplementary medical and social services that members of the CCM group received *during* treatment might have influenced their enhanced outcomes, independent of being assigned CCMs.)

In a similar vein, Alexander, Pollack, Nahra, Wells, and Lemak's (2007) substance-abuse study investigated the association between particular aspects of case management and outpatients' post-treatment use of health and social services. The *expected* results were that implementing case management during referral, as well as providing it throughout treatment, was positively related to clients' obtaining health care and auxiliary social services. However, the *unexpected* result was that these benefits were limited to clients' gaining access to general health and to

mental health services. Case management exerted little influence on the use of social services or aftercare programs (Alexander et al., 2007), both of which are key elements of ATR's recovery support services.

Other single-study results have investigated the efficacy of case management in contexts that are especially relevant to ATR. For example, Cosden, Ellens, Schnell, and Yamini-Diouf (2005) found that, compared to their control-group counterparts, participants in an assertive community treatment model of case management called Mental Health Treatment Court decreased their criminal activity and improved their psychosocial functioning. However, Needels, James-Burdumy and Burghardt's (2005) results—which concerned the effectiveness of Health Link, a program that offered incarcerated adult females and adolescent males case-management services for their first year after release—were more ambiguous. About 1,400 participants were assigned either to a Health-Link group that received a rigorous program of discharge planning and community-based case-management services or to a control group that received less intense discharge planning and no community-based services. The one-year follow-up data provided strong evidence for Health-Link's effect on increased participation in drug-treatment programs and somewhat weaker evidence for reduced drug use. But, in this case, the program did not reduce clients' re-arrest rates or their participation in activities associated with HIV infection.

Further, Friedmann, Hendrickson, Gerstein, and Zhang (2004) investigated whether implementing a case-management program *during* treatment increased substance-abuse clients' receipt of medical and psychosocial services. The 2,829 study participants comprised clients of long-term residential, outpatient, and methadone-treatment facilities. After the clients were discharged, they reported the extent to which they had received each of nine auxiliary services. The analyses, which controlled for various program and client factors, indicated that the availability of case managers increased clients' receipt of only two out of the nine potential services.

Similarly, Sarrazin and Hall (2004) conducted a randomized, longitudinal clinical trial—the Iowa Case Management Project (ICMP) for Rural Drug Abuse—to investigate case management's influence on substance-abuse clients' perceptions of social support one year later. Compared to the control group, the participants who had received case management indeed reported increased support, but—consistent with the Friedmann et al. (2004) findings—this perception was related to only two of the six social services provided. Moreover, although the case-management group also reported enhanced perceptions of general social support, such as feeling attached to others and reassured of their own worth, these effects were limited to participants who were married or who had significant partners.

***Multiple-study reviews.*** In addition to these single-study publications, a number of reviews have analyzed the results of multiple investigations dealing with the effect of implementing case management in substance-abuse programs. Hesse et al. (2007) systematically reviewed randomized clinical trials that had researched case management's influence on either (1) curtailing substance abusers' use of drugs (7 studies; 2,391 patients) or (2) facilitating their connection with other services (10 studies; 3,132 patients). Whereas case management's effect on facilitating connection with other services was significant, its impact on curtailing drug abuse was not. Finally, a comprehensive trial with only two groups—case management versus no case

management—found that case management was superior to both psycho-education and drug counseling in reducing drug use. In short, Hesse et al. (2007) conclude that, despite confirmation of case management's efficacy in some domains, support for the proposition that case management reduces drug use remains inconclusive.

Similarly, Vanderplasschen, Wolf, and Broekaert (2007), examined 48 peer-reviewed articles published between 1993 and 2003, to identify the effects of case management on various substance-abuse populations. Their results indicated that although several studies reported positive findings, few randomized controlled trials demonstrated that, overall, case management was more effective than other types of interventions.

**The Case for Differential Effectiveness**

Nonetheless, Vanderplasschen et al. (2007) also reported evidence regarding the *differential* effectiveness of case management for various populations (e.g., case management exerts a positive impact on homeless and dually-diagnosed substance abusers) and for different case-management approaches (e.g., strengths-based and generalist approaches are relatively effective for substance abusers in general). Outcomes that Vanderplasschen et al. cite as particularly influenced by case management include clients' increased use of inpatient and community-based services, clients' satisfaction with and retention in treatment, and clients' self-reported quality-of- life improvement. On the other hand, the findings related to substance use and psychosocial functioning are less consistent, although the effect of *treatment* on these outcomes appears to be *mediated* by case management Vanderplasschen et al. (2007)—that is, treatment affects substance use and psychosocial functioning, in part, through the *process* of case management.

Meyer and Morrissey (2007) sound the same theme in their review of evidence regarding the utility of community-based case management in rural areas. Because only one of the four identified case-management studies reflected a controlled design, the meaning of the results was unclear. Nevertheless, Meyer and Morrissey conclude that *if* a community can provide adequate treatment and support services, case management can increase clients' access to these benefits. Thus, Sarrazin and Hall (2004), Hesse et al. (2007), Vanderplasschen et al. (2007), and Meyer and Morrissey (2007) all underscore the importance of determining—not *if* case management "works"—but when, and for whom, it works best.

For example, client characteristics appear to comprise a major source of differential effects. Vaughn, Sarrazin, Saleh, Huber, and Hall (2002) examined the characteristics associated with substance-abuse clients' participation and retention in research that assessed case management's effect on treatment success. Their findings were (1) that being female and having a significant relationship (cf. Sarrazin and Hall, 2004, above) predicted initially agreeing to participate and subsequently remaining in an evaluation study; (2) that being older predicted a disinclination to participate but a likelihood of staying if enrolled; (3) that having been referred by the criminal-justice system predicted both a disinclination to participate and a lower likelihood of staying; and (4) that being an urban outpatient client predicted a likelihood of staying. This emphasis on the *differential* impact of case management is also sounded by Sun (2006), who, in reviewing 35 studies of female substance abusers, identified five elements related to treating women successfully, one of which was implementing case management in conjunction with a "one-stop shopping" model.

**Research Challenges**

Nonetheless, Sun (2006) also identified six prevalent limitations in the case-management research: (1) lack of randomized controlled designs, (2) confounding of multiple conditions, (3) lack of standardized definitions for treatment and outcome variables, (4) small sample sizes, (5) lack of comprehensive program descriptions, and (6) lack of appropriate quantitative analyses. Further, Huber, Hall, and Vaughn (2001) and Huber and Craig (2007) argue that the most appropriate criteria for measuring the success of case-management programs are *optimal patient outcomes* and *efficient resource allocation*. Yet, these researchers also note that demonstrating case management's effect on patient outcomes is difficult, partly because previous research offers scant information concerning the effect of different degrees or intensities of case management.

To address this issue, Huber, Hall, and Vaughn (2001) and Huber and Craig (2007) have conducted a longitudinal study of case-management models in substance-abuse programs, research that has identified four basic dimensions of case management: *amount, frequency, duration, and breadth*. Not only do the independent and interactive effects of these dimensions merit further investigation, but Huber and Craig (2007) advocate the following:

- Case management systems should be grounded in evidence-based practices.
- Case management systems should measure intervention intensity.
- Case management systems should identify the specific activities that improve outcomes.

An additional effectiveness factor that merits attention, one that Noel (2006) has addressed in examining the influence of therapeutic case management on female adolescents' attrition from an outpatient substance-abuse treatment program, is i*mplementation fidelity*. Noel's findings support the contention that unless programs implement case-management models fully and authentically, an evaluator cannot draw valid inferences regarding their effect on outcomes like attrition.

Finally, in reviewing the evidence that has evaluated the effects of various types of case management from 1995 to 2007, Smith and Newton (2007) conclude that, of all the outcomes that have been tested, only clients' use of social services has been consistently supported; all other criteria have produced mixed results. Furthermore, the weight of evidence in favor of case management has dissipated somewhat over time, primarily because of the aforementioned limitations of previous research designs.

**An Optimistic Future**

Nevertheless, the research conducted by Sorensen, Masson, Delucchi, Sporer, Barnett, Mitsuishi, Lin, Song, Chen, and Hall (2005) has provided strong (though perhaps inadvertent) support for the structure of ATR. Specifically, this study demonstrated the degree to which *vouchers* increase the effectiveness of case management. Explicitly, Sorensen et al. investigated the effect of case management and/or vouchers on opioid-dependent hospital patients' enrollment in a free methadone maintenance treatment (MMT) program. The results were as follows: at three months MMT enrollment was 47 percent for the case-management-only condition, 89 percent for

the voucher-only condition, and 93 percent for the case-management-plus-voucher condition; at six months the enrollment figures were 48 percent, 68 percent, and 79 percent, respectively (Sorensen et al., 2005).[2] Although the participants in this study received treatment on an in-patient basis, the results "vouch" for the role of vouchers in combination with case management—two program elements that are consistent with ATR theory and practice.

To conclude, we note that the issues addressed in this discussion are not unique to the United States. In comparing substance-abuse-treatment research from the U.S., the Netherlands, and Belgium, Vanderplasschen, Rapp, Wolf, and Broekaert (2004) report that some case-management models have definitely engendered highly desired results—like clients' increased participation and retention in treatment, clients' increased use of services, and clients' decreased use of drugs. Moreover, we believe that the key factors that foster these positive outcomes reflect case-management goals that can be realized in the world of ATR:

- Implement the program as it has been designed.
- Implement the program vigorously.
- Ensure that the program incorporates extensive training and supervision.
- Ensure that the program reflects a team approach.
- Ensure that the program offers continuity.
- Bolster the program with strong administrative support.
- Embed the program in an inclusive network of services (Vanderplasschen et al., 2004).

## Section 3: Case-Management Experience and Recommendations from ATR I

The previous sections have presented principles and research findings that might help ATR grantees design and implement effective case management. To supplement this information, the current section highlights case-management experiences and recommendations that the ATR I grantees recounted through semi-structured interviews and, for returning grantees, in their ATR II applications. This section focuses on three main issues: (1) case management in ATR I and II, (2) the role of client choice, and (3) acquiring and communicating information about provider quality.

### Case Management in ATR I and II

The extent to which the ATR I grantees used case management (CM) ranged from rarely using it at all (if, for example, the function was available to providers through another funding source) to establishing a formal, vouchered position called "case manager." Further, some grantees distinguished between a "case manager" on the *treatment* side of client services and a "care coordinator" or a "case coordinator" on the *recovery support services* (RSS) side.

***The "traditional case-management model."***[3] In the traditional case-management model (TCMM), which a number of grantees adopted in ATR I, case managers were chosen by

[2] The figures for the control condition, in which the patients received usual care, were 11% at three months and 21% at six months.

[3] For convenience of discussion, we have designated names for the models described in this section.

treatment providers, not by ATR or the client. ATR used a fee-for-service agreement to engage a provider organization that offered case management as well as treatment services. Case managers (CMs)—who often conducted initial assessments, as well—helped clients choose among treatment options (which might or might not include their own agencies) and managed referrals among organizations, as necessary.

In conjunction with or subsequent to treatment, either the case manager or a separate "care coordinator" (CC), selected by a provider or selected and trained by the ATR program, coordinated the client's receipt of recovery-support services from one or more faith-based or secular providers. Both case managers and care coordinators billed for referrals; in addition, they were generally responsible for collecting GPRA data. Finally, depending upon the program, CMs and/or CCs might be allowed to refer clients to services that were not part of ATR.

Some TCMMs also included a "motivational" component. For example, at least one ATR I program required clients to participate in a half-hour's case-management consultation following assessment. Thereafter, the CM met with the client once a week, usually for four to six weeks, but for as many as ten weeks, if necessary. Moreover, this program recruited and trained "recovery coaches," who, functioning in parallel with the CMs, took responsibility for certain recovery-support services, primarily liaison and education. Although CMs initially worried that recovery coaches would interfere with or undermine case management, these concerns proved unwarranted.

Last, one ATR I program with a particularly widespread geographical area offered a variant of the TCMM. Although this program did not designate case managers per se, it defined a case management *role* and funded the role through vouchers issued to service providers. The provider agency designated someone to meet personally with clients, as often as the provider deemed necessary.

***The "intensive case-management model."*** The "intensive case management model" (ICMM), which is recognized as a best practice, provides standards and guidelines for case management. In this ATR I model, clinical assessors also served as clinical case managers; along with RSS care coordinators, these case managers comprised the initial points of contact for voucher recipients. In one version of the ICMM, the CMs and CCs worked from a central admitting facility, where they told clients about available providers of treatment and RSS, thereby enabling clients to make informed choices. If clients were not satisfied with their choices, they could return to the admitting facility to discuss alternative options. However, the *providers*, not the CMs or CCs, were responsible for following up with the client or for notifying and coordinating with the admitting facility if they were unable to engage a client.

In another version of this model, providers who were assessors /case managers and care coordinators managed the clients within defined geographical areas; the CCs also collected GPRA data. Case management/care coordination continued on a monthly basis throughout the client's tenure in the program—through personal meetings, when possible, and otherwise by telephone. ATR tracked clients' progress by monitoring providers' redemption of vouchers.

***The "case-management position model."*** It might be noted that neither of the models described thus far included an independent position, separate from assessment, called "case manager." In contrast, the case-management position model (CMPM), in its strongest form, both defined and certified a formal case-manager job title.

In ATR I, this model shifted the ultimate responsibility for selecting a case manager from the provider to the ATR program. Providers applied to ATR to certify the individuals they proposed to designate as case managers; ATR made the final decision. Further, the CMPM viewed case management as a vouchered and continually motivated service that extended throughout the client's ATR tenure. However, only clients whose needs required the services of multiple providers were assigned a case manager. Finally, because the agency that linked the client to ATR collected GPRA information, numerous agencies were responsible for these data.

***Strengths-based case management in ATR II***. The case-management models proposed for ATR II reflect the increased ATR control that distinguished the case-management position model from the other models adopted in ATR I. As a result, the ATR II models are likely to give grantees more authority to implement the key effectiveness directives that Vanderplasschen et al. (2004) have advocated.

Generally speaking, the ATR II models appear analogous to the *strengths-based case-management model* that we mentioned previously, in conjunction with the Iowa Case Management Project (Kopelman et al., 2006). This model, developed by the University of Kansas's School of Social Welfare, has been identified by SAMHSA as a best practice. Applied to ATR, it allows clients to choose, not only their providers, but also the case manager who tells them about providers. Thus, as soon as a potential client is deemed eligible, client choice channels every step of the ensuing ATR process.

The strengths-based case manager, who also collects the GPRA data, works collaboratively with the client to develop a comprehensive plan of care, centered on the client's perspective. The case manager then finds providers and services that best meet the client's needs and preferences and helps the client make informed choices. Case managers' vouchered services are provided throughout the client's involvement with ATR. In short, this expanded model of case management manifests ATR's fundamental principle of self-determination.

Despite these obvious advantages, three caveats should be noted with respect to implementing a full-choice case-management model in ATR II. First, in ATR I at least one grantee allowed clients to choose their case managers. The innovation proved expensive, cumbersome, and inefficient because the program did not have a standardized schedule of rates—based on the average time a CM spends with a client—to apply to the vouchers. As a result, the grantee was trapped in a morass of CM accounting.

Second, one of the "lessons learned" through ATR I was that conflicts of interest can arise if a case manager is connected to an ATR provider agency. One way to avoid case managers' tendency to favor their own agencies—advertently or inadvertently—is to recruit a roster of case managers who are not affiliated with treatment or RSS providers. Few ATR I grantees opted for this strategy; however, a number of ATR II programs have endorsed it.

Third, although, ideally, every ATR client would choose and receive a case manager and/or a care coordinator, practical constraints—the most salient of which is economic—can militate against this ideal. As a result, certain ATR II grantees have determined either to offer case managers/care coordinators only to clients who need multiple providers or—under the assumption that good clinical care includes care management—to relegate case management solely to providers.

Nonetheless, if these three caveats are addressed—by defining standardized rates; by separating the case-management role from the provider role; and by "triaging" clients, if necessary, to identify those who most need a case manager—a *strengths-based case- management model* best exemplifies the spirit that engendered ATR. Thus, concurring with SAMHSA's designation of this model as a best practice generally, we add and suggest that it is also a best practice for ATR specifically.

**The Role of Client Choice**

***Choosing a provider.*** Given that ATR rests on the foundation of client choice, the semi-structured interviews asked ATR I grantees how their programs had manifested this philosophy. The most frequent response was that after clients had been assessed, they chose—from a list of available sources affiliated with ATR—one or more providers to deliver the vouchered service(s). The goal was always to fulfill ATR's mandate that clients be offered at least two providers, at least one of which was secular. Frequently, the program asked the client to sign a form acknowledging that he or she had been afforded a choice.

Certain programs instituted more elaborate systems to facilitate choice. For example, various grantees developed resource materials that told clients about each provider's location and size; the types of services that were offered; whether the provider was faith-based; whether the staff was all-female, all-male, or mixed-gender; etc. Clients usually reviewed this information by looking through hard-copy notebooks or by logging onto websites, some of which included an interactive map. In particularly thorough situations, providers who applied to join the ATR network were instructed to compose a program description to serve as the provider's "marketing tool." This description, along with other information, was then included in the program's database; assessors could access services needed by the client and print out the description of each relevant agency. In addition, at least one ATR II program intends to require each provider to supplement this description with information about the program's culture and therapeutic approach.

Finally, one ATR I program had initially received complaints from *providers,* not from clients, about the lack of informed choice. This program reported in the interview that its current evaluation of clients' satisfaction with providers indicated an 87 percent satisfaction rate. However, echoing an issue raised in the previous section, this program is also following up on some providers' concern that clients might be pressured to "choose" the agency that had assessed them.

***Choice in the context of case management.*** Although a number of ATR II programs will enable clients to choose a case manager or care coordinator, virtually none of the ATR I grantees did

so.[4] Moreover, ATR I grantees generally reported in their interviews that allowing clients to choose a case manager was simply not a priority in the models they implemented. One program added that many clients lacked the knowledge necessary to differentiate among case managers because clients understood neither the government system, in general, nor the case manager's function, in particular. In addition, clients' attention span might not accommodate their making detailed comparisons. As a result, rather than being "informed," clients' choices were likely to rely solely on factors like race, ethnicity, or gender. Another interviewee indicated that case-manager choice is relatively unimportant because the philosophy underlying care coordination is reasonably standardized.

**Acquiring and Communicating Information about Provider Quality**

The ATR I grantees tended to be skeptical about the wisdom of clients' choosing their own case managers, at least under the Phase 1 systems; nevertheless, grantees' acknowledgement of their clients' desire to know more about potential providers carried a certain poignancy. For example, grantees expressed that clients often want to view photos of providers, to "see if they look like me." Although we noted above that a provider's appearance should not be the *sole* criterion in determining a client's choice, neither is it unreasonable for the client to want someone "familiar."

Yet, ultimately, the information most likely to affect a client's outcome is information about the performance quality of the individual provider and of the agency. What kind of experience do they have? How do other professionals judge them? How do their clients evaluate them? What is their success rate in treating specific populations?

Acquiring this information was exceedingly difficult for the ATR I grantees and is not likely to be much easier in ATR II. For example, SAMHSA funded one ATR I grantee to collect data and develop a website that displayed ratings on a wide array of relevant provider-quality criteria: client outcomes, completion and readmission rates, staff qualifications, and professional ratings. However, not only did the program encounter resistance from providers, but its research consultants were apprehensive about posting data that might not be defensible. As a result, the program has decided not to pursue such information in ATR II.

Generally speaking, client surveys have had to serve as "proxies" for more objective measures of provider quality. But this method, too, has its drawbacks. In virtually all areas of research, low return rates pose an endemic problem whenever respondents are asked to complete surveys on their own time. As an instance, the program noted above received only 500 responses from the 11,000 clients it surveyed by mail. In ATR II this particular program will attempt to boost the response rate by asking assessors for permission to contact clients directly. But if ATR clients complete the survey by phone, in person, or under the supervision of a "monitor," they are likely to manifest another problem—one with a long tradition in the social sciences. Namely, clients are likely to rate their providers more favorably than might be warranted, thereby exhibiting a "social desirability bias."

[4] One quasi-exception was a program that assigned case managers to clients but told the clients that they could change CMs if they were dissatisfied with the initial assignment.

On the other hand, one ATR I grantee noted that the opposite problem can occur. Specifically, clients may criticize providers from whom they received what they *needed* because they failed to get what they thought they *wanted*, especially with regard to recovery-support services. To correct for this bias, the grantee suggests asking clients why they left a *provider* before asking how they would evaluate the agency as a whole. Their shortcomings notwithstanding, however, client surveys continue to remain the primary source of provider-quality information for most ATR programs.

Even so, several ATR I grantees expressed the intention of bolstering their provider-quality data, in ATR II, by collecting targeted information from sources other than clients. These sources include *individuals*, such as clinical supervisors who can share their professional evaluations of providers, and *regulatory requisites*, such as documentation of services and state certification or licensing requirements. Further, one ATR I grantee whose program is currently being funded by the state's legislature now requires a case manager to hold a bachelor's degree in human health services. In addition, this program is establishing mandatory training for all case managers and is using the WITS system to audit, in real time, the processes and outcomes of case managers' interactions with clients—what information the CM accesses from the system and what decisions the clients make. The program is also auditing clients' charts. Furthermore, because this program has implemented the GAIN as the required assessment tool, case managers are expected to use the GAIN's standardized, comprehensive information to select appropriate providers for each client.

One final approach to ensuring quality, particularly among RSS providers, was represented by a grantee who viewed ATR I as a business program because its main responsibility was to issue vouchers. This program gravitated towards case managers and providers who were familiar with business requirements, such as filling out forms and completing the necessary documentation. If a provider failed to follow through on promised care and the client complained, the provider was simply removed from the case manager's list. This program also tracked completion rates.

## Section 4: Future Research Directions

With all of the preceding sections in mind, this final discussion considers how future case-management research might enhance the success of ATR nationwide. We have described ATR I approaches to presenting clients with information intended to help them make knowledgeable decisions. And we have highlighted ATR I grantees' concerns regarding the limited effectiveness of these methods in preparing clients to base their decisions on relevant criteria regarding provider quality.

Here we suggest that, assuming implementation of the recommended *strengths-based case-management model*, the next challenge is to focus unswerving attention on *informed* choice writ large. Specifically, we propose that SAMHSA sponsor a comprehensive program of research (including ATR technical assistance) to answer the following questions:

- What information about provider quality do case managers need, to facilitate ATR treatment and recovery support services?
- How can case managers get such information?

- In how much detail, and in what format(s), should case managers give clients information about provider quality?
- How much—and in what form—should case managers dispense advice?
- How have similar programs dealt with providing advisors with standard, comparative information to use in assisting clients?

Along similar lines, the ATR II grantees that are planning to implement strengths-based case-management would benefit from technical assistance in the following areas:

- Developing formal job descriptions (e.g., qualifications, duties, requirements, etc.) for various levels of case managers and/or care coordinators (who, under the strengths-based case-management model, are not affiliated with provider agencies);
- Developing certification requirements for various levels of CM and/or CC positions;
- Developing training, especially for care coordinators drawn from faith-based or other volunteer-oriented community organizations.

## References

Alexander, J.A., Pollack, H., Nahra, T., Wells, R., & Lemak, C.H. (2007). *Journal of Behavioral Health Services & Research, 34* (3), 221-236.

Aliotta, S.L., Boling, J., Commander, C., Day, D., Greenberg, L., Lattimer, C., Marshall, D., & Rogers, S.A. (2007). The impact of CMSA's case management adherence guidelines and guidelines training on case manager-reported behavior change. *Professional Case Management, 12* (5), 288-295.

Brun, C. & Rapp, R.C. (2001). Strengths-based case management: Individuals' perspectives on strengths and the case manager relationship. *Social Work, 46* (3), 278-288.

Carr, D.D. (2007). Case managers optimize patient safety by facilitating effective care transitions. *Professional Case Management, 12* (2), 70-80.

Cosden, M., Ellens, J., Schnell, J., & Yamini-Diouf, Y. (2005). Efficacy of a mental health treatment court with assertive community treatment. *Behavioral Sciences and the Law, 23* (2), 199-214.

Friedmann, P.D., Hendrickson, J.C., Gerstein, D.R., & Zhang, Z. (2004). Designated case managers as facilitators in medical and psychosocial service delivery in addiction treatment programs. *Journal of Behavioral Health Services and Research, 31* (1), 86-97.

Hesse, M., Vanderplasschen, W., Rapp, R., Broekaert, E., & Fridell, M. (2007). Case management for personas with substance abuse disorders. *Cochrane Database of Systematic Reviews,* (4).

Huber, D.L & Craig, K. (2007). Acuity and case management: A healthy dose of outcomes, part III. *Professional Case Management, 12*(5), 254-269.

Huber, D.L, Hall, J.A., & Vaughn, T. (2001). Dose of case management interventions. *Lippincott's Case Management: Managing the Process of Patient Care, 6* (3), 119-126.

Kopelman, T., Huber, D.L, Kopelman, B.C., Sarrazin, M.V., & Hall, J.A. (2006). Client satisfaction with rural substance abuse case management services. *Journal of Case Management, 7* (4), 179-90.

McLellan, A.T., Hagan, T.A., Levine, M., Meyers, K., Gould, F., Bencivengo, M., Durell, J., & Jaffe, J. (1999). Does clinical case management improve outpatient addiction treatment? *Drug & Alcohol Dependence, 55* (1-2), 91-103.

Meyer, P.S. & Morrissey, J.P. (2007). A comparison of assertive community treatment and intensive case management for patients in rural areas. *Psychiatric Services, 58* (1), 121-127.

Needels, K., James-Burdumy, S., & Burghardt, J. (2005). Community case management for former jail inmates: Its impacts on rearrest, drug use, and HIV risk. *Journal of Urban Health, 82* (3), 420-433.

Noel, P.E. (2006). The impact of therapeutic case management on participation in adolescent substance abuse treatment. *American Journal of Drug and Alcohol Abuse, 32* (3), 311-327.

Sarrazin, M.V. & Hall, J.A. (2007). Impact of Iowa case management on provisions of social support for substance abuse clients. *Journal of Case Management, 5* (1), 3-11.

Simpson, A. (2007). The impact of team processes on psychiatric case management. *Journal of Advanced Nursing, 60* (4), 409-418.

Smith, L. & Newton, R. (2007). Systematic review of case management. *Australian and New Zealand Journal of Psychiatry, 41* (1), 2-9.

Sorensen, J.L., Masson, C.L., Delucchi, K., Sporer, K., Barnett, P.G., Mitsuishi, F., Lin, C., Song, Y., Chen, T., & Hall, S.M. (2005). Randomized trial of drug abuse treatment-linkage strategies. *Journal of Consulting and Clinical Psychology, 73* (6), 1026-1035.

Sun, A.P. (2006). Program factors related to women's substance abuse treatment retention and other outcomes: A review and critique. *Journal of Substance Abuse Treatment, 30* (1), 1-20.

Vanderplasscen, W., Rapp, R.C., Wolf, J.R., & Broekaert, E. (2004). The development and implementation of case management for substance use disorders in North America and Europe. *Psychiatric Services, 55* (8), 913-922.

Vanderplasschen, W., Wolf, J., Rapp, R.C., & Broekaert, E. (2007). Effectiveness of different models of case management for substance-abusing populations. *Journal of Psychiatric Drugs, 39* (1), 81-95.

Vaughn, T., Sarrazin, M.V., Saleh, S.S., Huber, D.L., & Hall, J.A. (2002). Participation and retention in drug abuse treatment services research. *Journal of Substance Abuse Treatment, 23* (4), 387-397.