

2 Applying Case Management to Substance Abuse Treatment

Case management is almost infinitely adaptable, but several broad principles are true of almost every application.

This chapter will discuss those principles, the competencies necessary to implement case management functions, and the relationship between those functions and the substance abuse treatment continuum. For the purposes of discussion, case management and substance abuse treatment are presented as separate and distinct aspects of the treatment continuum, although in reality they are complementary and at times thoroughly blended.

Case Management Principles

Case management offers the client a single point of contact with the health and social services systems. The strongest rationale for case management may be that it consolidates to a single point responsibility for clients who receive services from multiple agencies. Case management replaces a haphazard process of referrals with a single, well-structured service. In doing so, it offers the client continuity. As the single point of contact, case managers have obligations not only to their clients but also to the members of the systems with whom they interact. Case managers must familiarize themselves with protocols and operating procedures observed by these other

professionals. The case manager must mobilize needed resources, which requires the ability to negotiate formal systems, to barter informally among service providers, and to consistently pursue informal networks. These include self-help groups and their members, halfway and three-quarter-way houses, neighbors, and numerous other resources that are sometimes not identified in formal service directories.

Case management is client-driven and driven by client need. Throughout models of case management, in the substance abuse field and elsewhere, there is an overriding belief that clients must take the lead in identifying needed resources. The case manager uses her expertise to identify options for the client, but the client's right of self-determination is emphasized. Once the client chooses from the options identified, the case manager's expertise comes into play again in helping the client access the chosen services. Case management is grounded in an understanding of clients' experiences and the world they inhabit—the nature of addiction and the problems it causes, and other problems with which clients struggle (such as HIV infection, mental illness, or incarceration). This understanding forms the context for the case manager's work, which focuses on identifying psychosocial issues and anticipating and helping the client obtain resources. The aim of case management is to provide the least

restrictive level of care necessary so that the client's life is disrupted as little as possible.

Case management involves advocacy. The paramount goal when dealing with substance abuse clients and diverse services with frequently contradictory requirements is the need to promote the client's best interests. Case managers need to advocate with many systems, including agencies, families, legal systems, and legislative bodies. The case manager can advocate by educating non-treatment service providers about substance abuse problems in general and about the specific needs of a given client. At times the case manager must negotiate an agency's rules in order to gain access or continued involvement on behalf of a client. Advocacy can be vigorous, such as when a case manager must force an agency to serve its clients as required by law or contract. For criminal justice clients, advocacy may entail the recommendation of sanctions to encourage client compliance and motivation.

Case management is community-based. All case management approaches can be considered community-based because they help the client negotiate with community agencies and seek to integrate formalized services with informal care resources such as family, friends, self-help groups, and church. However, the degree of direct community involvement by the case manager varies with the agency. Some agencies mount aggressive community outreach efforts. In such programs, case managers accompany clients as they take buses or wait in lines to register for entitlements. This personal involvement validates clients' experiences in a way that other approaches cannot. It suits the subculture of addiction because it enables the case manager to understand the client's world better, to learn what streets are safe and where drug dealing takes place. This familiarity helps the professional appreciate the realities that clients face and set more appropriate treatment goals—and helps the client trust and respect the

case manager. Because it often transcends facility boundaries, and because the case manager is more involved in the community and the client's life, case management may be more successful in re-engaging the client in treatment and the community than agency-based efforts. For clients who are institutionalized, case management involves preparing the client for community-based treatment and living in the community. Case management can ensure that transitions are smooth and that obstacles to timely admissions into community-based programs are removed. Case management can also coordinate release dates to ensure that there are no gaps in service. The type of relationship described here is likely at times to stretch the more narrow boundaries of the traditional therapist-client relationship.

Case management is pragmatic. Case management begins "where the client is," by responding to such tangible needs as food, shelter, clothing, transportation, or child care. Entering treatment may not be a client priority; finding shelter, however, may be. Meeting these goals helps the case manager develop a relationship with and effectively engage the client. This client-centered perspective is maintained as the client moves through treatment. At the same time, however, the case manager must keep in mind the difficulty in achieving a balance between help that is positive and help that may impede treatment engagement. For example, the loss of housing may provide the impetus for residential treatment. Teaching clients the day-to-day skills necessary to live successfully and substance free in the community is an important part of case management. These pragmatic skills may be taught explicitly, or simply modeled during interactions between case manager and client.

Case management is anticipatory. Case management requires an ability to understand the natural course of addiction and recovery, to foresee a problem, to understand the options

available to manage it, and to take appropriate action. In some instances, the case manager may intervene directly; in others, the case manager will take action to ensure that another person on the care team intervenes as needed. The case manager, working with the treatment team, lays the foundation for the next phase of treatment.

Case management must be flexible. Case management with substance abusers must be adaptable to variations occasioned by a wide range of factors, including co-occurring problems such as AIDS or mental health issues, agency structure, availability or lack of particular resources, degree of autonomy and power granted to the case manager, and many others. The need for flexibility is largely responsible for the numerous models of case management and difficulties in evaluating interventions.

Case management is culturally sensitive. Accommodation for diversity, race, gender, ethnicity, disability, sexual orientation, and life stage (for example, adolescence or old age), should be built into the case management process. Five elements are associated with becoming culturally competent: (1) valuing diversity, (2) making a cultural self-assessment, (3) understanding the dynamics of cultural interaction, (4) incorporating cultural knowledge, and (5) adapting practices to the diversity present in a given setting (Cross et al., 1989).

Case Management Practice—Knowledge, Skills, and Attitudes

All professionals who provide services to substance abusers, including those specializing in case management, should possess particular knowledge, skills, and attitudes, which prepare them to provide more treatment-specific services. The basic prerequisites of effective practice include the ability to establish rapport

quickly, an awareness of how to maintain appropriate boundaries in the fluid case management relationship, the willingness to be nonjudgmental toward clients, and certain “transdisciplinary foundations” created by the Addiction Technology Transfer Centers (ATTCs) (see page 6). These foundations—understanding addiction, treatment knowledge, application to practice, and professional readiness—are articulated in 23 competencies and 82 specific points of knowledge and attitude. Examples of competencies include

- Understanding a variety of models and theories of addiction and other problems related to substance use
- Ability to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems
- Recognizing the importance of family, social networks, and community systems in the treatment and recovery process
- Understanding the variety of insurance and health maintenance options available and the importance of helping clients access those benefits
- Understanding diverse cultures and incorporating the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice
- Understanding the value of an interdisciplinary approach to addiction treatment (CSAT, 1998)

Even though case managers have not always enjoyed the same stature accorded other specialists in the substance abuse treatment continuum, they must possess an equally extensive body of knowledge and master a complex array of skills in order to provide optimal services to their clients. Case managers

must not only have many of the same abilities as other professionals who work with substance abusers (such as counselors), they must also possess special abilities relating to such areas as interagency functioning, negotiating, and advocacy. In recognition of the specific competencies applicable to conducting case management functions, two of the eight core dimensions—referral and service coordination—provide critical knowledge, skills, and attitudes pertinent to case management. Below are the activities covered under those dimensions.

Referral

- Establish and maintain relations with civic groups, agencies, other professionals, governmental entities, and the community at large to ensure appropriate referrals, identify service gaps, expand community resources, and help to address unmet needs
- Continuously assess and evaluate referral resources to determine their appropriateness
- Differentiate between situations in which it is more appropriate for the client to self-refer to a resource and those in which counselor referral is required
- Arrange referrals to other professionals, agencies, community programs, or other appropriate resources to meet client needs
- Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow-through
- Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality regulations and professional standards of care
- Evaluate the outcome of the referral

Service Coordination

Implement the treatment plan

- Initiate collaboration with referral source

- Obtain, review, and interpret all relevant screening, assessment, and initial treatment-planning information
- Confirm the client's eligibility for admission and continued readiness for treatment and change
- Complete necessary administrative procedures for admission to treatment
- Establish realistic treatment and recovery expectations with the client and involved significant others including, but not limited to
 - ◆ Nature of services
 - ◆ Program goals
 - ◆ Program procedures
 - ◆ Rules regarding client conduct
 - ◆ Schedule of treatment activities
 - ◆ Costs of treatment
 - ◆ Factors affecting duration of care
 - ◆ Client rights and responsibilities
- Coordinate all treatment activities with services provided to the client by other resources

Consulting

- Summarize the client's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress for purpose of ensuring quality of care, gaining feedback, and planning changes in the course of treatment
- Understand terminology, procedures, and roles of other disciplines related to the treatment of substance use disorders
- Contribute as part of a multidisciplinary treatment team
- Apply confidentiality regulations appropriately
- Demonstrate respect and nonjudgmental attitudes toward clients in all contacts with community professionals and agencies (CSAT, 1998)

Almost 200 specific knowledge items, skills, and attitudes are associated with these dimensions: They can be found in Appendix B.

The Substance Abuse Treatment Continuum and Functions of Case Management

Substance Abuse Continuum of Care

Substance abuse treatment can be characterized as a continuum arrayed along a particular measure, such as the gravity of the substance abuse problem, level of care—inpatient, residential, intermediate, or outpatient (Institute of Medicine, 1990)—or intensity of service (ASAM, 1997). The continuum in this TIP is arranged chronologically, moving from case finding and pretreatment through primary treatment, either residential or outpatient, and finally to aftercare. Inclusion of case finding and pretreatment acknowledges the wide variety of case management activities that take place before a client has actually become part of the formal treatment process.

While distinct goals and treatment activities are associated with each point on the continuum, clients' needs seldom fit neatly into any one area at a given time. For example, a client may need residential treatment for a serious substance abuse problem, but only be motivated to receive assistance for a housing problem. Case management is designed to span client needs and program structure.

Case finding and pretreatment

The case-finding aspect of treatment is generally of paramount concern to treatment programs because it generates the flow of clients into treatment. Pretreatment has changed enormously in the past five years as programs have closed, resources have dwindled, and

services available under managed care plans have been severely curtailed. Many individuals identified as viable treatment candidates cannot get through the gate, and pretreatment may in fact constitute brief intervention therapy. Treatment programs may undertake case-finding activities through formal liaisons with potential referral sources such as employers, law enforcement authorities, public welfare agencies, acute emergency medical care facilities, and managed care companies. Health maintenance organizations and managed care companies often require case finding when hotlines are called. General media campaigns and word of mouth also lead substance abusers to contact treatment programs.

Some treatment programs operate aggressive outreach street programs to identify and engage clients. Outreach workers contact prospective clients and offer to facilitate their entry into treatment. Although treatment admission may be the foremost goal of the worker and the treatment program, prospective clients frequently have other requests before agreeing to participate. Much of the assistance offered by outreach workers resembles case management in that it is community-based, responds to an immediate client need, and is pragmatic.

A pretreatment period is frequently the result of waiting lists or client reluctance to become fully engaged in primary treatment. In a criminal justice setting, it may be a time to prepare clients who are not ready for primary treatment because they do not have support systems in place and lack homes, transportation, or necessary work and living skills. The pretreatment period may be when clients lose interest in treatment. When the appropriate services are provided, however, it may actually increase the commitment to treatment at a later time. Numerous interventions—role induction techniques, pretreatment groups, and case management—have been instituted to improve outcomes associated with the pretreatment

period (Alterman et al., 1994; Gilbert, 1988; Stark and Kane, 1985; Zweben, 1981).

Primary treatment

Primary treatment is a broad term used to define the period in which substance abusers begin to examine the impact of substance use on various areas of their lives. The American Society of Addiction Medicine (ASAM) delineates five categories of primary treatment, characterized by the level of treatment intensity: early intervention, outpatient services, intensive outpatient or partial hospitalization, residential or inpatient services, and medically managed intensive inpatient services (ASAM, 1997).

Whatever the setting, an extensive biopsychosocial assessment is necessary. This assessment provides both the client and the treatment team the opportunity to determine clinical severity, client preference, coexisting diagnoses, prior treatment response, and other factors relevant to matching the client with the appropriate treatment modality and level of care. If not already established during the case finding/pre-treatment phase, this assessment should also consider the client's needs for various resources that case management can help secure.

Aftercare

Aftercare, or continuing care, is the stage following discharge, when the client no longer requires services at the intensity required during primary treatment. A client is able to function using a self-directed plan, which includes minimal interaction with a counselor.

Counselor interaction takes on a monitoring function. Clients continue to reorient their behavior to the ongoing reality of a pro-social, sober lifestyle. Aftercare can occur in a variety of settings, such as periodic outpatient aftercare, relapse/recovery groups, 12-Step and self-help groups, and halfway houses. Whether individuals completed primary treatment in a residential or outpatient program, they have at

least some of the skills to maintain sobriety and begin work on remediating various areas of their lives. Work is intrapersonal and interpersonal as well as environmental. Areas that relate to environmental issues, such as vocational rehabilitation, finding employment, and securing safe housing, fall within the purview of case management.

If different individuals perform case management and addictions counseling, they must communicate constantly during aftercare about the implementation and progress of all service plans. Because case managers interact with the client in the community, they are in a unique position to see the results of work being done in aftercare groups and provide perspective about the client's functioning in the community. Recent findings suggest that the case management relationship may be as valuable to the client during this phase of recovery as that with the addictions counselor (Siegal et al., 1997; Godley et al., 1994).

Aftercare is important in completing treatment both from a funding standpoint (many funders refuse to pay for aftercare services), as well as from the client's perspective.

Case Management Functions and the Treatment Continuum

In this section, case management functions are presented against the backdrop of the substance abuse continuum of care to highlight the relationship between treatment and case management. The primary difference between the two is case management's focus on assisting the substance abuser in acquiring needed resources. Treatment focuses on activities that help substance abusers recognize the extent of their substance abuse problem, acquire the motivation and tools to stay sober, and use those tools. Case management functions mirror the stages of treatment and recovery. If properly implemented, case management supports the client as she moves through the continuum,

encouraging participation, progress, retention, and positive outcomes. The implementation of the case management functions is shaped by many factors, including the client's place in the continuum and level of motivation to change, agency mission, staff training, configuration of the treatment or case management team, needs of the target population, and availability of resources. The fact that not all clients move through each phase of the treatment continuum or through a particular phase at the same pace adds to the variability inherent in case management.

Engagement

Case finding and pretreatment

Engagement during the case finding/pretreatment phase is particularly proactive. The case manager frequently needs to provide services in nontraditional ways, reaching out to the client instead of waiting for the client to seek help. Engagement is not just meeting clients and telling them that a particular resource exists. Engagement activities are intended to identify and *fulfill* the client's immediate needs, often with something as tangible as a pair of socks or a ride to the doctor.

This initial period is often difficult. Motivation may be fleeting and access to services limited. In many jurisdictions, there is a significant wait to schedule an orientation, assessment, or intake appointment. Third parties responsible for authorizing behavioral health benefits may be involved, and client persistence may be a key factor in accessing services.

Additional factors may come into play with clients referred from the criminal justice system. They may be angry about their treatment by the criminal justice system and may resent efforts to help them. Clients who begin treatment after serving time in jail or prison have significant life issues that must be addressed simultaneously (such as safe housing, money, and other

subsistence issues) as well as resentment, resistance, and anger. Others may have active addictions or be engaged in criminal activity. Requirements imposed by the criminal justice system must also be met; these can present conflicts with meeting other goals, including participation in substance abuse treatment.

Potential clients may be unfamiliar with the treatment process. Their expectations about treatment may not be realistic, and they may know very little about substance abuse and addiction. It is not uncommon for people at this stage to minimize the impact substance use or abuse has on their lives. These factors often manifest in client behaviors such as missing appointments, continued use, excuses, apathy, and an unwillingness to commit to change.

The goal of case management at this stage is to reduce barriers, both internal and external, that impede admission to treatment. Client reluctance to enter into services can be reduced by (1) motivational interviewing approaches; (2) basic education about addiction and recovery; (3) reminding clients of past and future consequences of continued substance abuse; (4) assistance in meeting the client's basic survival needs; and (5) commitment to developing the case manager-client relationship. Prescreening for program eligibility, coordinating referrals, and working to reduce any administrative barriers can facilitate access to services.

The process of motivating a client, beginning the education process, identifying essential needs, and forming a relationship can begin during a prescreening or screening interview. The motivational approaches suggested by Miller and Rollnick encourage client engagement through exploratory rather than confrontational means (Miller and Rollnick, 1991). Recognizing that not every client enters treatment with the same motivational levels, they build on Prochaska and DiClemente's stages of motivation for treatment. The stages move from the client's non-recognition of a

problem (precontemplation) to contemplation of a need for treatment, to determination, to action, and finally, to the maintenance of attained goals (Prochaska and DiClemente, 1982). Case management can use this framework to engage the client with stage-appropriate services. This means that clients who have not decided to address their substance abuse can often be “hooked” into more intensive treatment by providing basic practical supports. Providing these supports can have the additional effect of reducing the perceived desirability of continued substance use and the lifestyles associated with it.

A structured interview provides the client the opportunity to discuss her drug use and history with the case manager and to explore the losses that may have resulted from that use. For some clients, this history may reveal a pattern of increasing loss of control (and perhaps loss of freedom). Review and discussion of losses can serve to motivate clients to proceed to treatment. Listening empathetically and showing genuine concern about a client’s well-being can facilitate the beginning of a meaningful, supportive relationship between the client and the case manager and can serve to motivate the client as well. A good initial relationship between client and case manager can also be invaluable when the client experiences difficulties later on in treatment (Miller and Rollnick, 1991).

In addition to information regarding substance abuse and the treatment process, clients must be informed about requirements and obligations of the case manager or case management program, and about requirements they will be expected to meet once they are admitted to treatment. This type of discussion presents another opportunity to solidify the client’s commitment to participate in treatment. Even at the earliest stages, clients should be reminded that permanent changes are necessary for recovery. Finally, any questions the client has should be addressed. This can be

particularly important for clients referred by the criminal justice system, who may be somewhat confused about that system’s requirements, the consequences of noncompliance, and the difficulties they encounter in meeting those requirements.

While case management in the pretreatment phase may be intended to route clients to a particular program, engagement is not just a “come-on” to treatment. Many prospective clients will not formally enter treatment within an agency-defined period, but, within flexible limits, case management services should still be made available to these individuals. The transition from engagement to planning is a gradual one and does not lend itself to agency-created distinctions such as “pretreatment” and “primary treatment.”

Primary treatment

For clients who elect to enter treatment, engagement serves to orient the client to the program. Orientation involves explaining program rules and regulations in greater detail than was possible or necessary during pretreatment. The provider elicits the client’s expectations of the program and describes what the program expects of the client. The person responsible for delivering case management to a particular client is in a unique position to assist in the match between individual and treatment. During primary treatment, the case manager can serve as one of the client’s links with the outside world, assisting the client to resolve immediate concerns that may make it difficult to focus on dealing with the goal of primary treatment—coming to grips with a substance abuse problem.

In addition to orienting clients to treatment programs, case managers can orient treatment programs to the clients they refer. Sharing information gathered during the pretreatment phase can provide support for the treatment process that ensues upon program admission.

Aftercare

While in treatment, most of a client's time is spent dealing with substance use. Although discharge plans may have been considered, it is not until discharge that the day-to-day realities of living assume the most urgency. Because of their relationship with their clients and their community ties, case managers are well positioned to help clients make this delicate transition. Case management serves to coordinate all aspects of the client's treatment. This coordination occurs within a given treatment program, between the program and other resources, and among these other resources. The extent of the case manager's ability to work on the client's behalf will be guided both by the formal authority vested in the individual by the service providers involved and by the individual's informal relationships.

The case manager's extensive knowledge of the client's real-world needs can help the client who is no longer using. Clients in aftercare have an array of needs, including housing, a safe and drug-free home environment, a source of income, marketable skills, and a support system. Many have postponed medical or dental care; in recovery, they may seek it for the first time in years. Once an individual is in recovery, physician-prescribed medication for pain management can become a major problem, an issue that may require coordination and advocacy.

Assessment

The primary difference between treatment and case management assessments lies in case management's focus on the client's need for community resources. The findings from the assessment, including specific skill deficits, basic support needs, level of functioning, and risk status, define the scope and focus of the service plan.

Case finding and pretreatment

Depending on the structure and mission of the program providing case management, assessment may begin when engagement begins. It is case management's role to explore client needs, wants, skills, strengths, and deficits and relate those attributes to a service plan designed to address those needs efficiently. If the client is not eligible for a particular case manager's program, the case manager links the client with appropriate external treatment resources. This process includes assessing the client's eligibility and appropriateness for both substance abuse and other services and for a specific level of care within those services. If the client is both eligible and appropriate for the program, the case manager's role is to engage the client in treatment.

Primary treatment

For clients who enter primary treatment, the case management assessment function, which is primarily oriented to the acquisition of needed resources, is merged with an assessment that focuses on problems amenable to therapy—substance use, psychological problems, and family dysfunction. Ideally both assessments are integrated into a biopsychosocial assessment (Wallace, 1990). This biopsychosocial assessment should, at a minimum, examine the client's situation in the life domains of housing, finances, physical health, mental health, vocational/educational, social supports, family relationships, recreation, transportation, and spiritual needs. Detailed information should be gathered on drug use, drug use history, health history, current medical issues, mental health status, and family drug and alcohol use. This assessment, used in conjunction with the needs assessment, assists the treatment team in developing a formal treatment plan to be presented to, modified, and approved by the client. Whether one person or several conduct these two assessments is largely

irrelevant. Where a team approach exists, all members of the team, including the case manager or other professional identified in that role, should bring their expertise to the assessment. Discharge planning and long-range needs identification, particularly with current funding limitations, begins at treatment admission. Because of this, intensive case management for substance abuse clients, regardless of the level of care, is imperative.

As the individual responsible for coordinating diverse services, the case manager must take a broad view of client needs, look beyond primary therapy to the impact of the client's addiction on broader domains, and assess the impact of these domains on the client's recovery. He also must assess specific areas of functional skill deficits, including personal living skills, social or interpersonal skills, service procurement skills, and vocational skills. Individuals performing this function need to have strong knowledge of and experience in the field of substance abuse. The greater the number of problems the case manager can help the client identify and manage during primary treatment, the fewer problems the client must address during aftercare and ongoing recovery—and the greater the chances for treatment success.

A case management assessment should include a review of the following functional areas (Harvey et al., 1997; Bellack et al., 1997). These items are not exhaustive, but demonstrate some of the major skill and service need areas that should be explored. The assessment of these areas of functioning gives evidence of the client's degree of impairment and barriers to the client's recovery. The case manager may have to perform many services on behalf of the client until skills can be mastered.

Service procurement skills

While the focus of case management is to assist clients in accessing social services, the goal is for

clients to learn how to obtain those services. The client should therefore be assessed for

- Ability to obtain and follow through on medical services
- Ability to apply for benefits
- Ability to obtain and maintain safe housing
- Skill in using social service agencies
- Skill in accessing mental health and substance abuse treatment services

Prevocational and vocation-related skills

In order to reach the ultimate goal of independence, clients must also have vocational skills and should therefore be assessed for

- Basic reading and writing skills
- Skills in following instructions
- Transportation skills
- Manner of dealing with supervisors
- Timeliness, punctuality
- Telephone skills

The case management assessment should include a scan for indications of harm to self or others. The greater the deficits in social and interpersonal skills, the greater the likelihood of harm is to self and/or others, as well as endangerment from others. The case manager should also conduct an examination of criminal records. If the client is under the supervision of the criminal justice system, supervision officers should be contacted to determine whether or not there is a potential for violent behavior, and to elicit support should a crisis erupt.

Aftercare

The client's readiness to reintegrate into the community is a focus of case management assessment throughout the treatment continuum. Because the case manager is often out in the community with the client, she is in an excellent position to evaluate this important indicator. During aftercare, her assessment may reveal new, recurring, or unresolved problems the client must deal with before they interfere with recovery. The potential for relapse is a

particularly significant challenge, and the client must be able to identify personal relapse triggers and learn how to cope with them. Because case managers are familiar with the community, clients, and substance abuse treatment issues, they can spot such triggers and intervene appropriately. If, for example, a case manager fears that a client's decision to return to a familiar neighborhood could result in contact with drug-using friends that could jeopardize sobriety, a new residence may be necessary.

Planning, goal-setting, and implementation

Flowing directly and logically from the assessment process, planning, goal-setting, and implementation comprise the core of case management. Based on the biopsychosocial or case management assessment, the client and case manager identify goals in all relevant life domains, using the strengths, needs, and wants articulated in the assessment process. Service plan development and goal-setting are discussed in detail in numerous works on substance abuse and case management (Ballew and Mink, 1996; Rothman, 1994; Sullivan, 1991). These authors agree on several points: Each goal in service plans should be broken down into objectives and possibly into even smaller steps or strategies that are behaviorally specific, measurable, and tangible. Distinct, manageable objectives help keep clients from feeling overwhelmed and provide a benchmark against which to measure progress. Goals, objectives, and strategies should be developed in partnership with the client. They should be framed in a positive context—as something to be achieved rather than something to be avoided. Time frames for completing the objectives and strategies should be identified. Abbreviated, user-friendly treatment planning templates make client participation in development of a service plan more likely. The availability of staff to assist in the planning, goal-setting, and

implementation of the case management aspects of the treatment plan is crucial.

Successful completion of an objective should provide the client the satisfaction of gaining a needed resource and demonstrating success. Failure to complete an objective should be emphasized as an opportunity to reevaluate one's efforts. In the latter situation, the case manager should be prepared to help the client come up with alternative approaches or to begin an advocacy process.

A deliberate, carefully considered approach to identifying client goals offers benefits that go beyond the actual acquisition of needed resources. Clients benefit by

- Learning a process for systematically setting goals
- Understanding how to achieve desired goals through the accomplishment of smaller objectives
- Gaining mastery of themselves and their environment through brainstorming ways around possible barriers to a particular goal or objective
- Experiencing the process of accessing and accepting assistance from others in goal-setting and goal attainment

These and other individually centered outcomes make the planning and goal-setting process as important as the final outcome in some cases. This is the action stage of case management, when the client participates in many new or foreign activities and may have multiple requirements imposed by multiple programs or systems. Many significant and stressful transitions may be involved—from substance use to abstinence, from institutionalization or residential placement to community reintegration, and from a drug- or alcohol-using peer group to new, abstinent friends. As clients struggle to stop using, many will relapse, sometimes after a significant period of abstinence. They may feel overwhelmed, and

it is not uncommon for clients in recovery to experience feelings of isolation and depression as they develop new peer associations and lifestyle patterns, and come to grips with their losses. In addition, the very real pressures of finances, employment, housing, and perhaps reunifying with and caring for children can be very stressful.

Case finding and pretreatment

During the pretreatment phase the planning function of case management focuses on supporting clients in achieving immediate needs and facilitating their entry into treatment.

Ideally, the professional implementing case management meets with the client to plan the goals and objectives for the service plan. While planning and goal setting are important in this early stage of treatment, it may be difficult to follow traditional approaches given the immediacy of clients' needs and the possibility that they are still using alcohol or other drugs. The case manager may decide to complete a formal plan after an action is undertaken and present it to the client as a summary of work that was accomplished. If a client's capacity is diminished by substance abuse and the presence of multiple, serious life problems, the case manager may have to delay teaching and modeling for the client, and instead trade on his own contacts, resources, and abilities. As the client progresses through the treatment continuum, the case manager can turn more and more of the responsibility for action over to the client.

Clients who are using addictive substances while receiving case management services present a significant dilemma for the case manager. On the one hand, the client may not be willing or able to participate in treatment; on the other, treatment providers normally expect some commitment to sobriety before clients begin the treatment process. As a result, the case manager frequently needs to negotiate common ground between client and program.

For example, a case manager might require the client to identify and make progress toward mutually understood goals pending entry into treatment. Structured correctly, such an approach fosters a win-win situation.

Attainment of these goals either eliminates the client's need for treatment or prepares him to accept treatment more willingly. Even if the client is unwilling or unable to achieve those goals, the case manager and treatment program have additional information to use in attempting to motivate the client to seek treatment.

Primary treatment

During primary treatment, the case manager and client develop a service plan that identifies and proposes strategies to meet the client's short- and medium-term needs. The case management plan should reflect the level and intensity of the service along with the client's specific objectives. Virtually all clients have multiple needs; consequently, the service plan should be structured to enable clients to focus on addressing their problems *while* they participate in treatment. The idea that one can put lack of housing, employment issues, or a child's illness aside to concentrate exclusively on addiction treatment and recovery is unrealistic and sets up both the treatment provider and the client for failure. At the same time, it is often necessary for the client and case manager to prioritize problems.

During primary treatment, the case manager must (1) continue to motivate the client to remain engaged and to progress in treatment; (2) organize the timing and application of services to facilitate client success; (3) provide support during transitions; (4) intervene to avoid or respond to crises; (5) promote independence; and (6) develop external support structures to facilitate sustained community integration. Case management techniques should be designed to reduce the client's internal barriers, as well as external barriers that may impede progress.

Providing ongoing motivation to clients is critical throughout the treatment continuum. Clients need encouragement to commit to entering treatment, to remain in treatment, and to continue to progress. The case manager must continually seek client-specific incentives. Clients are encouraged by different factors, and the same client may respond differently depending on the situation. For instance, many clients referred by the criminal justice system will be initially motivated to try treatment in order to avoid a jail sentence; they may be motivated to stay in treatment for very different reasons (e.g., they start to feel better, they hope to regain custody of children). The treatment process is difficult, and many clients become discouraged after their initial enthusiasm. Recovery may require them to explore uncomfortable issues. Physical discomfort, as well as depression, can ensue. Case managers can provide support during these periods by supplying information on coping techniques such as exercise, diet, and leisure activities. If depression is significant, case managers can work with substance abuse counselors to have a mental health evaluation conducted, and, if appropriate, enable the client to seek additional therapeutic support for the depression. Continued empathetic caring can also motivate clients.

Disincentives may also be used. For example, the case manager might remind clients of the outcome of terminating treatment—for some, this might mean a return to prison, for others it might mean dealing with the health or safety consequences of addictive behaviors. For clients under the control of the criminal justice system, sanctions, including possible jail stays, may be necessary to regain commitment and motivation.

In criminal justice settings, particularly drug courts, regular “status hearings” before a judge may motivate the client. In status hearings, the judge is informed of the client’s progress (or lack

thereof), and engages the client in a dialogue. The judge can then apply rewards (encouragement, or reduction of criminal sanctions), adjust treatment requirements, or apply sanctions. Sanctions vary, but may include warnings, community service, short jail stays, or ultimately, termination from the program and incarceration.

Another fundamental role of case management during the active treatment phase is to coordinate the timing of various interventions to ensure that the client can achieve his goals. The case manager has to work with the client to balance competing interests, and to develop strategies so the client can meet basic survival needs while in treatment. For example, a case manager may have to negotiate between probation and treatment to ensure that the client can attend treatment sessions and meet with his probation officer. Some activities require staging to ensure that they are applied at the right time and in the correct order. Clients who are unemployed and lack employment skills, for instance, should begin job readiness and training activities after they are stabilized in treatment; they will need additional support for seeking and maintaining employment. It is not uncommon for clients to feel they can take on the world once they are stabilized in treatment. If this is the case, the job of the case manager is to encourage clients to go slowly and take on responsibility one step at a time. This can be particularly critical for women anxious to reconnect with their children. The financial and emotional responsibilities are great, and the case manager should work with the woman and child protective services to transition these responsibilities in manageable ways.

Transition among programs—from institutional programming to residential treatment; from residential treatment to outpatient; or to lower level services within an outpatient setting — is always stressful, and frequently triggers relapse. In order to avoid

crises during transitions, case managers should intensify their contact with clients. Case managers should work to ensure that service is not interrupted. When possible, release dates should be coordinated to coincide with admission to the next program.

If the client is under the control of the criminal justice system, the case manager should work to ensure that supervision activities remain the same or increase when treatment activity decreases. Too frequently, a client completes a treatment program and is moved to a lower level of supervision at the same time. This pulls out support all at once. If possible, supervision and treatment activities should be coordinated to promote gradual movement to independence in order to reduce the likelihood of relapse.

In addition to activities designed to avoid a crisis or relapse, the case manager should be available to respond to relapses and crises when they do occur. In many cases, the case manager leads the response effort. Case managers should be in frequent contact with the treatment program to check on client attendance and progress. Lapses in attendance and/or poor progress can signal an impending crisis, and a case conference should be held. The case conference can resolve problems and prevent the client's termination from the program. While violence toward staff or other patients is obviously adequate grounds for immediate program termination, other infractions do not necessarily warrant expulsion. The case management team and client should work together to develop alternatives that will keep the client engaged in treatment. If removal from the program is absolutely necessary, it may be possible to have the client readmitted after he "adjusts his attitude" and re-commits to treatment and to obeying the rules.

The Treatment Alternatives for Safe Communities (TASC) Project has developed a special form of case conference, known as

"jeopardy meetings" for treatment clients involved in the criminal justice system. These meetings are attended by the case manager, treatment counselor, probation officer, client, and anyone else involved in the case. The purpose of the meeting is to confront the client with the problem, and to discuss its resolution as a team. The client must agree to the proposed resolution in writing. The jeopardy meeting provides a clear warning to the client (three jeopardy meetings can result in client termination); reduces the "triangulation" or manipulation that can occur if all parties aren't working in a coordinated fashion; and brings together the skills and resources of multiple agencies and professionals. (For more on jeopardy meetings, including structure and format, see the *TASC Implementation Guide* (Bureau of Justice Assistance, 1988).

Aftercare

One of the anticipatory roles for case management during primary care is to plan for aftercare, discharge, and community reentry. During primary care and into aftercare, the case manager helps the client master basic skills needed to function independently in the community, including budgeting, parenting, and housekeeping. Short-term goals increasingly become supplanted by long-term goals of integrating the individual into a recovery lifestyle. When appropriate, service plans should reflect an ever-increasing emphasis on clients' accepting greater responsibility for their actions. The case management intervention may increase or decrease in intensity, depending on client response to independence and progress toward community reintegration.

Linking, monitoring, and advocacy

Some findings suggest that while persons with substance abuse problems are generally adept at accessing resources on their own without case management, they often have trouble using the

services effectively (Ashery et al., 1995). This is where the linking, ongoing monitoring, and, in many cases, advocacy, of case management can be valuable. An additional crucial function of case management is coordinating all the various providers and plans and integrating them into a unified whole.

Linking goes beyond merely providing clients with a referral list of available resources. Case managers must work to develop a network of formal and informal resources and contacts to provide needed services for their clients.

Case finding and pretreatment

Case managers may be especially active in providing linking and advocacy during the pretreatment phase of the treatment continuum. As with each of the case management functions, the roots of linking begin much earlier, while conducting an assessment with the client and in creating goals in which the client is vested. The authors of one primer on case management identify five tasks related to linking that should be undertaken with the client before actual contact with a needed resource even occurs. Case managers must (1) enhance the client's commitment to contacting the resource; (2) plan implementation of the contact; (3) analyze potential obstacles; (4) model and rehearse implementation; and (5) summarize the first four steps for the client (Ballew and Mink, 1996).

Primary treatment

After the linkage is made, the case manager moves on to monitoring the fit and relationship between client and resource. Monitoring client progress, and adjusting services plans as needed, is an essential function of case management. Coupled with monitoring is the need to share client information with relevant parties. For instance, if a client who is involved in the criminal justice system tests positive for drugs, both the treatment counselor and the probation officer may need to know. If the case manager is aware that the client is having

problems at work, this information may need to be shared with the treatment provider, within the constraints of confidentiality regulations.

Case managers who are responsible for offenders in treatment may oversee regular drug testing. This is an effective way to obtain objective information on a client's drug use, as well as to structure boundaries for the client to help prevent relapse.

Monitoring may reveal that the case manager needs to take additional steps on the client's behalf. Simply put, *advocacy* is speaking out on behalf of clients. Advocacy can be precipitated by any one of a number of events, such as

- A client being refused resources because of discrimination, whether discrimination is based on some intrinsic aspect of the client, such as gender or ethnicity, or on the nature of the client's problems, such as addiction
- A client being refused services despite meeting eligibility requirements
- A client being discharged from services for reasons outside the rules or guidelines of that service
- A client being refused services because they were previously accessed but not utilized
- The case manager's belief that a service can be broadened to include a client's needs without compromising the basic nature of the service

Advocacy on behalf of a client should always be direct and professional. Advocacy can take many forms, from a straightforward discussion with a landlord or an employer, to a letter to a judge or probation officer, to reassuring the community that the client's recovery is stable enough to permit reentry. Advocacy often involves educating service providers to dispel myths they may believe about substance abusers, or ameliorating negative interactions that may have taken place between the client and the service provider. This is particularly important for certain groups with whom some

programs are reluctant to work, such as clients with AIDS/HIV or clients involved in the criminal justice system.

More complicated advocacy involves, for example, appealing a particular decision by a service staff member to progressively higher levels of authority in an organization. The highest, most involved levels of advocacy include organizing a community response to a particular situation or initiating a legal process. Modrcin and colleagues provide an advocacy strategy matrix that can help case managers systematically plan advocacy efforts (Modrcin et al., 1985). In this view of advocacy, the levels at which advocacy can be effected (individual, administrative, or policy) are weighed against varying approaches (positive, negative, or neutral). Three guidelines for advocating on behalf of a client are getting at least three “No’s” before escalating the advocacy effort, understanding the point of view of the organization that is withholding service, and consulting with supervisory personnel regularly before moving to the next level of advocacy (Sullivan, 1991).

Client advocacy should always be geared toward achieving the goals established in the service plan. Advocacy does not mean that the client always gets what she wants. Particularly for clients whose continued drug use or cessation of treatment will present considerable negative consequences such as incarceration or death, advocacy may involve doing whatever it takes to keep them in treatment, even if that means recommending jail to get them stabilized. It is not uncommon, in fact, for clients to state their preference for jail when treatment gets difficult. Even when advocating for clients, the case manager must respect system boundaries. For example, a case manager might negotiate hard to keep an offender client in community-based treatment, but agree to inform the probation office of positive drug tests or suspected criminal behavior. While advocacy

for certain client populations is essential, concern for the client should not override goals of public safety. Effective, client-centered advocacy may put the case manager in a position of conflict with co-workers, program administrators, or even supervisors. Case managers who advocate for an extension of benefits for their clients may put themselves and their supervisors in jeopardy with funding sources. A coordinated infrastructure with existing policies and procedures for client centered collaboration will help.

Disengagement

Disengagement in the case management setting, as with clinical termination, is not an event but a process. In some ways, the process begins during engagement. For both client and case manager, it entails physical as well as emotional separation, set in motion once the client has developed a sense of self-efficacy and is able to function independently. To a significant degree, this decision can be based on progress defined by the service plan. If the plan has truly been developed with the client’s active involvement, there will be a great deal of objective information that will help both the case manager and client decide when disengagement is appropriate. It is preferable that disengagement be planned and deliberate rather than have the relationship end in a flurry of missed appointments, with no summary of what has been learned by the client and professional. Formal disengagement gives clients the opportunity to explore what they learned about interacting with service providers and about setting and accomplishing goals. The case manager has a chance to hear from clients what they considered beneficial—or not beneficial—about the relationship. Reviewing and summarizing client progress can be an important aspect of consolidating clients’ gains and encouraging their future ability to access resources on their own.

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, 1994). 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, 1977). 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, 1991). 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., 1992). 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, 1992). 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, 1992). 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., 1995).

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, 1992). 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, 1993). 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.