Brief Review of Approaches to Case Management for the ACT Drug and Alcohol Program

For the ACT Department of Health

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1 BACKGROUND

1.1 RATIONALE

The ACT Department of Health is working to develop a new and more effective case management framework for clients of drug and alcohol services who have complex needs. The goal is to develop a more holistic approach that encompasses collaboration between service providers, including the ACT Drug and Alcohol Program, ACT Mental Health and non-government services.

This paper provides a brief overview of approaches to case management both within the field of alcohol and drug treatment (ADT) as well as examples from other sectors. It is not a comprehensive review of all available literature but rather a scoping paper designed to provide an overview of models, principles and practices.

This is the first stage in the process of developing a new approach to case management. Further research into specific models of case management that might be suitable for use in the ACT context, as well as broad consultation with stakeholders is also planned.

1.2 CURRENT SERVICE PROFILE

Case management services for clients with drug and alcohol problems are provided by the ACT Health Alcohol and Drug Program and a range of alcohol and drug non-government agencies.

The report of the National Minimum Dataset collection (AIHW, 2004) indicates that ACT government-funded alcohol and other drug treatment agencies (including both government operated and non-government operated services) provided 3,001 'closed treatment episodes' during the 2002-03 reporting period. Of these closed treatment episodes, withdrawal management (detoxification) was the most common form of main treatment provided (51%), followed by support and case management only and counselling (16% each).

1.3 CLIENT PROFILE

It is beyond the scope of this paper to look in detail at the epidemiology of substance use in the ACT. At a very broad level, the majority of closed treatment episodes in ACT ADT services, as reported in the National Minimum Dataset during 2002-03 were for clients aged between 20 and 39 years of age (61%), with over one-third of all treatment episodes (36%) provided for clients in the 20–29 year age group. Male clients in the ACT accounted for nearly two-thirds (64%) of all closed treatment episodes.

Clients of the ACT Health Alcohol and Drug Program typically have multiple and ongoing issues. Many clients are in contact with the criminal justice system and/or experiencing issues related to mental health, poverty and homelessness. ADT treatment services also work with other family members including the children of people affected by drug and alcohol problems.

There is no universal definition of 'high and complex needs' but within any given human service system the term is usually used to refer to people who:

a) Require intensive, ongoing or complex support or treatment; and/or

b) Present with a combination of difficulties requiring the coordination of support across different service systems.

Within alcohol and drug treatment programs the term 'high and complex' needs typically applies to people who require intensive withdrawal management such as detoxification and/or ongoing pharmacotherapy[1] and/or have multiple support needs. Clients who have high and complex needs are often experiencing a range of significant issues such as homelessness, poverty, poor health, mental health difficulties and contact with the criminal justice system. There is a need to integrate service delivery across key sectors in order to achieve sustainable improvements in health and quality of life. Some specific examples of the need for cross-sector coordination are identified below.

Poverty and Homelessness

The links between alcohol and drug problems, poverty and homelessness are well established. For example, Horn (1999) found that in an adult population of people experiencing homelessness, an estimated 25% have major issues related to alcohol use and homeless people are 7.5 times more likely to be heroin dependent compared to the general population.

The ACT Government (2003) recently undertook a whole-of-government project – 'Addressing disadvantage in the ACT'. Consultation with community organisations undertaken as part of this project identified that:

- the greatest areas of need in the ACT were housing, health, advocacy, education and employment;

[1] Pharmacotherapies are medicines used in the treatment of drug dependency. Examples include Methadone, Buprenorphine and Naltrexone which are some of the medications used for the treatment of heroin dependency and Acamprosate and Naltrexone which are used in combination with counselling in the treatment alcohol dependence (NSW Health Drug Programs Bureau).

- disadvantaged people in the ACT experience multiple types of disadvantage and have complex needs requiring holistic, person centred service provision;
- consumers lack awareness of their rights;
- many consumer advocacy and representative organisations are unable to provide adequate levels of advocacy for individuals due to lack of resources; and
- consumer organisations are focused on delivery of services and felt they did not have the resources for innovation, administration, training, development or collaboration.

The 'Addressing Disadvantage' report concluded that an integrated approach to providing services is required in order to empower people to overcome financial disadvantage.

Parenting and Children

Many studies suggest that drug misuse by parents is often associated with less than optimum outcomes for children (Tresidder, 2004; citing the Advisory Council on the Misuse of Drugs 2003). For example, over half of the cases investigated by child protection services across Australia involve parental substance misuse (Department of Human Services 2002).

Contemporary commentators suggest that it is important that ADT treatment services address both the parents' and their children's needs in case management plans. This inevitably involves the ADT service networking with other services (including children's services) and going beyond the normal boundaries of alcohol and drug treatment (Tresidder, 2004).

Co morbidity ADT & Mental Health

The prevalence of combined mental illness and substance abuse is very high. It is estimated that up to 80% of people with a diagnosed mental illness also has a diagnosis of problematic substance use and within alcohol and drug services, up to 20% of people presenting, are estimated to have a co-existing mental illness (Cupitt et al, 1999). Among people using illicit drugs the incidence of psychiatric disorder is seven times that of the general population (NSW Health, 2001).

2 CASE MANAGEMENT APPROACHES

2.1 INTRODUCTION

The term 'case management' is contentious and difficult to define (Greche, 2002; Fine, 1997). Some of the difficulties include:

- Case management is not a cohesive philosophy or disciplined set of ideas;
- Approaches to case management are strongly influenced by culture and the characteristics of service sectors; and
- Approaches to case management have developed simultaneously across a diverse range of service sectors and the term 'case management' is often used interchangeably with other terms such as 'support planning' or 'care management'.

Despite these difficulties, the common purpose of case management approaches is to coordinate service delivery in a way that provides integration and continuity for individuals. The following definition relates to case management plans but captures the essence of case management in community service settings:

"A case management plan is a personal plan or a support agreement that usually has a statement of the person(s) problems or needs, some goals for the person(s) and strategies to achieve those goals. It is usually developed between the person and agency as a result of an assessment process. The plan or agreement can relate to services provided by one agency or a number of agencies" (AIHW National Community Services Data Dictionary, 2000).

Common tasks in case management include:

- Assessment and needs identification;
- Setting goals for treatment and/or support;
- Identifying services and supports (this usually includes a range of services across multiple agencies);
- Planning and negotiating service delivery (this may include brokerage or the administration of funding);
- Monitoring ongoing needs and the delivery of services;
- Evaluating outcomes and achievements; and
- Record keeping.

Key differences in approaches to case management include:

- Intensity of contact and support;
- Control over resources and service delivery; and
- Training and skills of key persons.

The following discussion identifies a number of approaches to case management. It is important to note that these approaches are not universally agreed in the literature, some authors would argue that not all of the approaches described are forms of 'case management' others would suggest that some approaches go beyond case management. In response to the lack of consensus amongst experts, we have included more rather than less approaches and used plain-English terms as far as possible.

2.2 Clinical or Primary Care Case Management

The clinical case management model recognises that case managers may need to provide services directly and hence act as clinicians (Grech, 2002). The clinical case manager typically undertakes the tasks of:

- Initial engagement of the client,
- Assessment and service planning;
- Identifying interventions;
- Delivery of interventions and assessment of effectiveness;
- Liaising with other support providers including other services and family members or carers.

Fine (1997) briefly critiques the General Practitioner referral system as an example of a primary care approach to coordinating services. The General Practitioner's function as the entry point to health and welfare services in Australia, they undertake assessment, provide referrals and monitor treatments when appropriate. Advantages of this model include the potential for clients to develop a long term relationship with a primary care provider and to have a central point of contact or advice for a diverse range of assistance. Problems with this model include:

- The need for the General Practitioner to understand the broader service sector and maintain networks;
- Issues of 'profession' and the lack of clear established networks and clear legally recognised referral pathways for services other than specialist medical treatments; and
- The cultural tendency and funding mechanisms that favour the use of prescriptions and medicines over referrals to support services such as counselling or self-help groups.

The same issues may be pertinent in ADT clinical models of case management. For example, people with clinical expertise in ADT may have excellent knowledge of the clinical treatment options for addressing an individual's substance use issues but may find it challenging to coordinate supports across the domains of housing, parenting and the development of life skills, all of which may be important to enabling an individual to participate and benefit from treatment services.

2.3 BROKER MODEL

The broker model of case management, places the emphasis on assessing the needs of clients, treatment planning and referring on to other agencies (Greche, 2002). This model, views the case manager as the client's advocate who is responsible for coordinating between various services and for the ongoing monitoring of care. There is an assumption that in acting as a "broker" the case manager does not require any specific clinical skills, but rather the ability to match available resources with needs.

Brokerage is increasingly used in service sectors where clients have complex and changing needs, requiring a diverse range of responses. It is also a mechanism for providing individuals with support to choose from alternative support options and service providers. Brokers can provide independent or impartial advice, reducing the extent to which individuals are dependent on one service provider agency to meet all of their needs. For example, brokerage agencies in the disability sector assist people to identify and access a broad range of services including personal care, home help, equipment and technology advisers, vocational training options and other types of support available from a diverse range of provider agencies. This allows individuals to change their support arrangements over time and navigate an increasingly complex service sector.

The role of a broker is usually less directive than a clinical case manager. The focus tends to be on providing advice and information to allow the client to make informed decisions, rather than on clinical assessment to determine appropriate interventions. In the ADT sector, access to clinical interventions and treatments such as pharmacology is likely to continue to rely on clinical assessments. A broker role may be an adjunct to assist people through the process and to assist individuals to identify and coordinate broader familial and social supports, particularly through key transition stages such as entering and leaving intensive rehabilitation.

2.4 MULTI-DISCIPLINARY ASSESSMENT AND REFERRAL TEAMS

The multi-disciplinary approach involves a team of people from relevant service sectors who collaborate to plan and coordinate support. This approach is often used when individuals and/or households require ongoing support and/or support from multiple agencies.

Multi-disciplinary teams can be particularly effective in the assessment of people with high and complex needs and in making referrals to a broad range of services. The team approach can also address the problem of individuals falling between service systems and the problems of ownership or responsibility when multiple services are involved providing support.

An example of this approach is the Aged Care Assessment Teams (ACAT) established to provide an objective, public and multi-disciplinary mechanisms for assessing all applicants for nursing home places. The ACAT teams now also assess people needing community based care and makes referrals to both residential aged care services and home and community care services. The ACAT model has been very successful in streaming people into appropriate service systems but its weakness is that it has no capacity to purchase services or direct funding and therefore cannot guarantee that clients are able to access the services to which they are referred (Fine, 1997).

Multi-disciplinary teams can be given responsibility for service delivery and/or a 'developed budget' from which to purchase services on behalf of the client. These approaches are typically used to support individuals or family groups that have either long-term support needs (such as people accessing aged care, mental health and disability services) or critical, urgent or complex needs requiring an intensive response that may or may not be short-term (such as families with child protection issues).

The resources available to the case management teams are usually tied to individuals – either through an individual funding model or a 'package' or 'budget' model (see later discussion on funding models).

Another example of this approach is the use of Assertive Community Treatment (ACT) in mental health services. ACT is designed as a package of care for sufferers of more severe mental disorders and is characterised by more frequent client contact, in comparison to other case management models (Grech, 2002). It is provided by the multi-disciplinary team with services delivered in the community rather than the clinician's office. Caseloads are low (about 10-15 clients), shared across clinicians and are not "brokered out" to other agencies. Twenty-four hour provision of care and assertive outreach is characteristic of this approach and services are generally regarded as time limited. However, Freeman (2000) found that evidence from the United States suggests that ACT is most successful in reducing hospitalisation rates when a comprehensive and enduring approach is adopted. Similarly, Marks et al (1994) find that many clients require an assertive outreach approach indefinitely. Harris (2002) reports that Assertive Community Treatment (ACT) teams are operating in the US, Canada and the UK as a key element of care for clients with a dual diagnosis – substance abuse and mental illness - including those with complex needs.

3 SERVICE COORDINATION AND INTEGRATION

3.1 BEYOND CASE MANAGEMENT

If one of the goals of developing an improved approach to case management is to improve the integration and coordination of supports across service sectors then a broader framework may be needed, beyond simply a new case management process.

The US Substance Abuse and Mental Health Services Administration (SAMHSA, 2002) defines integrated treatment as *"any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting"* (cited in Harris, 2002).

Integration must be conceptualized on two levels: (1) organisational/program and (2) clinical/individual and both levels must be achieved in order to expect improvements in participant outcomes (SAMHSA, 2000; Konrad, 1996). To be considered integrated, sites must be operating at a "coordination" level which is characterized by joint planning processes, formal interagency agreements, regular meetings, cross-training, and shared activities.

3.2 SHARED CARE

Shared care is a structured system for achieving integrated care across multiple autonomous providers and services, including GPs and specialist services. Shared care involves:

- systems to create linkages between services or organisations;
- common goals, objectives and guidelines;
- information and communication systems;
- education and quality assurance; and
- care planning.

The Centre for General Practice Integration Studies (2002) conducted the Illicit Drug Shared Care Project, funded by the Commonwealth Department of Health and Ageing to develop and trial a model for developing shared care treatment programs for people with illicit drug problems. The model included general practitioners (GPs), drug and alcohol workers and other service providers. The model including the local treatment programs, were trialled and evaluated in an urban and rural areas (SouthWest Sydney and Central/Mid Western NSW) with the results disseminated nationally.

The dissemination report from this project provides detailed advice for developing mechanisms to support sharing care, without prescribing one particular model. It suggests a three stage process of 1) Development; 2) Implementation; and 3) Monitoring and quality improvement.

Key lessons learned from the project have been identified in the report as follows:

1. Engagement needs to occur at all levels, including senior management, to clarify not only key roles but also the human resources, training and time required to develop shared care.

2. Local advisory groups are a key structure to develop and oversee the implementation of shared care processes.

   It takes time to develop shared care processes, which are dependent upon the quality of relationships, communication and trust between service providers as well as between service providers and clients. Sharing care also requires flexibility and responsiveness to local situations as they develop in order to provide for clients' changing needs. It is important that the partners recognise that a lengthy period of time may be needed to develop the systems, policies and procedures necessary to ensure seamless care.

3. Sufficient time needs to be devoted to the development of shared care programs and the systems and supports required to make them work.

   Consultation with consumers is especially important. This can be difficult at the local level where there may not be organisations or structures to facilitate this. Consumers were supportive of the development of shared care. However, they were concerned to protect their rights and treatment options.

4. Consumer consultation questionnaires and a charter of rights and responsibilities should be considered as part of the development of any shared care program.

   The treatment options provided by GPs in this trial included general health care, assessment, provision of community detoxification, brief interventions, pharmacotherapies, relapse prevention and referral. The most important constraint in the development of the trial was the availability of specialised drug and alcohol services with which GPs could share care. Shared care referral and consultation pathways cannot work where services are in short supply or absent.

5. A multidisciplinary approach is required which provides a menu of treatment options, depending on client needs and local service availability.

   Building on existing programs and activities, such as methadone maintenance treatment services and activities under the Enhanced Primary Care Program (EPC), was a successful strategy in both urban and rural areas. The EPC activities provided a model for GPs to engage in multidisciplinary care planning as well as an opportunity for

Divisions to help build the capacity of practices to work with people who use illicit drugs.

6. Shared care programs should build on existing drug and alcohol shared care programs and other initiatives such as the EPC.

7. Education and training for all health providers are critical components of any shared care program.

   Although providers' needs did differ, most GPs, drug and alcohol providers and other providers expressed the need for some further education and information about various aspects of illicit drug use and treatment options. Despite the considerable problems experienced with staff shortages and other demands on drug and alcohol services during the time of this Project, most providers felt that their knowledge and skills had improved, as had access to support and quality of care. Most felt that their clients had achieved improved outcomes as a result of the Project.

3.3 Integrating ADT & Mental Health Services

Integrated approaches to treating people with alcohol and drug issues as well as mental health issues has been the subject of considerable development and research since the early 1990's.

A major review by the National Drug and Alcohol Research Centre (Teesson & Proudfoot, 2003) examined contemporary research and practice relating to the epidemiology, prevention and treatment. Co morbid mental disorders and substance use disorders. This review examined in detail the complexities of assisting people with dual diagnosis including some of the interactions between specific psychiatric conditions and various approaches to ADT (eg the effects of some pharmacotherapy treatments on people with particular psychiatric conditions).

The review supports the continued development of integrated treatments for substance use disorders and severe mental disorders as these "tend to have superior outcomes to standard treatment and to parallel or sequential approaches". For example, NSW Health (2001) identify that "*where there is an effective treatment, treatment for the associated psychiatric diagnosis often leads to markedly improved functioning and less relapse to illegal drug use, in particular, accurate psychiatric diagnosis can identify patients who need and are likely to benefit from psychotherapy as an adjunct to methadone maintenance"*

However, integrating treatments is not easy. The following extract from Teesson & Proudfoot (2003) highlight just some of the challenges: *"A treatment for the substance use may need to comprise a combination of reduced medication dosage, effective medical and psychological strategies for symptom control, together with a substance use treatment that is compatible with*

other psychiatric symptoms that at times may only be partially controlled. The management plan as a whole needs to avoid over-taxing the patient, or increasing either symptoms or personal risk. These requirements are very difficult to fulfil in an environment with separate services for substance misuse and mental illness, where each has evolved differing service priorities and treatment philosophies. Many patients miss out on effective treatment for one or both disorders, staff in each service often have difficulty obtaining consultations and timely referrals, and joint case conferences are rare (Kavanagh et al., 2000). Jointly managed patients often face conflicting advice, and interventions that are at odds (eg confrontational interventions for substance use that exacerbate psychiatric symptoms, or increased dosage of antipsychoticmedication at the same time as a quit-smoking attempt).

Despite the challenges, Teesson & Proudfoot (2003) identify useful areas of current knowledge, including:

- Screening measures that can be used to detect people with co-morbidity across and within sectors (eg AUDIT, SDS, DALI and DrugCheck).
- Measures of readiness to change substance use, readiness for treatment and insight into mental disorders are also available.
- The effectiveness of approaches to engagement and motivational enhancement and goal setting; and
- Developments in the use of pharmacotherapy treatments which can be used effectively and safely.

The development of improved treatment approaches for people with a dual diagnosis of mental illness and alcohol and substance abuse in the ACT was the subject of a comprehensive project undertaken in 1999 - *Dual Diagnosis: Stopping the merry-go-round* (Cupitt et al, 1999). The project explored several potential approaches to the development of services and rejected the use of specialist, stand-alone services favouring a comprehensive, integrated service system which brings together mental health and alcohol and drug services, working collaboratively with consumers, families and non-government services. ACT Health has identified that considerable progress has been made in developing a framework for better coordinating services.

3.4 IMPLICATIONS

Developments in shared care and service integration offer insight into the principles and practices that may lead to improved service coordination and outcomes for clients. Case management has an important role within these broader frameworks and must be flexible to accommodate cross-sector collaboration when appropriate.

4 ISSUES IN CASE MANAGEMENT AND SERVICE INTEGRATION

4.1 CASE MANAGEMENT PITFALLS

Case management has been subject to criticism when it is seen to be imposed by government agencies as a mechanism for exercising greater control over service delivery or transferring responsibility of care to community agencies. For example:

"UK policy [in mental health] governs the development and application of case management and has been the subject of much criticism… It could be said that in hiding its motivation to transfer the financial burden of care from the state to the community, the establishment has exploited the fear of institutionalisation held by many health care professionals." Grech (2000)

Unless case managers have the authority to allocate new funding for service delivery they cannot address shortfalls in access to services. Furthermore, if relationships between service delivery agencies are problematic or there is a lack of cross-sector collaboration, implementing a case management process is not likely to improve the situation on its own.

People with high and complex needs typically have contact with multiple service sectors and can find themselves in a situation of having multiple case managers, with little capacity for cross-sector coordination. This was a situation identified by high need clients in ACT SAAP services, consulted as part of the *Homelessness Needs Analysis in the ACT,* some of whom had up to 8 case managers in different service systems (such as income support, drug and alcohol, mental health, youth services etc) but reported that there had been little effort to coordinate support across sectors or bring case managers together to resolve difficulties (ACT Government, 2002). This can lead to clients spending an extraordinary amount of time meeting with case managers, telling their story and explaining their circumstances over and over again (which can be re-traumatising) and trying to navigate complex service systems at a time when they are vulnerable and struggling to cope with everyday life. Eventually this can lead to frustration and disillusionment resulting in clients withdrawing from services, rather than engaging in support planning.

4.2 SUPPORTING CASE MANAGERS

It is intuitively reasonable that the size of the case load on individual case managers or case management teams will impact on the effectiveness of the case management provided.

In the case of UK mental health services, Grech (2000) summarises conflicting evidence. Some research argues for maximum case loads in intensive case management models (eg

10-15 clients), while others suggest that clinical effectiveness is not related to case load. For example, Burns et al (1999) found no evidence of differences in client outcomes in Assertive Community Treatment between case loads of 15 and 30 suggesting that instead "energy and investment should aim at the specific content of care … rather than its form and delivery". The development of a new approach to case management may need to allow for some flexibility in setting case loads.

Case managers also need adequate support in the form of:

- Regular planned and informal supervision;
- Opportunities for reflection and review;
- Access to ongoing training, particularly in specialist areas such as mental health, disability and cultural sensitivity;
- Adequate resources such as phones, cars, computers etc.; and
- Time to develop relationships and networks.

4.3 Funding & Service Models

When case management is funded as a discrete activity it is vulnerable to being seen as an 'add-on' or a diversion of resources away from direct support or treatment (Fine 1997 suggests that case management adds 20-30% to service delivery costs). Mechanisms to quarantine and minimise funding for case management include limits on the amount of case management to be provided or the timeframe for which case management is provided. However, research from various service sectors, including family support and child protection, suggests that particularly for clients with high and complex needs setting time-limits can restrict the effectiveness of services. For example, the evaluation of the Strengthening Families Initiative (DHS, 2001) found that best practice allows workers to work with families for as long as necessary - families should not be rushed into early termination, in order to meet throughput requirements. The evaluation also suggested that services should have the flexibility to provide repeated bursts of service over long periods of time to families with ongoing needs.

Some service sectors are moving toward individual funding models where funding is allocated to an individual and is portable across service providers. All the State/Territory and Commonwealth Disability Programs now have one or more individual funding mechanisms. The most common benefits identified by proponents and researchers in the disability field include:

- Individuals and families experience an increase in control and self-determination.
- Because individual funding is often negotiated, individuals and families feel that they have a stronger role in identifying their needs with less emphasis on 'technical' or 'expert' assessments.

- The supports provided to individuals and their families are often more effective because there is more attention to individual need and involvement in the design of supports.
- Individuals and families have increased choice because they have the capacity to purchase from a range of service providers as well as alternatives to formal services (if this option is available);
- Funding is portable across services and settings allowing for people to change their support arrangements and provider as their needs or preferences change;
- Providers are discouraged from providing 'one size fits all' services and grouping people together, instead they are encouraged to treat each person as an individual and respond to specific needs.

However, implementing individual funding is a significant undertaking that requires careful planning and broad consultation. There are substantial implications for non-government organisations in relation to viability and staffing.

4.4 HOLISTIC ASSESSMENT AND SUPPORT PLANNING

Whole of Life Needs

People with alcohol and drug issues, particularly those with high and complex needs, are likely to experience a range of difficulties beyond substance abuse. For example: "*Drug misuse fractures a persons social integration. Often drug users are friendless and jobless, increasing their social exclusion. This compounded with a history of profound childhood deprivation (even amongst the wealthier addicts) leads to the picture of an isolated, bored person with very low self-esteem. Treatment aims to address and for some to redress these and to enable the patient gain some control over their lives. For many, it is not even to reinstate a previous high functioning state, as most drug users began their habit before they were able to set up the networks and develop the life skills that would carry them forth. Therefore, treatment must teach these people basic social, educational and life skills necessary to integrate them into their society"* NSW Health (2001).

Flexibility in Service Delivery

People with high and complex needs are often difficult to support in standard treatment or support programs. For example, they may not be suitable for residential treatment programs or they may need additional support. Service 'rules' established to protect scarce resources and/or to implement evidence of good practice may need to be bent to accommodate people with specific needs or complex problems.

Increasing the flexibility of services requires ongoing negotiation between consumers, funding bodies, brokers or advisers and

providers. The practical difficulties such as staffing, accountability and monitoring quality are not easily resolved and are not the sole responsibility of one party or another, so a collaborative approach is necessary. Writing on the topic of designing flexible service systems in the disability sector, O'Brien (2001) uses the analogy of airlines working with engine builders to develop the engines that they need including collaboration on design, production, materials and costs, training for personnel and problem-solving. This collaboration constitutes a long-term relationship of mutual dependency and benefit.

Treatment and Support Planning

Across human service sectors there is increasing research evidence linking successful outcomes and health/well-being to processes that respect and empower clients to take control and make informed decisions.

The nature of the relationship between the case manager and the client is also very important and is substantially influenced by the attitude and beliefs of case management staff. For example: "*The attitudes and beliefs of practitioners have a major impact on treatment outcomes. Practitioners with an orientation to abstinence alone rather than other treatment goals, particularly those who do not tolerate any heroin use, are likely to have a poor retention in treatment and paradoxically, more heroin use in treatment than practitioners who are oriented to providing care for patients over the longer term,and have non-judgmental attitudes towards drug use." (NSW Health, 2001)*

NSW Health has introduced treatment plans and treatment agreements for people accessing methadone treatment. These are developed in conjunction with the client, following a comprehensive assessment. This includes:

- plans for the patients methadone dose (eg, maintenance, reduction, review in one month)
- strategies to deal with drug use problems (including alcohol);
- strategies to deal with risk behaviours (eg, needle sharing, overdose); and
- strategies to deal with identified major medical, psychiatric and psychosocial problem areas. Employment, parenting, accommodation, and relationships should all be areas explored and dealt with.

The treatment plan is reviewed at least every three months in collaboration with the case manager, and pharmacist or dispensing staff.

4.5 EFFECTIVENESS

It is important to define outcomes for case management functions, both in relation to immediate outputs such as assessment, referral and coordination as well as longer term improvements in client treatment outcomes, access to services etc.

Tools such as the Brief Treatment Outcome Measure (BTOM) can be used to assist decision making and measure outcomes. The BTOM is a brief, multidimensional instrument designed to monitor treatment outcomes for clients receiving opioid maintenance pharmacotherapy and for use in treatment evaluation research. Treatment outcome is measured by scales developed or adapted from other instruments across the domains of dependence, blood borne virus exposure risk, drug use, health, psychological functioning and social functioning. The BTOM is typically administered at the commencement of treatment (or intervention, in the case of a research study) and thereafter 3 monthly, in conjunction with case management reviews. Results from the 30-month clinical trial and a psychometric evaluation study indicate that the BTOM has good reliability, acceptable validity and is capable of measuring change in treatment outcome. The clients in the clinical trial showed statistically significant improvement in all of the treatment outcome domains. Findings from a survey of clinicians using the BTOM indicate that clinicians approve of the BTOM content and find the instrument to be clinically useful. (Lawrinson, Copeland & Indig, 2003)

Another area of performance measurement that is receiving increasing attention in defining outcomes within human service systems is that of client satisfaction. Some authors argue that clinical intervention should centre around empowerment of the service user with priority given to the user's right to voice opinions regarding the access to and delivery of mental health services (see for example Rohde, 1997).

A self-administered questionnaire and survey protocol for opiate dependent patients receiving pharmacotherapy from Rankin Court the clinic located at St Vincent's Hospital in Sydney was developed in 2004. The project undertook a literature review of consumer satisfaction in health care services (1985 – 2003). At the time, only one instrument had been developed to measure opioid dependent patients' satisfaction with services from methadone clinics: the Verona Service Satisfaction Scale–MT (VSSS-MT). This was judged inappropriate for implementation in NSW. Instead, conceptual dimensions underpinning the questionnaire were drawn from the VSSS-MT and other previously validated patient satisfaction instruments, and corroborated against and extended by qualitative research with opioid dependent patients attending local pharmacotherapy clinics.. Low literacy within the target population was addressed in the questionnaire through the use of simplified language, and the addition of visual cues alongside text.

5 TOWARDS A DRAFT FRAMEWORK

5.1 WHY HAVE CASE MANAGEMENT?

Before developing a model of case management it is important to identify the rationale for including case management in the program and define as specifically as possible the function of case management within the program. This is an activity worth doing in consultation with stakeholders. Some useful discussion questions might include:

- How does case management add value to service delivery?
- What outcomes do we expect from case management?
- What is meant by the term 'case' do we mean a patient within a treatment service, an individual in or out of treatment or a household or family unit or even broader than that?
- When does case management begin and end - should clients have access to case management on an ongoing basis or for a time-limited or treatment specific period?
- What supports and services are we planning to coordinate through case management – are they specifically drug and alcohol related or broader that that?

5.2 WHAT ARE THE PRINCIPLES OF EFFECTIVE CASE MANAGEMENT?

A framework for case management in ACT Alcohol and Drug treatment services needs to be based on clear principles. Some principles can be drawn from the literature, others may be developed through consultation with stakeholders including service providers and service users.

Examples of principles drawn from the literature and comparable ADT programs, include:

- Aim to reduce harm and improve social functioning and health (abstinence should be seen as only one possible outcome).
- Offer treatment and interventions based on evidence of effectiveness (where available) but with the flexibility to accommodate individual circumstances and preferences.
- Assess needs in a way that is holistic and encompasses the family and social context – recognising that issues such as housing, mental health and the needs of other family members are important in identifying appropriate treatment options and sustainable outcomes.
- Respect the rights of persons with drug-related problems and recognise their strengths.
- Maximise the options available to individuals and support them to make informed decisions.
- Establish treatment goals that are reachable and practical.

- Provide timely access to treatments and ongoing support;
- Coordinate supports across human service sectors, including mental health services and family support services.
- Strive to provide equity in access to support and services, by welcoming and supporting diversity.
- Make efficient use of resources and evaluation the effectiveness of case management in contributing to client outcomes.

Useful Resources

The Drug Office of the Western Australian Department of Health developed a *Strategic Framework for Enhancing Access to Treatment and Support Services 2003 – 2005* to complement the *WA Drug and Alcohol Strategy and the Model for Drug and Alcohol Treatment and Support Services* (August 2002). This Framework has an aim, objectives and principles followed by seven outcomes. http://www.dao.health.wa.gov.au

Principles for developing shared care approaches to were identified in the Shared Care of Illicit Drug Problems project undertaken by the National Drug and Alcohol Research Centre. Useful documents include the Dissemination Report (2002) and the Literature Review - Penrose-Wall, J., Copeland, J. & Harris, M. (2000). *Shared Care of Illicit Drug Problems by General Practitioners and Primary Health Care Providers: A Review of the Literature*. Centre for General Practice Integration Studies/National Drug and Alcohol Research Centre: School of Community Medicine, University of New South Wales: Sydney. Both documents are available from: http://notes.med.unsw.edu.au/ndarc.nsf/website/Research.completed.cmp17

5.3 WHAT SHOULD HAPPEN IN CASE MANAGEMENT?

A coherent model that identifies each stage of the case management process and who/what is involved at that stage is needed. The process of getting to that point may involve exploring all the alternative approaches to the work of case management. An example of a staged approach with discussion questions is provided below as a starting point.

Stage 1) Initial Engagement

The process for initial engagement with clients would encompass both existing and potential pathways clients follow to access ADT services. Within these pathways the model must identify who is responsible for identifying clients with high and complex needs and beginning the case management process.

- How do clients access ADT in the ACT at the moment? What are the major pathways and referral sources?
- Is there benefit in central points of contact, case management or coordination or are there benefits in a range of agencies provide access to drug and alcohol services for people with complex needs?

- What is the focus of initial engagement and how much does this vary – for example crisis response, or gradual engagement? Preparing for assessment, allocating resources or supporting the client to make decisions?
- Who needs to be involved at this stage?

Stage 2) Assessment

The model should describe how and when the needs of the client are assessed and by whom. It is also important to define the range of needs that may be considered (eg housing, parenting, income support etc). The needs assessment process can allow for flexibility in service responses by including a range of tools that may be used and/or allowing for people with various skills to be involved in the process as well as accommodating differences in relation to the timing of assessment and the amount of resources that may be needed. It may be desirable to have some consistency in the ways that assessments are documented and reported, while supporting flexibility in how they are conducted..

- Would it be possible to have a multi-disciplinary assessment, including both clinical elements and whole-of-life needs?
- What assessment tools are available to help with identifying treatment options and supports?
- How can a consistent approach to needs assessment be established while allowing for flexibility in service responses based on individual needs?
- Who needs to be involved at this stage?

Stage 3) Treatment Selection

- What case management practices and tools are empowering for clients while also clinically effective in facilitating appropriate treatment choices?
- There is an extensive range of clinical guides to assist case managers to select appropriate treatments and supports for people accessing ADT services – beyond the scope of this paper but worth further technical research.
- How does case management influence the mix of services and supports available to people with drug and alcohol issues – particularly those receiving ongoing pharmacotherapy?
- How can research and development continually feed into the case management process?
- Who needs to be involved at this stage?

Stage 4) Support Planning

If a multi-disciplinary team is a realistic option for case management, there is a need to consider:

- Who might be involved?

- What roles/responsibilities would team members have?
- Would there be a lead agency or key worker?

Regardless of whether the case management role is fulfilled by a team or an individual there is a need to:

- Map the range of services and supports that might be needed by people in case management;
- Examine how can case managers realistically coordinate these services/supports (eg who has control over resources and access? how do services collaborate?); and
- Define the role of the case manager or case management team to service providers.

Stage 5) Outcome Measurement

- What outcomes are important – eg harm reduction, drug use, stability in housing, improvements in health etc.?
- How can these outcomes be measured by case managers, in consultation with clients?
- How can we collect client satifaction feedback?
- How should outcome measures be recorded and reported to inform program improvements?

5.4 PARTNERSHIPS

Collaborative case management, whether undertaken by individuals or teams, will require formal frameworks such as for partnerships and interagency protocols. Some of which may already be in place – a review of their effectiveness may be valuable.

One of the issues with a multi-disciplinary approach in the ACT is that if the majority of clients of alcohol and drug programs are males aged 20-39 years, there may be a lack of services across a number of sectors – shortages have been identified in homelessness services, mental health services and other key sectors.

The Victorian evaluation of community drug programs highlights the importance of clearly articulating what is expected of services with regard to case management, including a recognition of the limitations faced by short term services in working with clients with long term issues.

5.5 DECISION-MAKING TOOLS

The case management model might help practitioners to identify useful decision-making tools, but should not be too prescriptive about the use of individual tools.

There is an extensive range of clinical guides to assist case managers to select appropriate treatments and supports for people accessing ADOT services. There are also useful clinical guides for assisting clients with complex behaviour and support needs (see Turning Point information below).

In addition, there is a range of tools that can be used to measure the nature of partnerships/networks delivering human services, such as the *Partnership Health Check* from the UK developed by McCabe, Lowndes and Skelcher (1996) and the *Partnerships Analysis Tool (* VicHealth, 2003). The PAT has the benefit of being contextualised for Australia.

Tools for measuring client satisfaction are not as well-developed but there are a few examples and the self-administered questionnaire and survey protocol for opiate dependent patients receiving pharmacotherapy from Rankin Court the clinic located at St Vincent's Hospital in Sydney may be particularly useful.

Useful Resources

Turning Point is a specialist alcohol and drug organisation integrating treatment and support service delivery with research, education and training. The Turning Point Alcohol and Drug Centre has developed *Clinical Treatment Guidelines for Alcohol and Drug Clinicians* series as a definitive resource in the treatment of people with alcohol and other drug problems. One of the guidelines developed by Turning Point is titled *Managing Difficult and Complex Behaviours* (10contains strategies to manage difficult behaviour including aggression and violence, self-harm and intoxication. The principles and practices of managing difficult behaviour are drawn from research findings and the expertise of clinicians working in the field. They aim to assist agencies and individuals to integrate preventative and reactive strategies at an organisational and service delivery level. This publication also presents guidelines for managing difficult behaviour in a research context and in outreach service settings. http://www.turningpoint.org.au/

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