Aggregate Case Management Consumer Satisfaction Report, 2003

Consumer Quality Initiatives, Inc.

Consumer Quality Initiatives (CQI)

CQI's written mission is to "give consumers a greater voice and an integral role in evaluating the effectiveness of their [our] treatment" through "fair and balanced" reports on consumers' satisfaction and their perceptions of quality. CQI provides a forum for the consumer voice through 30-minute confidential interviews with mental health consumers and family members. This mission also permits CQI "to hope to initiate changes to improve the system for all, consumers and providers alike." Through small group discussions about data among consumers, providers and health care authorities, CQI is beginning to bridge information gaps and establish a common understanding of quality and mental health.

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1 Executive Summary

- CQI interviewed 254 DMH clients from nine site areas about their case management services. Sixty percent were male. A large majority (81%) were Caucasian/white. Their median length of time having worked with a case manager was 6 years. In addition, 57% were level A clients.

- General Satisfaction: A solid majority of respondents (79%) were satisfied overall with their case management services.

- Access to Case Managers
  - *Regularity of Access*
    a. About one-half of the respondents had face to face contact with their case managers at least once per month. 71% of clients were satisfied with the frequency of face to face contact they had with their case managers.
    b. About one-half of the respondents had telephone contact with their case managers at least once per month. Three-quarters were satisfied with the frequency of their telephone contact with their case managers.
  - *Availability of Case Managers When Problems Arise:* Sixty-two percent of survey participants were satisfied with their ability to reach their case managers when they were having problems with their mental health services, and 70% were satisfied that their case managers were able to help them with mental health service-related problems.

- Relations with Case Managers: A large majority (88%) of respondents believed that their case managers at least usually treated with respect and dignity. About three-quarters of respondents were satisfied that their case managers understood both their mental health issues and their rehabilitative service needs. Slightly less than three-quarters were satisfied with the help they received from case managers obtaining desired services. A large majority (87%) were satisfied that case managers were sensitive to their cultural/ethnic background.

- Coordination of Care: Over three-quarters of respondents (78%) expressed satisfaction with their case managers' efforts to coordinate their care.

  With regard to particular treatment programs, consumers were most satisfied with the effectiveness of referrals to clubhouses/day programs (93%) and places to contact when in crisis (90%), with the remaining satisfaction rates (individual and group therapy, medication doctor, substance abuse and peer support/education) ranging from 82% and 86%.

  Satisfaction rates for rehabilitation referrals were lower that those for treatment, including housing programs (80%), education programs (78%), and vocational and job supports (77%). In addition, of the 55% of all respondents that wanted to live without case management services, 72% were satisfied with referrals to programs that would help them with that goal.

- Monitoring by Case Managers: About three-quarters (78%) of participants were satisfied with their case manager's efforts to monitor their services.

- ISP Development: Two-thirds of respondents knew what an Individual Service Plan (ISP) was. Of those, 91% had an ISP, and 82% were satisfied with their case manager's efforts to involve them in developing their plan.

- Outcomes: Overall, about two-thirds reported improvements over the previous 6 months in their ability to prevent a crisis (71%), in their mental health (69%) and in their daily activities (67%). Fewer than half of respondents reported improvements in their ability hold a job or volunteer position (46%) and in their ability to live without case management services (41%).

- How Case Management Has Helped: Respondents reported that case management had most commonly helped them by providing support, advice, and encouragement, by helping to coordinate services, and by providing guidance with practical aspects of their lives.

- How Else Case Management Could Be Helping: When asked to describe how case management services could be improved, respondents most commonly mentioned more frequent contact with and increased access to their case managers, more help with managing their housing situation, and more vocational and educational support.

- Comparison of Level A and Level B Services: B clients were more satisfied than A clients in general, and far more satisfied with regard to several specific areas, such as the frequency of contacts and the quality of referrals to treatment programs. Difficulties with access to and coordination of care appeared to most influence the general dissatisfaction of A clients.

- Recommendations: CQI recommends that each DMH site develop quality improvement initiatives guided by individual reports we completed for them. We suggest that DMH consider several additional recommendations, including:
    - Reviewing A/B system for effectiveness
    - Establishing collaborative relationships with other state and local agencies to better coordinate housing and vocational assistance for DMH clients
    - Promoting consumer-directed recovery and rehabilitation policies and programs, such as Recovery Learning Centers and the Wellness Recovery Action Plan process.
    - Establishing training opportunities for case managers in psychiatric rehabilitation and on gender differences in recovery.

2 Survey Methodology

Interviewing Protocol

CQI scheduled interview dates in 2002 and 2003 at clubhouses, residential programs, and other sites where people who use DMH case management services commonly spend time together. To recruit survey participants, CQI interviewers presented information about the survey to consumers at group meetings, and then interviewed volunteers who said they had case managers.

Before beginning interviews, CQI interviewers obtained informed consent from participants. Interviewers also sought permission from participants to record their names so they could later use the information to determine whether each client received Level A, B or C case management services. Of 254 individuals completing interviews, 195 (77%) allowed CQI to record their names for the purpose of determining case management levels. CQI staff submitted these names to the DMH area office, and DMH staff reported case management levels to CQI.

The Instrument

The CQI case management survey consists of 37 questions that assess satisfaction with services (Appendix A). Thirty (30) questions are answered according to a four-point scale.

The satisfaction scales used in the questionnaire are as follows:

1	2	3	4
Poor	Fair	Good	Excellent
Never	Sometimes	Usually	Always
Worse	Same	Better	Much Better
Not Enough	Too Much	About the Right Amount	Exactly the Right Amount

For some questions, consumers were also given the option of answering “not applicable” (N/A).

Additionally, consumers were asked three open-ended questions to assess how case management services were helping them and how else they could be helping them. The interviewers recorded comments and responses to these questions using respondents’ own words as much as possible, though longer responses are sometimes paraphrased.

Interviewers asked respondents six other questions to determine the identity of the respondents’ current case managers, the length of time respondents had worked with their current case managers, the length of time respondents had received any DMH case management services, and respondents’ knowledge of their case management service levels.

Assessing Satisfaction

For items using four-point scales, responses on the first and second scale points were considered markers of dissatisfaction, and responses on the third and fourth scale points were considered markers of satisfaction. To assess "satisfaction" for a particular item with a four-point scale, CQI staff totaled the number of responses on the scale's third and fourth point, and then divided that number by the total number of responses on all four points to obtain a percentage. Those failing to respond or those providing answers such as *n/a* or *not sure* were not included in the total number of responses for the calculation. Percentage calculations were rounded to the nearest whole number percent; therefore, some percentages may add up to slightly more or slightly less than 100%. Items that were not answered by all survey participants are noted in the results that follow.

Further analyses of the data revealed differences that varied by the level of services, by gender, and by the site at which services were provided. Separate sections are devoted to the respected topics. For more detail, we encourage the reader to look at the individual reports.

3 *Description of Services*

The case manager's role is three-fold:

-help client set up and maintain an Individual Service Plan ("ISP")
-help coordinate and access care
-monitor care

Compared to consumers with Level A services, consumers with Level B services receive more direct assistance in accessing care and have more frequent contact with their case manager. The Solomon Carter Fuller site maintains a Level C service for people who no longer receive formal services but who continue to have contact with case managers.

4 Client Demographics

CQI interviewed a total of 254 respondents from nine case management sites throughout the state of Massachusetts. Information about these respondents' backgrounds and their experiences with DMH case management are shown below:

Demographic	Frequency
Gender (N=254)	
Male	60%
Female	40%
Race (N=254)	
Caucasian or White	81%
African American or Black	11%
Native American	2%
Multiracial	5%
Other	2%
Time with Current Case Manager (N=247)	
Mean	4.2 yrs.
Median	3 yrs.
Range	1 wk. – 28 yrs.
Total Time with DMH Case Management (N=229)	
Mean	7.5 yrs.
Median	6 yrs.
Range	1 mo. – 28 yrs.
CM Level (N= 186)	
Level A	40%
Level B	57%
Level C	3%

5 Key Trends

Overall Satisfaction

(Question 26)

The following table shows respondents' ratings of their overall satisfaction with their DMH case management services:

Satisfaction-Related Item	1	2	3	4	N	Scale	Ques.
Respondents' rating of DMH case management services	7%	14%	44%	35%	245	Poor (1) – Excellent (4)	26

Over three-quarters (79%) of respondents were satisfied with their services. Satisfaction rates at individual sites ranged from 77% to 85%, except at one site, (Cape Cod) where only 63% of respondents were satisfied.

Access to Case Manager

(Questions 7-9)

Respondents were asked about the frequency of their phone and face-to-face contact with their case managers (CMs), with face-to-face contact being relatively more frequent:

Access-Related Item	Not in the last year	Once a year	A few times a year	Once a month or more	N	Ques.
Face-to-face contact with CM	2%	8%	36%	54%	250	8a
Telephone contact with CM	16%	7%	25%	53%	245	7a

Respondents were asked several questions about their satisfaction with their case manager's accessibility and effectiveness:

Access-Related Item	1	2	3	4	N	Scale	Ques.
Satisfaction with Frequency of:							
Face-to-face contact	25%	4%	49%	22%	252	Not enough (1) – Exactly right amt. (4)	8b
Telephone contact	24%	2%	54%	21%	247	Not enough (1) – Exactly right amt. (4)	7b
CM's Availability & Effectiveness							

Respondent able to reach CM	13%	25%	26%	36%	232	Never (1) – Always (4)	9a
CM able to help with problem	8%	22%	33%	37%	228	Never (1) – Always (4)	9b

As the table shows, 71% of all respondents were satisfied with the amount of face-to-face contact with their case managers, with slightly more (75%) satisfied with the amount of telephone contact.

Only 62% of all respondents could reach their case managers *usually* or *always* when they needed to. This was the lowest rate of satisfaction for all areas covered by this report. Representative comments from dissatisfied participants included:

She doesn't always return my calls.

Some workers are hard to get access to. Some people will be around only one or two days a week.

My case manager is "overbooked", doesn't have time.

Many of those who got help from their case manager were appreciative of the practical assistance they received, such as help with credit cards, job problems, reviewing treatment plans and getting into respite. But mostly, people appreciated the feedback and counseling. As one person noted: *"By reaching a case manager, I feel I can function on less medication."*

For those who reached their case manager, a number of respondents expressed concerns about their housing:

I notice a discrepancy between what they say and what they do. I mentioned I'm worried about being homeless. Immediately, "You're too connected to be homeless." If I really ran into a crisis, I'm not sure I could count on him, especially regarding housing."

Section 8. I was going through supported housing and nothing happened. Turned it over to case manager and got it in 6 months.

My case manager has not been supportive of getting me and my husband housing together.

Some others did not feel understood:

I would call her and she would leave her answering machine and she doesn't call back. Some questions she can't answer—what's going on. Situation where I live—stigma—the feeling I get that they're trying to move me. She should level with me what the story is.

I try to explain things to [case manager] and I never get anywhere.

There's been times when I've still had questions.

Relations with Case Managers

(Questions 10-13, 15)

Interviewers asked respondents a number of questions about their relationships with their case managers:

CM Relationship-Related Item	1	2	3	4	N	Scale	Ques.
CM understands consumer's mental health issues	8%	17%	29%	45%	245	Never (1) – Always (4)	10
CM understands what mental & rehabilitative services are wanted	6%	19%	34%	41%	240	Never (1) – Always (4)	11
CM helps respondent get desired services	9%	18%	36%	37%	247	Never (1) – Always (4)	12
CM treats respondent with respect and dignity	2%	10%	15%	73%	251	Never (1) – Always (4)	13
CM sensitive to respondent's cultural and ethnic background	6%	7%	39%	48%	231	Poor (1) – Excellent (4)	15

A large majority of respondents from all sites felt that their case managers *usually* or *always* treated them with respect and dignity (88%) and had a *good* or *excellent* understanding of their cultural and ethnic background (87%). About three-quarters of respondents were satisfied that their case managers understood their mental health issues and their rehabilitation service needs. Slightly less than three-quarters were satisfied with the help they had getting services.

Coordination of Care

(Questions 14, 16b, 17a-g, 18a-c)

Interviewers asked respondents questions about their case managers' efforts to coordinate services in general, and to make effective referrals in particular:

Coordination-Related Item	1	2	3	4	N	Scale	Ques.
CM Coordination Overall							
Respondents' rating of CM's coordination efforts	7%	15%	45%	33%	249	Poor (1) – Excellent (4)	14
Referrals to Independent Living Skills Programs							
CM's efforts to coordinate independent living programs	10%	19%	41%	31%	134	Poor (1) – Excellent (4)	16b
CM's Efforts to Set Person up with Particular Treatment and Treatment Programs							
Clubhouse or day program	2%	5%	41%	52%	141	Poor (1) – Excellent (4)	17e2
Place to contact when in crisis	4%	6%	45%	45%	130	Poor (1) – Excellent (4)	17f2
Individual therapist	8%	8%	46%	38%	96	Poor (1) – Excellent (4)	17b2
Medication doctor	4%	11%	42%	43%	91	Poor (1) – Excellent (4)	17a2

Coordination-Related Item	1	2	3	4	N	Scale	Ques.
Peer support or education groups	5%	12%	45%	38%	58	Poor (1) – Excellent (4)	17d2
Group therapy	9%	9%	40%	42%	57	Poor (1) – Excellent (4)	17c2
Substance abuse or addictions program	2%	12%	44%	42%	41	Poor (1) – Excellent (4)	17g2
CM's Efforts to set person up with Particular Rehabilitation Programs							
Housing program	10%	10%	39%	41%	171	Poor (1) – Excellent (4)	18a2
Vocational training and job seeking service	10%	14%	38%	39%	109	Poor (1) – Excellent (4)	18b2
Education program	16%	7%	39%	39%	88	Poor (1) – Excellent (4)	18c2

Over three-quarters of respondents (78%) expressed satisfaction with their case managers' efforts to coordinate their care.

With regard to particular treatment programs, consumers were most satisfied with the effectiveness of referrals to clubhouses/day programs (93%) and places to contact when in crisis (90%), with the remaining satisfaction rates (individual and group therapy, medication doctor, substance abuse and peer support/education) ranging between 82% and 86%.

Satisfaction rates for rehabilitation referrals were lower that those for treatment, including housing programs (80%), education programs (78%), and vocational and job supports (77%). In addition, of the 55% of all respondents that wanted to live without case management services, 72% were satisfied with referrals to programs that would help them with their goal.

Monitoring Services

(Question 19, 22)

Respondents answered a few questions about their case managers' efforts to explain case management and monitor their services:

Monitoring-Related Item	1	2	3	4	N	Scale	Ques.
CM explained her/his role to respondent	--	28%	72%	--	249	No (2) – Yes (3)	22
Respondent's rating of CM's efforts to monitor services	7%	14%	43%	35%	246	Poor (1) – Excellent (4)	19

About three-quarters (78%) of participants were satisfied with their case manager's efforts to monitor their services.

ISP Development

(Question 20)

Interviewers asked respondents questions about their Individual Service Plans (ISP's) and their role in ISP development:

ISP-Related Item	1	2	3	4	N	Scale	Ques.
Respondent knew what ISP was	--	33%	67%	--	246	No (2) – Yes (3)	20a
Respondent had ISP	--	9%	91%	--	160	No (2) – Yes (3)	20b
CM's efforts to involve respondent in developing ISP	8%	10%	44%	38%	144	Poor (1) – Excellent (4)	20c

Of the number of respondents from all sites that knew what an ISP was, 91% had an ISP and 82% were satisfied with their case manager's efforts to involve them in developing their plan.

Outcomes of Services

(Questions 23a-e)

Interviewers asked respondents to compare how they felt about certain aspects of their lives compared to six months prior to the day of the interview, or since starting case management:

Outcome	Worse	Same	Better	Much Better	N	Ques.
Mental health	7%	25%	38%	31%	248	23a
Ability to prevent a crisis	5%	24%	36%	35%	247	23b
Involvement in work, school or other activities	6%	27%	38%	29%	242	23c
Ability to hold a job or volunteer position	16%	38%	24%	22%	232	23d
Ability to live without case management	17%	42%	23%	18%	231	23e

Overall, about two-thirds reported improvements over the past 6 months in their ability to prevent a crisis (71%), their mental health (69%) and their daily activities (67%). Fewer than half of respondents reported improvements in their ability hold a job or volunteer position (46%) and in their ability to live without case management services (41%). Thus, about 20% - 25% of those clients who felt better about their mental health overall did not feel better about their capacity to hold a job, and a larger amount did not feel they could live without case management services.

Respondents' Reports of Case Management Benefits

(Question 24)

Interviewers asked respondents how DMH case management services had helped them over the past six months. Respondents at all nine sites most frequently mentioned their case managers' **practical assistance.** Respondents had help with ongoing and specific matters, including: finances, housing, work, education, family, medication management, transportation and shopping. Representative comments included:

They've helped me pay rent, they've helped feed me, they've helped me get coffee and cigarettes in the morning. They've provided transportation for me.

In the last 6 months he's taken me to look at furniture for my new apartment.

They've given me food, kept me out from the cold…Always been in touch to make sure I'm OK physically and mentally, that I'm taking care of myself, my hygiene, my territory…

…Money, he always makes sure I get my money. Money matters … that I don't spend too much or too little. He makes sure I spend the right amount.

DMH case management helped me get my MassHealth and helped get me custody of my child…

…He helped me get housing…I got a roof over my head; I'm not on the street.

[Case manager] helped me out tremendously with going about my daily life. I know how to go about it myself, especially how to take medication on my own, see doctor regularly, etc…

One time…all this junk mail came for me. He organized it for me. [Case manager] is helping me share household responsibilities and caring with my wife.

Almost as common were comments about clients' **supportive relationships** with their case managers. The nature, quality, and accessibility of contacts with their case managers were valued by respondents at all sites.

We hit it off, shoot the breeze. It makes me feel great that he's that honest with me. Lays things on the table. I know whenever that happens they're going to watch out for me.

Case management services have helped me understand myself and my surroundings by [case manager's] unique ability to get into my situation…She remembers things about me that I've forgotten.

Encouragement. I've developed better self-esteem and more independence.

…She knew in the past I had a hard time around 9-11 and she came to see me a couple of times and I ended up going to crisis evaluation…

I enjoy working with [case manager]. She is a wonderful person, and each time I speak with her I feel better. We have a genuine rapport. I really don't know how I ever got along without her.

They help me. I don't know how to explain. They give me hope. She's there to help me a lot.

…My case manager worked very hard to find me a house. She and I have talked about work and school and with the things we've talked about I've had the courage to at least try. She's made it clear that it's always good to try.

[Case management services] gave me contact. Five to six days a week, my case manager can be found. If I leave a message with him, he will contact me. He always replies. He knows where I work and he knows where I live. We can go out for a coffee at any given moment.

In a great way. He does a lot for me. He comes around to talk to me, he gives me change for coffee. He's a friend. He's a nice guy. He's a very trusting person. He's a pot of gold. He offered me his friendship.

If I didn't have a case manager, I would probably be on the streets right now because she helped me get into a place where I feel safe when I wasn't doing good.

…She is like a guardian angel.

Another benefit identified by many respondents was the value of the **coordination and monitoring** of their progress and services.

…visiting me in the hospital and attending treatment team meeting. Good to know that I have an overall person in the system to look out for me and who knows the whole picture. Also, on a more personal level, he's very available, very helpful and friendly to me.

…[Case management services] get me medication, a place to stay during the day. They get me off the street…help me to go the clubhouse…

She has set me up with a lot of services. She found me a general MD and helped me with some physical problems. I have a stable place to live…and I really like that. They have helped me to find a …course to enroll in to get a job eventually.

She came to [residence] twice and we met with them. I don't know when I'm alone in the house and the condition is bad…I suffer so much in that house, you have no idea.

[She] got me out of the hospital. Warned me about drinking and drugging…Talks to me nice, doesn't talk down to me. Got me into a group home…

I got all the things I asked for. Got what I needed. Parenting groups, see my son more often, [vocational] program.

She helps me with getting better on my anxiety, my anger. She's going to get me involved in an anger management group. I'm starting next week.

They've hospitalized me when it was necessary.

They got me into the group home again. They did mostly everything for me---housing, drug and AA programs, gamblers' anonymous. They did all that for me, they set it up. They asked me if I wanted to get my GED and all that.

She monitors me. When I've been going down hill, she monitors me and adds some control and stability to my life.

Many talked specifically about help they had meeting their **vocational and educational** goals:

They've helped me with my education and job-seeking. They've helped me when I've had conflicts with the…job seeking service by setting up meetings between the service and herself.

Just recently, I asked [case manager] to look into computer classes. They are free at [community center]. I'm going to computer classes because I'm going to be volunteering. She had to call and make a referral.

Respondents' Suggestions for Improving Case Management

(Question 25)

Respondents were asked how else case management services could be helping them. Most suggestions fell into the categories that follow.

Housing was the most common theme for improvement and was mentioned frequently at six of the nine sites. Respondents wanted more help looking for affordable, comfortable, and/or more independent housing:

At the moment, I'd like him to help me get applications and see apartments at more than one place. He said we could go to one place, but I want to shop around.

She could have gotten me better housing. I'm in a rest home with elderly people.

I would like my own place, not to live in a group home…

Get me an apartment for myself so that I could become an independent person again.

Increased contact and improved access to their case mangers was another common theme, mentioned frequently at five sites:

When I was in the mental hospital, I could have had my case manager's business card or something to give to the doctor in charge. When I was in the hospital they gave me a list of names of people to contact if I needed further services. My case manager could have helped me with that.

Maybe keep in touch with me more. They are supposed to see me once every two months. I had to ask for that.

I want her to meet with me more often. At one time she did step in and try to help me, but the [vendor] didn't like it.

If I had a particular time to check in with my case manager. See what's happening with my ISP. I haven't sent in a response, there was no stamped envelope… I'd like a regular time to check in on appointments…

More vocational and educational support was wanted by at least some respondents at all nine sites:

I guess I could use more help with trying to get back to work. I've never asked her about this, but I could use some help.

…Go back to school and learn to read and spell and get back in math. Be a productive citizen again instead of a productive mental patient.

…Every time I go to Mass Rehab, I want training and they want me to take a lowdown job. Maybe they could give me a referral or paperwork stating my handicap…

Service coordination and referrals to medical, mental health and substance abuse services were identified as areas needing improvement by smaller numbers of respondents at most sites:

They could have tried to help about my medication. They refused to help me and pushed me around too much. They could have talked to me or put me on a different med. Done something with me. I was going insane.

If I'm in crisis, he'll tell me to come here [mental health center], but usually I have to go somewhere else…I appreciate the effort, but the process can be difficult.,,

Increased independence was desired by clients at a number of sites:

I would like to be independent. If something comes up, I would contact her. I like being my own rep. payee.

Let me live on my own in my own place. They could've let me have some time off from my clubhouse. I see other people doing that.

I want to be out of case management completely. I want to get my meds in bottles every two weeks, instead of having them brought to me by DMH. Case management hasn't helped me at all.

I want them to help me live independently, get supported housing. I feel better when I can be independent and they haven't tried to make that happen yet. They're just putting everything off.

I want to be more active by self-medicating and living in more independent housing. I want to be my own payee—no more rep. payee.

Management of finances was a concern for respondents at a few sites:

They could have paid my bills correctly, instead of overpaying them…

She's supposed to be working on getting me a bus pass, but I haven't got it yet and I could really use it to go grocery shopping.

They could have provided me with more money on the weekends, especially when I have more money in the account like I do.

Help with learning skills and solving problems was wanted by a few respondents:

I would like her to help me strategize about a problem I'm having with a neighbor who is in the system.

I'd like her to help me make better meals and make some of the meals I can't make. Talk to me better and help me get along better with my friends at my group home.

Improvements in the working relationship with their case manager was desired by respondents at a few sites:

I don't know what his job is.

…They keep switching social workers on me.

She treats me like a kid. I am over 40 years old. I need a receipt for a haircut and shave. She don't give me the benefit of the doubt on what I spend money on. She doesn't want to be bothered by me, so I don't want to be bothered by her.

6 Comparative Analyses

Given the richness of the data collected, CQI was able to conduct comparative analyses of the quantitative responses by respondents' gender and by the level of case management (A or B) they received. The following subsections review these comparisons by reporting substantial differences in general satisfaction, specific quality indicators, and demographic information. Overall satisfaction rates and differences in frequency or satisfaction of 9% or greater are included in the table. **Differences of 15% or more are bolded.**

Comparison by Case Management Level

CQI was able to determine the level of service for 186 participants. Of those, 57% received B level, 40% received A level, and 3% received C level services. Only Solomon Carter Fuller used the Level C designation, which is not included in the analysis below.

Variable	Level A Respondents	Level B Respondents
OVERALL SATISFACTION	77% satisfied *(n=77)*	85% satisfied *(n=105)*
ACCESS TO CASE MANAGER		
Frequency of face to face contact	68% satisfied *(n=79)*	77% satisfied *(n=106)*

Variable	Level A Respondents	Level B Respondents
Frequency of phone contact	**70% satisfied** ***(n=79)***	**85% satisfied** ***(n=104)***
Respondents able to reach case managers to discuss problems with mental health services	**55% satisfied** ***(n=75)***	**70% satisfied** ***(n=96)***
Case manager able to help with mental health service-related problems	65% satisfied *(n=72)*	76% satisfied *(n=95)*
COORDINATION OF CARE Case managers' efforts to help respondents find: *individual therapy*	**70% satisfied** ***(n=37)***	**97% satisfied** ***(n=30)***
a place to contact when in crisis	80% satisfied *(n=44)*	94% satisfied *(n=54)*
support for vocational goals	69% satisfied *(n=36)*	78% satisfied *(n=46)*
support for educational goals	**63% satisfied** ***(n=30)***	**87% satisfied** ***(n=31)***
Number of respondents who know what an ISP is	58% *(n=76)*	71% *(n=104)*
Case managers have explained what they do for respondents	**64%** ***(n=78)***	**79%** ***(n=106)***
OUTCOMES Number of respondents who felt better over the past 6 months <u>or</u> since starting case management about their:		
mental health	75% *(n=77)*	66% *(n=107)*
involvement in work, school, and other daily activities	**81%** ***(n=75)***	**63%** ***(n=104)***
ability to live without case management services	48% *(n=73)*	34% *(n=101)*
DEMOGRAPHICS		
Length of time using case management services *Mean*	7.2 yrs. *(n=71)*	8.3 yrs. *(n=97)*
Median	6 yrs.	5.5 yrs.
Range	1 mo.-20 yrs.	1 mo.-28 yrs.
Male respondents	54% *(n=79)*	64% *(n=107)*

Variable	Level A Respondents	Level B Respondents
Female respondents	46% *(n=74)*	36% *(n=107)*
Caucasian or white respondents	90% *(n=79)*	77% *(n=107)*
Respondents who meet face-to-face with their case manager at least once a month	**34%** ***(n=77)***	**64%** ***(n=105)***
Respondents who talked on the phone with their case manager at least once a month	**41%** ***(n=75)***	**60%** ***(n=102)***
Respondents who needed or wanted their case managers to set them up with a:		
medication doctor	42% *(n=79)*	33% *(n=106)*
individual therapist	**48%** ***(n=79)***	**28%** ***(n=106)***
group therapy	28% *(n=78)*	18% *(n=106)*
educational supports	41% *(n=79)*	31% *(n=105)*

B clients were more satisfied in general, and far more satisfied with regard to several specific areas. Difficulties with access to and coordination of care appeared to most influence the general dissatisfaction of A clients. This effect was amplified by the fact that A clients tended to need and want more referrals than B clients.

Of note, B clients reported significantly lower levels of improvement in their lives over the previous six months, in spite of their higher levels of satisfaction. One possible explanation is that responses to these questions are more representative of the clients' current state of well-being rather than their level of improvement, and A clients in general would be expected to feel better. A clients were also clear that they missed having more regular contact with their case manager that they had as B clients, making them more likely to be dissatisfied with the A services.

Comparison by Gender

All of the 254 respondents identified their gender, with 60% male and 40% female. Differences are listed in the table below:

Variable	Male Respondents	Female Respondents
OVERALL SATISFACTION	79% satisfied *(n=146)*	79% satisfied *(n=99)*

Variable	Level A Respondents	Level B Respondents
COORDINATION OF CARE Case managers' efforts to help respondents find substance abuse/addictions programs	**76% satisfied** ***(n=21)***	**95% satisfied** ***(n=20)***
Case manager understands mental health issues	70% satisfied *(n=148)*	82% satisfied *(n=97)*
Case managers' efforts to involve respondents in developing ISP	87% satisfied *(n=98)*	76% satisfied *(n=59)*
OUTCOMES Number of respondents who felt better in the last 6 months or since starting CM about their: *mental health*	65% *(n=147)*	75% *(n=101)*
ability to live without a case manager	45% *(n=137)*	36% *(n=94)*
DEMOGRAPHICS Respondents with A Level of service	38% *(n=112)*	49% *(n=74)*
Respondents with B Level of service	62% *(n=112)*	51% *(n=74)*
Respondents who talked on the phone with their case manager alt least once a month	49% *(n=146)*	59% *(n=99)*
Respondents who want to live independently without case management services	**61%** ***(n=148)***	**46%** ***(n=101)***
Respondents who needed or wanted their case managers to set them up with: *medication doctor*	33% *(n=150)*	44% *(n=101)*
group therapy	19% *(n=149)*	29% *(n=101)*
clubhouse or day program	51% *(n=149)*	64% *(n=101)*
place to contact when in crisis	**45%** ***(n=151)***	**63%** ***(n=101)***

General satisfaction rates were equal between men and women. One general conclusion that can be drawn is that female respondents desired more contact with the mental health system than males. Thus, females may have initiated more telephone contact with their case managers and were more likely to want their case manager set them up with other services, such as group programs and crisis programs. In addition, male respondents were more likely to want to live without case management services at some point. There is some irony here in that males were more likely to have a B level of service. In addition, males felt less understood than females by their case manager, though were more satisfied with their involvement in developing their ISP. The data suggests that males are more likely to disagree with their case managers about their need for treatment than females are.

Comparison by Site

The questions that elicited particularly varied responses from the different sites are listed in the table below. Unless they are identified as "n" or "yrs", figures noted here represent the percentage of people saying that they were satisfied, or felt better, about the **indicator**, listed in the far left column. The number of people interviewed at each site, "**n**", is included below the name of the site. Since there were notably fewer respondents to the "Referral" questions, we have noted the number of response for each site to specific "Referral" questions below the respective satisfaction rates.[4] The average, or **mean**, for each indicator is bolded and listed in the far right column. Rates that are **higher** than the mean by 7% are underlined and bolded. Those that are lower by 7% or more are underlined.

Total n=254

	SPRING FIELD	FRANK. N.QUA.	SOL. C.F.	CAPE COD	ARL.	LOWELL	MILF.	FALL RIVER[5]	CAMB./ SOMER.	SPREAD low-high	MEAN
n=	27	29	28	24	35	27	39	24	20		
Overall satisfaction	77	80	85	63	83	85	79	79	79	22	**79%**
Median yrs w/ CM services	5 yrs	4 yrs	7.5 yrs	8 yrs	7 yrs	5 yrs	8 yrs	5.5 yrs	3 yrs	5 yrs	**6 yrs**
						SATISFACTION W/ ACCESS & EFFECTIVENESS:					
Satis. w/ amt. of phone contact	**85**	76	75	57	63	81	73	79	**90**	33	**75%**
Satis. w/ amt. of in pers. contact	**78**	71	75	58	63	**78**	**64**	75	**80**	22	**71%**
Able to reach CM w/ problem	58	67	65	48	57	64	58	**73**	**77**	29	**62%**
CM able to help w/ serv. probs.	67	62	64	35	72	**80**	73	**82**	**94**	59	**70%**
CM able to get serves desired	**85**	65	79	52	70	77	**63**	**92**	**85**	40	**73%**
						ISP PROCESS:					
Knows what ISP is	**74**	**86**	68	**75**	63	69	66	26	**82**	60	**67%**
Sat w/ involv. w/ ISP	**90**	86	72	80	72	83	**87**	**90**	84	18	**82%**
						SATISFACTION W/ REFERRALS TO:					
med. Doctor	**100**	**100**	88	63	73	85	86	89	**100**	37	**85%**
n=	6	9	8	8	19	13	7	18	3	3-19	

[4] See the body of this report and individual reports for information about the "n" for all other questions.
[5] Fall River respondents were overly representative of Level A clients, with 86% compared to 40% of the aggregate. See individual reports for comparisons of A/B levels at each site

	SPRING FIELD	FRANK. N. QUA.	SOL. C.F.	CAPE COD	ARL.	LOWELL	MILF.	FALL RIVER	CAMB./ SOMER.	SPREAD low-high	MEAN
indiv. therapist	85	88	80	86	65	92	**100**	78	**100**	35	**84%**
n=	13	8	10	7	17	12	12	13	4	4-17	
housing	**94**	**88**	79	58	70	80	**95**	71	**92**	37	**80%**
n=	17	17	19	19	27	21	20	17	13	13-27	
vocational	**100**	61	**64**	63	78	**100**	72	**60**	76	40	**77%**
n=	10	7	14	8	8	8	14	10	13	7-14	
educational	**100**	**100**	73	55	**88**	**100**	61	64	75	45	**78%**
n=	6	7	15	9	17	5	13	11	4	4-17	
indep. services	77	75	77	61	68	71	75	73	67	16	**72%**
n=	13	8	22	18	19	14	16	15	9	8-19	
IMPROVED OUTCOMES IN LAST 6 MONTHS											
mental health	61	67	64	74	**83**	74	57	**84**	55	29	**69%**
ability to prevent a crisis	74	57	**79**	**78**	67	**85**	62	54	70	31	**71%**
work, school & daily activities	**80**	46	57	**74**	**88**	67	58	**88**	37	51	**67%**
ability to hold job/volunteer	44	41	46	**57**	52	**56**	36	**63**	21	42	**46%**
ability to live w/o CM services	**48**	38	**62**	39	**60**	45	34	26	26	38	**41%**

The greatest contrast in findings was between Cambridge/Somerville and Cape Cod. Respondents in Cambridge/Somerville had been in case management a relatively short amount of time and reported the highest satisfaction rates and the lowest levels of improvement. Case managers reported that clinicians in the Cambridge/Somerville area have not had a recovery/rehabilitation oriented focus, which may explain the low improvement rates; DMH regional staff said they are now placing a greater emphasis on this.

Respondents in Cape Cod had been in case management services a relatively long time and reported the lowest satisfaction rates and above average levels of improvement. Case managers at this site describe a number of challenges, including being understaffed and without many basic resources for housing and vocational supports. Case managers said that some hospitals did not allow them to contact DMH clients while they were hospitalized. Staff are anticipating that consumers will be less satisfied with access when the site splits into two locations.

Springfield and Lowell were notable for having a number of indicators rating 7% points or more above the mean and none more than 4% points below it. An important variable that is not measured by this survey is the strength of the recovery culture at each case management site, among clients, and in the local community. Each site, in turn, is situated in a unique geographic and socioeconomic context. For example, the three most rural sites (Franklin/N. Quabbin, Cape Cod, and Milford) had the lowest satisfaction rates for case managers being able to get the services that respondents wanted.

7 Discussion

This report integrates interview data obtained from 254 clients at 9 DMH sites. It illustrates the opinions, experiences, and desires of DMH clients themselves.

A large majority of respondents (79%) were satisfied in general with their case management services. Respondents were most satisfied with the quality of their relationships with their case managers, and the case managers' effectiveness in referring them to treatment programs. For example, 88% were satisfied that they were treated with respect and dignity by their case manager, with 73% saying they *always* were. Also, 87% were satisfied with their case manager's sensitivity to their cultural/ethnic background. In addition, large majorities were satisfied with the effectiveness of referrals to:

- clubhouse/day programs (93%)
- places to contact when in crisis (90%)
- addiction programs (86%)
- psychopharmacology (85%)
- peer support (83%)
- individual therapists (82%)

Respondents were least satisfied with the amount of contact with their case managers, their ability to reach case managers when they needed help, and with finding skills-based programs or supports. The following measures and rates of satisfaction are representative:

- their ability to reach a case manger when they needed their assistance (62%)
- their case manager's ability to help them once reached (70%)
- the frequency of face to face contact with their case manager (71%)
- case manager's efforts to help them find independent living skills programs for interested people (72%)

Open ended responses indicated that many respondents who expressed dissatisfaction fell into one of two major categories:

1) One group includes clients who wanted greater independence and self-sufficiency, but who were frustrated with their progress and with the insufficient help they received to achieve their goals. They were most commonly frustrated with the support available for their goals related to housing, employment, education, control over their finances, and access to skill-building activities. Ultimately, many respondents said they wanted more help from their case managers with regard to both housing and vocational needs, though many were satisfied with services overall.

2) The second group were those who felt that their case managers were not responsive to their specific needs, that the frequency of contact was not sufficient, and/or that case managers were not able to address their problems *as they came up*. There were some respondents that had had no phone contact with their case

manager in the past year, but did see them face-to-face. A number of respondents also wanted more predictable contact with their case managers. Greater dissatisfaction in this area was found among level A clients, some of whom didn't realize that their level of service may have changed. The question of whether it is case managers or clients who initiate meetings is also worth consideration.

A clients were less satisfied than B clients, reflecting less access to case managers and greater frustration with the quality of help they received from case managers. Frustration was most apparent with regard to A clients' vocational and educational goals and with their interest in getting referrals for individual therapy. Case managers talked in provider meetings about how challenging it has been to explain and implement the level system. Transitions from the long-established B level to the less intensive A level of support have been particularly difficult, according to staff. In more than one meeting, case managers said that they believed that talking with clients about the level system and their status would be unnecessarily confusing and counter-productive. The findings of this report, however, show that keeping clients out of the conversation has not served them well.

Many clients believed that they would struggle without case management services. It appeared, however, that clients had not given much though to this possibility prior to the interview, nor had they developed a life or crisis plan to increase their chances of success. A few case managers said that they spent most of their time responding to clients who needed help with symptoms of their mental illness, or attending to acute housing and medical problems. Some clients described wanting to take risks that their case manager was not willing to support, including moving to more independent housing or being trusted with their money.

In developing service plans, it is critical to consider the conflict between liability issues and the risks that are necessary for growth and responsibility. It appears that some clients have wanted to make changes that their case managers may not have been prepared for. This makes sense, given the differing interests and pressures that clients and case managers have had to contend with. To varying degrees, DMH case managers, administrators, and clients are probably aware of the dissonance between their various needs. Given the generally long-term, invested nature of so many client/case manager relationships, it seems that the potential for even more direct communication between case managers and clients can be realized. Through ongoing discussion, the energy and wisdom that is inherent in each participant will reveal the most effective strategies for systems change and individual recovery.

8 Recommendations

Policy

- Identify the purpose and intended functions of the A/B level system in order to re-evaluate its effectiveness and plan for improvements.

- For DMH to work collectively with Medicaid, MRC, community colleges, public housing, DSS, and DPH over the next 5 years on mutually agreed upon goals that will coordinate housing and employment assistance for mental health clients.

- Prioritize and increase opportunities for community-based learning and rehabilitation by establishing

Recovery Learning Centers.[6] (Excerpts from 2003 proposal of Medicaid sponsored consumer-family workgroup at Appendix B.)

- Develop opportunities for consumers to reduce their dependence on the mental health system by creating opportunities for them to participate in the Wellness Recovery Action Plan (WRAP) process.[7]

- Based on the rich experience of clients and case managers, identify, record (written, audio and video tape), and distribute accounts of what successful transitions to independence look and sound like.

Site Administration

- Develop incentives for investigating and improving areas of low client satisfaction, particularly in areas showing a discrepancy between A and B client satisfaction.

- Identify "best practices" at each site, compile booklets, and distribute them.

- Establish opportunities for clients with specific areas of expertise (eg., in recovery or money management) to mentor both clients and case managers.

Training

- Educate DMH clients, case managers, and administrators on the A/B level system and on how to use the system to promote recovery.

- Have case managers attend the psychiatric rehabilitation training program developed by Massachusetts chapter of the International Association of Psychiatric Rehabilitation Services (IAPSRS). A summary of the curriculum can be found in the Appendix C.

- Offer training to clients and staff on the topic of gender differences in recovery.[8]

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[6] In 2003, the Executive Office of Human Services offered the Massachusetts Behavioral Health Partnership (MBHP) a performance incentive to conduct a feasibility study for the start-up and operations of Recovery Learning Centers. MBHP is projected to have that study completed in June 2004.

[7] **"WRAP Train-the-Trainer"** Coordinated by Cheryl Stevens, Director of Consumer Affairs, at the Western MA Area Office. Cheryl.Stevens@dmh.state.ma.us. For information about starting your own WRAP or about programs introducing it on a system-wide level, see Mary Ellen Copeland's web page:www.maryellencopeland.com. Visual, audio and written recovery materials are also available through the site.

[8] **Gender Differences in Characteristics and Service Use of Public Mental Health Patients With Schizophrenia** Laurie A. Lindamer, Anne Bailey, William Hawthorne, David P. Folsom, Todd P. Gilmer, Piedad Garcia, Richard L. Hough, and Dilip V. Jeste Psychiatr. Serv. 2003; 54: 1407-1409;**The Stone Center for Women's Research at Wellesley College** Offers symposiums and has published extensively on relational differences in "normal" populations seeking therapy.

Appendix A

Consumer Quality Initiatives, Inc.

Case Management Survey

Mission Statement

CQI's mission is to give consumers a greater voice and an accepted role in evaluating the effectiveness of their treatment. Through consumers and family members interviewing consumers, we aim to give providers and consumers an honest, fair and balanced evaluation of mental health and substance abuse services. Through our survey, we hope to initiate changes that will improve the present system for all, consumers and providers alike. Consumers' dignity and confidentiality are paramount.

© February, 2002 Consumer Quality Initiatives, Inc.

FACILITY INFORMATION:

ID Number : ______________________________

Facility Name: ______________________________

Facility Type: *Clubhouse* *Group home* *Other:* ________

____

Case Management Site: ______________________________

Survey Date: ______________________________

Interviewer Initials: ______________________________

Survey Complete? *Yes* *No*

Use quotes? *Yes* *No*

Comments on privacy of location of interview:

____
______
____

TRANSLATOR INFORMATION:

Translator used? *Yes* *No*

Is translator a staff member at the facility? *Yes* *No*

Translator language: ____________

Translator initials: ____________

Rep

FOR CQI OFFICE USE ONLY:

Use survey? *Yes* *No*

Quantitative data entry: Date: _____ Initials: ________

Qualitative date entry: Date: _____ Initials: ________

Case Management Survey
Consumer Quality Initiative, Inc.

During interview, read aloud everything but interviewer instructions, which are bolded and italicized.

INTERVIEWER SAYS: **We are here to survey you about the case management services you are receiving. Please answer the following questions.**

1. Do you have a case manager? *No (2)* *Yes (3)*

2. What is her or his name?
____

3. How long have you had her or him as a case manager?
____

(For data enterer only, convert time to months:
____________________________________***(months)***

4. How long have you had DMH case management services?
____

(For data enterer only, convert time to months:
____________________________________***(months)***

5. Do you know that there are two levels of case management services that DMH provides?
No (2) *Yes (3)*
(If no, go to #7. If yes, go to #6.)

6. Please tell me which level of DMH services you have: *Level A (1)* *Level B (2)*

INTERVIEWER SAYS: **For the following items, I will read the question, then give you four response choices. Please choose the response that most closely matches what is true for you.**

I. ACCESS ISSUES

		1	2	3	4
7a.	How often do you talk on the telephone to _________________________________? *(Insert case manager's name)*	*Once per month or more*	*A few times a year*	*Once per year*	*Not in the last year*
7b.	Is that . . .	*Not enough*	*Too much*	*About the right amount*	*Exactly the right amount*
8a.	How often do you meet face-to-face with __________________________________? *(Insert case manager's name)*	*Once per month or more*	*A few times a year*	*Once per year*	*Not in the last year*
8b.	Is that . . .	*Not enough*	*Too much*	*About the right amount*	*Exactly the right amount*

INTERVIEWER SAYS: **Unless otherwise stated, the following questions refer to the last six months, since ___________________ of _________. (If you have not had your current case manager for six months, then please rate the combined efforts of all your case managers over the past *six months.*) Please answer these questions "never," "sometimes," "usually," or "always."**

		1	2	3	4
9a.	When you're having a problem with your mental health services, how often are you able to reach ________________________ *(Insert case manager's name)* to discuss the problem?	*Never*	*Sometimes*	*Usually*	*Always*
9b.	How often has ________________________ *(Insert case manager's name)* been able to help you with this kind of problem?	*Never*	*Sometimes*	*Usually*	*Always*

Please comment: ____

____

II. APPROPRIATENESS OF SERVICES

10.	How often does ________________________ *(Insert case manager's name)* understand what your mental health issues are?	*Never*	*Sometimes*	*Usually*	*Always*
11.	How often does ________________________ *(Insert case manager's name)* understand what mental and rehabilitative services you want?	*Never*	*Sometimes*	*Usually*	*Always*
12.	How often is ________________________ *(Insert case manager's name)* able to help you get the services you want?	*Never*	*Sometimes*	*Usually*	*Always*
13.	How often are you treated with respect and dignity by ________________________? *(Insert case manager's name)*	*Never*	*Sometimes*	*Usually*	*Always*

INTERVIEWER SAYS: **Please answer the following questions using the scale "poor," "fair," "good," "excellent." Remember that we are asking you about _________________________'s services for the last *six months.* Again, if you have not had your current case manager for six months, then please rate the combined efforts of all your case managers over the past *six months.***

		1	2	3	4
14.	Rate ___________'s efforts to coordinate your care with other organizations that help you out.	*Poor*	*Fair*	*Good*	*Excellent*
15.	Rate _____________________________'s *(Insert case manager's name)* sensitivity to your cultural and ethnic background.	*Poor*	*Fair*	*Good*	*Excellent*
16a.	Do you want to live independently without DMH case management? Is that a goal of yours?		*No* ***(Go to #17)***	*Yes* ***(Go to #16b)***	
16b.	Rate your ___________________________'s *(Insert case manager's name)* efforts to help you get into programs that will give you the skills to live independently.	*Poor*	*Fair*	*Good*	*Excellent*

INTERVIEWER SAYS: **The following questions look at how case managers are connecting you with different kinds of mental health services you want. I have here a list of various types of mental health services.**

IF RESPONDENT HAS HAD CURRENT CASE MANAGER FOR SIX MONTHS OR MORE, SAY:
For each service, I want to know if you have needed or wanted __________________________'s help getting that service. If you have needed or wanted __________________________'s help getting that service, I will ask you to rate __________________________'s efforts to set you up with that service. If you have not needed or wanted _________________________'s help getting that service, I will move on to the next type of service on my list. ***(Insert case manager's name in blanks in questions 17 and 18 below.)***

IF RESPONDENT HAS HAD CURRENT CASE MANAGER FOR LESS THAN SIX MONTHS, SAY:
For each service, I want to know if you have needed or wanted any DMH case management help getting that service over the last ***six months*****. If you have needed or wanted any DMH case management help getting that service within the last six months, I will ask you to rate the efforts of the DMH case manager who set you up with that service. If you have not wanted any DMH case management help getting that service within the last six months, I will move on to the next type of service on the list.** ***(Insert phrase "DMH case management over the last six months" in the blanks in questions 17 and 18 below.)***

17a1.	Have you ever needed or wanted _________ to set you up with an appropriate medication doctor (psychopharmacologist)?	*No* ***(Go to #17b1)***	*Yes* ***(Go to #17a2)***

		1	2	3	4
17a2.	Rate the efforts of____________________ to set you up with an appropriate medication doctor(psychopharmacologist).	*Poor*	*Fair*	*Good*	*Excellent*
17b1.	Have you ever needed or wanted _________ to set you up with an appropriate individual therapist for talk therapy?		*No* ***(Go to #17c1)***	*Yes* ***(Go to #17b2)***	
17b2.	Rate the efforts of ____________________ to set you up with an appropriate individual therapist for talk therapy.	*Poor*	*Fair*	*Good*	*Excellent*
17c1.	Have you ever needed or wanted _________ to set you up with appropriate group therapy?		*No* ***(Go to #17d1)***	*Yes* ***(Go to #17c2)***	
17c2.	Rate the efforts of __________________to set you up with appropriate group therapy.	*Poor*	*Fair*	*Good*	*Excellent*
17d1.	Have you ever needed or wanted _________ to set you up with appropriate peer support or education groups?		*No* ***(Go to #17e1)***	*Yes* ***(Go to #17d2)***	
17d2.	Rate the efforts of ____________________ to set you up with appropriate peer support or education groups.	*Poor*	*Fair*	*Good*	*Excellent*
17e1.	Have you ever needed or wanted _________ to set you up with an appropriate clubhouse or day program?		*No* ***(Go to #17f1)***	*Yes* ***(Go to #17e2)***	
17e2.	Rate the efforts of ____________________ to set you up with an appropriate clubhouse or day program.	*Poor*	*Fair*	*Good*	*Excellent*
17f1.	Have you ever needed or wanted __________ to set you up with an appropriate place to contact when you're in crisis?		*No* ***(Go to #17g1)***	*Yes* ***(Go to #17f2)***	
17f2.	Rate the efforts of _____________________ to set you up with an appropriate place to contact when you're in crisis.	*Poor*	*Fair*	*Good*	*Excellent*
17g1.	Have you ever needed or wanted __________ to set you up with an appropriate substance abuse and addictions program?		*No* ***(Go to #18a1)***	*Yes* ***(Go to #17g2)***	

		1	2	3	4
17g2.	Rate the efforts of ____________________ to set you up with an appropriate substance abuse or addictions program.	*Poor*	*Fair*	*Good*	*Excellent*
18a1.	Have you ever needed or wanted __________ to set you up with a program that helps you with your housing?		*No* ***(Go to #18b1)***	*Yes* ***(Go to #18a2)***	
18a2.	Rate the efforts of ____________________ to set you up with a program that helps you with your housing.	*Poor*	*Fair*	*Good*	*Excellent*
18b1.	Have you ever needed or wanted __________ to set you up with a program that provides vocational training and job seeking services?		*No* ***(Go to #18c1)***	*Yes* ***(Go to #18b2)***	
18b2.	Rate the efforts of ____________________ to set you up with a program that provides vocational training and job seeking services.	*Poor*	*Fair*	*Good*	*Excellent*
18c1.	Have you ever needed or wanted __________ to set you up with a program that helps you with your educational goals?		*No* ***(Go to #19)***	*Yes* ***(Go to #18c2)***	
18c2.	Rate the efforts of ____________________ to set you up with a program that helps you with your educational goals.	*Poor*	*Fair*	*Good*	*Excellent*
19.	Rate _________________'s efforts over the *(Insert case manager's name)* last six months to monitor your services and make sure that things are working out.	*Poor*	*Fair*	*Good*	*Excellent*
20a.	Do you know what an Individual Service Plan (ISP) or _____________________ is? *(Program's term for ISP)*		*No*	*Yes*	
20b.	Do you have an ISP or ___________________________________? *(Program's term for ISP)*		*No* ***(Go to #22)***	*Yes* ***(Go to #20c)***	
20c.	Rate the _________________'s efforts over *(Insert case manager's name)* time to involve you in developing your ISP or ___________________________________. *(Program's term for ISP)*	*Poor*	*Fair*	*Good*	*Excellent*
21.	(Reserved)				

		1	2	3	4
22.	Has ____________________ ever explained *(Insert case manager's name)* to you what she or he is supposed to do for you?		*No*	*Yes*	

INTERVIEWER SAYS: **For the following questions, I want you to think about various aspects of your life and compare how you feel about those aspects now to how you felt about them six months ago in ___________________ of ______________ (If you have not been receiving case management services for six months, compare your feelings now to your feelings the day you started receiving case management services.) The scale you will use for these questions is "worse," "same," "better," or "much better."**

Compared to six months ago (in __________ of ___________, how do you feel today about:
(Month) *(Year)*

23a.	Your mental health?	*Worse*	*Same*	*Better*	*Much Better*
23b.	Your ability to prevent a crisis (e.g. a hospitalization)?	*Worse*	*Same*	*Better*	*Much Better*
23c.	Your involvement in work, school, or other daily activities?	*Worse*	*Same*	*Better*	*Much Better*
23d.	Your ability to hold a job or volunteer position?	*Worse*	*Same*	*Better*	*Much Better*
23e.	Your ability to live without case management services?	*Worse*	*Same*	*Better*	*Much Better*

INTERVIEWER SAYS: **In your own words, please answer the following questions:**

24. Over the last six months, how have DMH case management services helped you?

25. Over the last six months, how else could DMH case management services have helped you?

26.	How would you rate your DMH case management services over the last six months?		*Poor (1)*	*Fair (2)*	*Good (3)*	*Excellent*	
27.	Gender:	*Male (1)*	*Female (2)*				
28.	Race:	*African American or Black (1)*	*Asian or Pacific Islander (2)*	*Caucasian or White (3)*	*Native American (4)*	*Multiracial (5)*	*Other (6):*

Interviewer Comments

1. Was the interview completed?

   1 = Yes
   2 = No

2. Please rate your confidence that the respondent understood the questions answered on scales (i.e. from "poor" to "excellent") and answered them appropriately.

   1 = Very confident
   2 = Generally confident
   3 = Generally unconfident
   4 = Very unconfident

3. Please rate your confidence that the respondent understood the open-ended questions and answered them appropriately.

   1 = Very confident
   2 = Generally confident
   3 = Generally unconfident
   4 = Very unconfident

4. Please list any additional comments.

ID # ____________________ Interview Site Name: __________________________ Interviewer(s): _________

Date: ____________________ Case Mgmt. Site: ______________________________ ___________________________

Case Management Informed Consent Form

Consumer Quality Initiatives, Inc.

I work for an organization called Consumer Quality Initiatives (CQI), which employs mental health consumers and their family members. CQI's goal is to give consumers a stronger voice in planning mental health services through consumer interviews and reports that include the themes that emerge from these interviews.

The Department of Mental Health (DMH) has asked our organization to help them better understand the needs of mental health consumers. To participate in this interview, you must have a case manager or have had a case manager.

The survey is completely voluntary.

- If you choose not to participate, there should be no negative consequences to your choice; CQI will not inform DMH or your providers that you have chosen not to participate.
- If you are uncomfortable during the interview, you may take a break or stop the interview entirely.

The survey is confidential.

- No one except people who work for CQI will see a copy of the completed survey; no one from ________________________________ will see the completed survey.
  Facility where interview taking place
- The report CQI writes will not include your name. We will not include a statement you make to us in the report unless you give us permission to do so and the use of the quote does not clearly identify you as the speaker.
- Your answers will not become part of your clinical record.
- The only time we might have to tell someone something you said is if we find out that you have been abused by another person, that you have abused another person, or that you have a plan to harm yourself. If any of these situations should occur during the interview, we will discuss what we need to do with you.

Please review the statements below, provide any missing information, and initial each statement:
I understand how the interview will take place and how the information collected will be used. I now give my consent to be interviewed by Consumer Quality Initiatives, Inc. ("CQI").

____

____

(Date) *(Initials)*

Further, I *agree / do not agree* ***(please circle appropriate choice)*** to give permission to Consumer Quality Initiatives to include in their reports statements, or parts of those statements, I make to the interviewer, as long as the statement does not clearly identify me as speaker, and my name is not used in the report.

____

(Initials)

DMH offers two kinds of case management services, level A and level B, which is more supportive and intensive. We would like to compare the satisfaction rates of people receiving level A case management services to the satisfaction rates of people

receiving level B case management services. This is by no means required, but after we've completed the surveys, we would like to submit all the names of the people we have interviewed to the DMH area office. DMH can then tell us which level of case management each interviewee has.

I *(agree / do not agree)* ***(please circle appropriate choice)*** to give permission to Consumer Quality Initiatives, Inc. to submit my name to DMH, but only for the sole purpose of learning whether I have level A or level B case management services; I realize that DMH will learn that I participated in the survey, but CQI has otherwise agreed to maintain my confidentiality as discussed above.

____
____
(Initials)

Name: ____

Appendix B

The Recovery Learning Center

Proposed Program Model

April 2003

Excerpt- **<u>The Program: Learning Centers (RLC)</u>**

The Consumer Family Workgroup proposes that the RLC would consist of six to ten regional Learning Centers based on peer-oriented recovery models that maximize community integration in favor of real-world goals set and directed by the consumer. The RLC is not program centered, but about moving consumers to increased independence and life choices. The workgroup believes that Learning Centers have a strong values component based on valuing and accepting where the Member is in life, and that people need partners, not minders, in gaining greater autonomy, skills, and self-determination. To build a community that offers natural supports and a growth path to its members, Learning Center membership would include those with high and low intensity needs.

The Consumer Family Workgroup envisions that the Learning Centers need their own space and autonomy to develop and function, but they can be elements of providers' larger system of care. It is the Workgroup's intention that providers will be creative in using their own experience and be willing to participate in shared model development. Learning Centers may develop in different ways and within a variety of structures. Each center would develop its own design based on the cultural, linguistic, and other needs of the geographic area. The Workgroup proposes staffing levels of at least 5.0 FTE.

The Learning Centers would offer a variety of culturally appropriate **educational** and **peer support** opportunities that emphasize skill-building and community integration and enhance access to **wellness**, as opposed to "normalcy." Wellness has its roots in holism and in both individual and cultural diversity. As a result, the Learning Centers would sponsor a range of structured programs and less structured support groups, and provide mentors as needed. Members would choose what supports should be provided and all participation would be flexible and voluntary.

The Learning Centers would develop recovery learning opportunities such as self-help groups in other locations throughout their respective regions. They would also conduct outreach and offer training, technical assistance and support to consumers leading support and education groups in a range of community-based locations. We also propose that the Centers conduct outreach at homeless shelters, street hangouts, and other nontraditional sites, and that they would serve as training centers in recovery for mental health staff.

The Workgroup proposes that the Learning Centers also have the capacity to respond to the needs of consumers with co-occurring disorders. These Members, whose symptoms combined with substance abuse

lead to a high risk of violence toward self and others, need a range of self-help opportunities subsidized and supported by the Learning Centers. They could include culturally appropriate offerings based on Dual Recovery Anonymous, Women for Sobriety, SMART Recovery, and Recovery, Inc. models, as well as substance abuse educational meetings for those still contemplating recovery. Alcoholics Anonymous, Narcotics Anonymous, and Double Trouble meetings may also be offered. Consumers with co-occurring disorders also can profit from being linked to other peer education, support, and advocacy opportunities in order to make informed choices about their lives.

The Consumer Family Workgroup proposes that the Learning Centers commit to staffing both management and support positions with consumers who are in recovery. Our vision is that over 50 percent of the local governing and review body for each Center would be comprised of consumers (see "Program Structure & Governance"). The Consumer Family Workgroup would play a continuing role in implementation and oversight.

The Workgroup considers it critically important that consumers who are open about their status as consumers and their paths to recovery play key roles in the Learning Center. The consumer staff could play a very important role in developing a truly consumer-driven culture and perspective and in developing effective services and supports at the Learning Centers. Developing these perspectives and services, the Workgroup believes, should also be supported through intensive training and technical assistance with people experienced in consumer-driven models. The Workgroup proposes that it play a role in developing these key aspects of the Learning Center model.

Excerpt- **Program Values**

The Consumer Family Workgroup upholds the following values in this proposal:

* *Freedom:* Members will establish how they will work and live, how they will give to the community, and what kind of help they need.

* *Authority or control:* Members will be full partners in decision-making about how the budget for their individual mental health care is allocated in order to meet the goals for their lives that they set.

* *Support:* Members will care for themselves to the best of their ability. They will seek companionship for support and make plans to get help with tasks for which they need assistance (i.e., they are not subjects of "supervision" and "staffing").

* *Responsibility:* Members will use resources such as public dollars as an investment in support of their lives, not the purchase of "units of service" or "slots." Members will undertake all the responsibilities of American citizenship, such as voting, obeying laws, directing their own lives, and contributing to their communities in meaningful ways.

Excerpt- **Program Cautions**

The flexibility of the Learning Center model would offer the opportunity to more closely satisfy the daily human choices and needs of Members, which will contribute to their on-going stability and recovery in a comparatively low-cost treatment setting. The comparatively low utilization of clinical and professional services in this model also offers the opportunity for cost savings.

However, the Consumer Family Workgroup believes strongly that it would be a misuse of this model to use it to remove more intensive and costly clinical services needed by program participants from time to time, or needed by other MassHealth Members. Moreover, if other levels of care and supports are cut, the need for intensive treatment, such as emergency care, may increase.

Appendix C

IAPSRS MA Certificate in Psychiatric Rehabilitation Curriculum
Brief Description

Lesson Plans:
A one-page lesson plan is presented for each class session topic. All classes are formatted in a similar way. An assignment is due every week, and the course instructor will return the assignment with feedback the following week. A mid-term and a final exam will be offered as take-home tests. The objectives listed for each class can be used to formulate exam questions. Handouts and assignments will be included in a later version of the curriculum.

Important Points: *(adapted from materials produced by the Boston University Center for Psychiatric Rehabilitation and BCPR, Inc.)*

The content and process of the curriculum for this course focuses on increasing awareness about psychosocial rehabilitation. The course is designed for training direct service personnel, yet students in the course may or may not have experience in the field. Whenever possible, use experienced students to contribute examples of the principles and concepts being discussed.

Psychiatric rehabilitation is based on certain fundamental values and principles. Because of this, and because students often learn a great deal from what the instructor models, selection of the instructor will be important. Course instructors and guest speakers must actively demonstrate the psych rehab values throughout the course. Some examples are:

Immediate feedback on performance: Frequent assignments, along with a quick turn-around and detailed comments from the instructor, will maximize learning. Assignments will emphasize use of knowledge, not just memorization.

Interpersonal skills: Good interpersonal skills contribute to rehabilitation and recovery, and are a key component of cultural competence. Therefore, instructors need to focus attention on the students, not on notes. Summarizing student comments, along with prompt and accurate reflection, will encourage students to contribute to class discussions, while clarifying and summarizing the point made. Highlighting similarities and differences among students can help create cohesiveness while appreciating diversity.

Language use: Use “person-first” language—neutral and descriptive terms that put the words “person with” or “person who has” ahead of the label of any medical or psychiatric disorder. For example, say “a person who has schizophrenia,” not “schizophrenics.” The use of terms such as patient, client, and consumer refer to an individual’s role in a service system. When describing the role, such terms are acceptable. For example, you might say, “the psychiatrist met with his patient,” or “the lawyer met with his client,” or “the advisory board includes both consumers and providers.” When discussing a human experience, where the role is not necessarily relevant, using an individual’s name or the term “person” is preferable. For example, say “a person diagnosed with schizophrenia might experience auditory hallucinations,” not “patients hear voices.” Similarly, help students learn to avoid emotion-laden terms like “suffers” or “afflicted” or “victim.”

Class Titles

Week 1	**Introduction and Overview**
Week 2	**History of Psychiatric Rehabilitation**
Week 3	**Psychiatric Disability**
Week 4	**Role of the psych rehab practitioner**
Week 5	**Professional Responsibility**
Week 6	**Ethics, Laws, and Regulations**
Week 7	**Community Resources and Systems**
Week 8	**Psychiatric Rehab Program Models**
Week 9	**Advocacy and Self-help**
Week 10	**Helping Skills**
Week 11	**Helping People Change**
Week 12	**Cultural Competence**
Week 13	**Assessment**
Week 14	**Planning and Interventions**