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“More to life than mental health”: Investigating the Roles of Community Mental Health Case Managers in Promoting Community Integration for Adults with Psychiatric Disabilities

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“More to life than mental health”: Investigating the Roles of Community
Mental Health Case Managers in Promoting Community Integration
for Adults with Psychiatric Disabilities

by

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First and foremost, I'd like to thank my advisor and committee chair, Dr. Bret Kloos, for his patient guidance and support throughout my graduate career. The invaluable training I have received from him as a clinical-community psychologist with a unique approach to working with adults with psychiatric disabilities—and the systems designed to serve them—has shaped every part of my professional identity and is a perspective which I seem to appreciate more every year. I also want to thank my committee member Dr. Michele Burnette for her constant support and the central role she has played in my development as a clinician. Thank you also to my other committee members, Dr. Anna Scheyett and Dr. Elma Lorenzo-Blanco, for their thoughtful feedback that was central in shaping the direction of this research—their efforts to ensure that I was set up for success in this project could not be more appreciated. I also want to thank my internship research mentor, Dr. Marcia Hunt, for her time, energy, suggestions, and—most importantly—steady encouragement throughout some of the most trying phases of the research process.

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ABSTRACT

The recovery movement in the field of community mental health has brought attention to more holistic outcomes of services for adults with psychiatric disabilities, including community integration. However, there is a lack of empirical investigations of the roles that service providers, and case managers (CMs) in particular, can play in promoting such outcomes for their clients. The present study took an exploratory, hypothesis-building approach to describing the ways in which CMs supported the community integration of their clients with serious mental illness. A cross-sectional design was used with qualitative and quantitative data collected from 6 CMs and a sampling of 20 clients.

Findings documented that clients' community issues were often viewed as relevant to CM services, though to varying degrees. CMs were primarily described as promoting community integration by connecting clients to resources, providing encouragement, and serving other supportive functions (e.g., goal planning, accountability, regular check-ins). CM practices varied in the extent to which they aligned with recovery principles, including CM's primary goals in case management, CMs viewing themselves as central vs. supplemental to clients' community lives, how they related to clients (parental vs. coach roles), and methods they used to connect clients to community resources. Mixed method analyses revealed that CMs whose practices

aligned more closely with the principles of recovery and client-centered care (e.g., holistic, collaborative approaches) tended to have clients with higher community integration scores. Higher functioning clients generally reported more peripheral, supplemental support from CMs whereas lower functioning clients described support from their CMs as involving stronger guidance and direction.

The present study was intended to be exploratory and hypothesis-building; as such, limitations included having a small sample size and a cross-sectional design. Nevertheless, a key benefit of this study was its ability to identify recommendations for future research and considerations for practice which are more likely to be implementable in real-world settings. One key recommendation generated from this study to be tested in future research is that bolstering CMs' use of client-centered approaches to case management (holistic perspective, collaborative approach) might allow them to more effectively promote clients' community integration.

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CHAPTER 1

INTRODUCTION

A major focus of mental health research over the past several decades has been on developing new programs and models of care to promote clients' recovery from serious mental illness within community mental health systems (e.g., assertive community treatment, supported housing programs, Illness Management and Recovery; Bond, Salyers, Rollins, Rapp, & Zipple, 2004). There has also been a recent trend in research to explore the competencies needed by service providers for effectively promoting client recovery (Aubry, Flynn, Gerber, & Dostaler, 2005; Aubry & O'Hagan, 2014; Lakeman, 2010; Russinova, Rogers, Ellison, & Lyass, 2011). However, this existing literature has generally considered a broad range of "mental health service providers" as a single group (Aubry & O'Hagan, 2014), rather than considering what might be uniquely needed for different types of providers, such as case managers.

Within this literature on recovery-oriented provider competencies, there has also been a lack of research linking provider characteristics to measured client outcomes; much of the research to date has used client or expert opinion of what provider characteristics are thought to be most critical for promoting recovery (Aubry & O'Hagan, 2014). The empirical research involving client outcomes that does exist is largely within the substance use and psychotherapy literatures, with an emphasis on

traditional clinical outcomes such as treatment engagement and symptom reduction (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Najavits & Weiss, 1994; Saarnio, 2010; Valle, 1981). Little is known about how these findings of providers' impacts on clients translate into the case management context, especially in promoting broader outcomes such as community integration, life satisfaction, a sense of empowerment, and holistic recovery (Anthony, 1993; Drake et al., 2001; Geller, 2000; Russinova, 1999).

The purpose of this exploratory study was to empirically investigate client and case manager perceptions of the roles that case managers can play in facilitating clients' community integration. Furthermore, this study described details of this process within client-case manager interactions and provided preliminary associations between case manager practices and their clients' community integration outcomes. A mixed methods approach to these research questions was chosen to bring together the strengths of both quantitative and qualitative research in building theory around the potential role of case managers in promoting clients' recovery and community integration. The ultimate goal of this larger program of research is to identify components of current case management practice that can be built upon and expanded to promote greater recovery and community integration for all clients in mental health systems. The present study contributed a first look at these issues within a real-world setting from both client and case manager perspectives.

The following report begins by introducing the conceptual framework underlying the present study, including the literature on mental health recovery and community

integration, mental health case management, and characteristics of providers' approaches to practice that have been linked with positive client outcomes. This section concludes by articulating a specific set of research questions which guided the study. The report then presents a justification for the present study's methodological approaches, including why a naturalistic design using mixed method data was used to answer the defined research questions. The Method section details the specific research design used, including sampling and recruitment procedures, interview questions, and analysis procedures. Results of the analyses are then organized by the predefined list of research questions. This section ends with a description of second order themes which are drawn from across the primary results and framed within a theory of recovery; this section was included to demonstrate how recovery-oriented case management practices can be identified within traditional models of practice.

In the Discussion section, several broad themes were identified from across the research questions which are elaborated on within the context of existing literature: (a) comparing the described case manager activities with established case management models, (b) identifying specific characteristics of case managers and their practices which were linked with positive client outcomes, (c) discussing barriers to effective case management practice, and (d) describing differences in how clients of varying levels of functioning viewed their case managers helping them with their community lives. Limitations of this study are then presented, followed by a discussion of the implications of the present findings for future research with an emphasis on some of the key hypotheses that were generated by this exploratory study. Finally, considerations are

presented for ways in which the present findings may inform case management services.

Conceptual Framework

The conceptual framework underlying the present study involved literature from several different fields of study, including the mental health recovery movement which pushes for community integration as a valuable outcome of interest, the history of the community mental health system and the evolution of the role of mental health case managers, and the characteristics of service providers—such as having a client-centered approach to care—which are often associated with positive client outcomes. The role that clients’ functioning levels may play in these service dynamics is also discussed. This framework provides the rationale for the present research study, which drew from these different fields of study in exploring how case manager characteristics and practices were associated with client recovery and community integration outcomes within a community mental health setting.

Recovery. The present study explored individuals’ experiences of recovery and community integration as they related to case management services. Recovery from serious mental illness, often defined as “living a satisfying, hopeful, and contributing life even with limitations caused by illness,” has increasingly become a focus of research and mental health services since the recovery movement of the 1970s and 1980s (Anthony, 1993, p. 527). Prompted by research showing that recovery from mental illness is a reality for a significant portion of those with even the most severe mental health problems (Harding, Brooks, Ashikaga, Strauss, & Brejer, 1987; Strauss & Carpenter,

1977; Vaillant, 1978) and a growing dissatisfaction with the fragmented mental health system of that time, mental health service clients (renamed “consumers”) led a movement for change in the mental health system (Rappaport, 2014). This consumer movement drew inspiration and ideas from the experiences of those with physical disabilities who asserted their rights, contributions, and value to society even in the presence of lifelong “disability” conditions.

Patricia Deegan (1988) and other mental health consumers were instrumental in advocating for the incorporation of these recovery principles into mental health practice, including creating flexibility in treatment programs to allow for client choice and autonomy in supporting each individual’s unique recovery journey. This recovery movement ultimately called for a service system that focused on *promoting* meaning, purpose, and life satisfaction as much as it aimed to decrease symptoms and impairment (Anthony, 1993; Russinova, 1999). Since that time, there has been a gradual push to broaden the scope of the service outcomes that are evaluated in order to reflect this shift as well.

In 1993, psychologist William Anthony introduced the ideas of recovery into the academic literature and proclaimed recovery as the “guiding vision” for mental health care in the 1990s. Adapting the concept of recovery from other disability movements, Anthony (1993) identified recovery as involving “the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (p. 527). The US Substance Abuse and Mental Health Service Administration (2012) defined ten principles of recovery which were informed by mental health consumers, service

providers, and other stakeholders: person-driven, occurs via many pathways, holistic, supported by peers and allies, relationship-focused, culturally-informed, addresses trauma, draws on personal and community strengths, involves respect from self and others, and promotes hope. In both of these definitions, recovery is seen as a personal orientation that can help mental health consumers, their family members, and their service providers have hope in working toward a renewed sense of identity and purpose as consumers begin to accept and adapt to the limitations of their disability.

Recovery-oriented service systems. Recovery can also be a guiding paradigm for a transformed mental health system. Anthony (1993) described a vision of a recovery-oriented mental health system which addresses the whole experience of mental illness, including social rejection and stigmatizing attitudes, decreased control over one's life choices, and the negative effects of unemployment. Since this time, there have been broader, system-wide calls to integrate these recovery principles into the entire mental health service system in the United States. A report produced by President George W. Bush's New Freedom Commission on Mental Health (PNFCMH) renewed Anthony's vision of a mental health system which supports recovery (Hogan, 2003). The Commission's report identified recovery as the "single most important goal of the people [the mental health system] serves," but acknowledged the failure of the present system to effectively promote it for most clients (Hogan, 2003, p. 5). A major challenge in this system transformation is working to seamlessly integrate recovery principles with current practice. As Davidson and colleagues stated, "we cannot afford to have a recovery-oriented system grow up parallel to, and distinct from, existing systems of

care” (Davidson, O’Connell, Tondora, Styron, & Kangas, 2006, p. 643). In pursuit of this goal, there is a need to identify characteristics of current systems and providers that are already effective at promoting recovery outcomes in order to build on these existing practices.

Specific recommendations for transforming current practice into more recovery-oriented models of care focus on two principles: (a) providing client- and family-centered care and (b) broadening the focus of care beyond symptom management (Hogan, 2003). This call for client-centered, holistic care has been echoed by many of the conceptualizations of recovery that have developed over the past decade (Andresen, Oades, & Caputi, 2003; Substance Abuse & Mental Health Service Administration, 2012; Whitley & Drake, 2010), as well as by discussions of provider competencies needed to promote client recovery (Aubry & O’Hagan, 2014; Hunt & Resnick, 2015). A common element across these models is the importance of reaching beyond a focus on symptom management to recognizing mental health clients as *whole people* with unique and complex constellations of strengths, interests, needs, resources, and histories. Any efforts to promote recovery by service systems and providers, including case managers, must prioritize listening to the client’s experiences, concerns, and goals throughout the treatment process and view clients as equal partners, if not the leaders, in their own recovery journeys. However, these characteristics have yet to be empirically linked with client recovery outcomes. A fuller description of the elements of client-centered care will be presented below along with other characteristics of providers and their practices which are thought to promote positive client outcomes.

Community integration. This push for recovery within community mental health services has led to a more holistic set of prioritized service system outcomes, including the quality of clients' lives in the community (Drake et al., 2001; Bond et al., 2004). In fact, the PNFCMH report included a description of community integration ("living, working, learning, and participating fully in the community") as an integral component of recovery (Hogan, 2003, p. 1). The present study focused on client community integration as a key outcome of interest because it is both a fundamental right of all persons with disabilities (Rosenthal & Kanter, 2002) and a predictor of other positive outcomes including quality of life, self-esteem, and symptom reduction among adults with serious mental illness (Arns & Linney, 1993; Bengtsson-Tops & Hansson, 2001; Bond et al., 2001).

Broadly, community integration refers to the level of participation and engagement an individual has within various spaces of his or her community, such as workplaces, neighborhoods, religious groups, or recreational activities. Salzer and Baron (2006) succinctly defined it as "the opportunity to live in the community and be valued for one's uniqueness and abilities, like everyone else" (p. 2). A definitive characteristic of community integration is the importance of a presence in "regular" community settings, where people with and without disabilities spend time, rather than simply increasing activity levels within specialized, and often segregated, mental health settings (Bond et al., 2004; Minnes et al., 2001).

Conceptually, community integration can be divided into three components: *physical* (i.e., presence in the community and frequency of community activity

participation), *social* (i.e., quality of interactions with neighbors and other community members), and *psychological* (i.e., sense of belonging in the community) integration (Aubry & Myner, 1996). These components can be measured as more subjective elements, such as individuals' satisfaction with their community activity level (Brown et al., 2004), their sense of loneliness or social support (Farone, 2006), and their sense of belonging in the community (McColl, Davies, Carlson, Johnston, & Minnes, 2001). Community integration can also be measured more objectively as the frequency of participation in activities per week or month (Brown et al., 2004), the geographical size of individuals' "activity spaces" (Townley, Kloos, & Wright, 2009), and the size of individuals' social networks (Townley, Miller, & Kloos, 2013).

Decreased community integration across all dimensions, but especially social integration, has been found in people with psychiatric disabilities, as compared with the general population (Abdallah, Cohen, Sanchez-Almira, Reyes, & Ramirez, 2009; Aubry & Myner, 1996). Low community integration can be a direct result of symptoms (e.g., loss of interest, anxiety, paranoia), of the decreased social functioning or resources (e.g., finances, transportation) often concomitant with psychiatric disabilities (Perese & Wolf, 2005), and of social factors such as stigmatizing attitudes and discrimination (Prince & Prince, 2002; Stuart, 2006).

It is valuable to note a recent trend in both mental health and broader disability communities toward using the term community *inclusion* over community integration because it emphasizes the role of community members in welcoming individuals with psychiatric and other disabilities into community spaces, in addition to supporting

individuals in accessing those spaces themselves (Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities, 2016). Community inclusion tends to address system- and community-level issues which can inhibit participation in community life, such as community resources (e.g., public transportation access) and problems with stigma and discrimination, alongside providing individual-level supportive services. For the purposes of the present study, the term community integration was chosen because (a) it is a more established and familiar term within community mental health settings and (b) it is most relevant to the level of analysis considered here (i.e., individual services). That is, case management cannot be expected to address all of the barriers to community inclusion faced by individuals with psychiatric disabilities; combating higher-level forces like resource allocation and societal stigma requires higher-order interventions (e.g., policy changes and broad community interventions), which is beyond the scope of typical case management services.

Relevance to present study. Although, as noted above, case managers cannot be expected to address all of the barriers to community integration for clients, it is expected that case managers who value these outcomes will tend to focus more energy on helping their clients overcome or work around such barriers on an individual basis. As described below, specific models of case management, including assertive community treatment (ACT) teams and the strengths model of case management, explicitly target client community integration; their main aims are to assist clients in living self-directed, independent lives through successfully engaging their natural community resources

(Rapp, 1998; Weick, Rapp, Sullivan, & Kisthardt, 1989). Research supports the effectiveness of these models in promoting community integration-related outcomes, including housing tenure (Phillips et al., 2001), quality of life, and vocational or educational outcomes (Stanard, 1999). However, less is known about how much providers within standard models of case management may value their clients' community experiences or the extent to which these issues are incorporated into the services they provide.

Recovery and community integration. Community integration is closely related to recovery principles and may even be viewed as a manifest indicator of one's level of recovery (Bond et al., 2004). That is, recovery often involves moving beyond the mental health system and developing one's sense of identity outside of psychiatric disabilities, usually by engaging broader and more naturalized community structures like workplaces, neighborhoods, and recreational activities (Farone, 2006). Interventions designed to promote one's sense of recovery have been found to increase clients' engagement in activities, social integration, and community functioning (Hodgekins & Fowler, 2010; Segal, Silverman, & Temkin, 2010). Furthermore, many recovery-oriented services within mental health systems aim to specifically promote community integration outcomes such as "employment, housing, education, participation in leisure/social activities" and access to health and social resources (Lloyd, Tse, & Deane, 2006, p. 2). However, these two concepts remain distinct constructs, with recovery representing an underlying philosophy and community integration more directly relating to individuals' actions and experiences as well as to higher-order factors like the

availability of support resources and the level of stigma and discrimination present in the community.

As mentioned, there are many factors which impact an individual's level of community integration, both within and beyond mental health systems. Access to social support and financial resources, experiences of community support or discrimination, environmental factors like safety and access to public transportation, and availability of support services like supported housing or employment programs are all critical in predicting an individual's level of community integration and recovery (Carling, 1990; Cook et al., 2005; Corrigan & Phelan, 2004; Davidson, Rowe, Tandora, O'Connell, & Lawless, 2008; Townley & Kloos, 2011; Wong & Solomon, 2002). The present study acknowledged the importance of each of these factors and also asked whether factors related to case management services, a central element of community mental health systems, might play an additional role in predicting these outcomes for clients.

Overview of community mental health case management. Because the focus of the present study was on community mental health case management, a brief review of the key elements of case management will provide a basic understanding of the purpose and core components of this practice. The primary roles of case managers are commonly defined as: (a) *assessing client needs and resources* including social support networks, capabilities, and areas of need, (b) *developing a "case plan"* which identifies community supports and services available that can help meet client needs, (c) *linking clients to resources* through referrals, assisting with service applications (e.g., governmental benefits programs), and helping address barriers to access, and (d)

monitoring the client's progress toward service goals through regular meetings and revising the plan as needed (Mas-Expósito, Amador-Campos, Gómez-Benito, & Lalucat-Jo, 2014; Rubin, 1992, p. 9). Case managers also perform other functions as needed such as systems advocacy and change, client outreach, and, at times, providing an otherwise unavailable service such as teaching clients independent living skills (Mas-Expósito et al., 2014; Rubin, 1992).

The original model of case management, often called the broker model, emerged during the mid-century deinstitutionalization movement as a way to coordinate services across a fragmented mental health system (Rose, 1992a). In recent decades, however, this model has been criticized for being systems- and provider-oriented rather than focused on client needs (Rose, 1992b). Because the goal of the case manager in this model is primarily to act as a liaison between the client and service systems, some have argued that clients' needs are limited in scope to mental health issues and viewed within the lens of what can be addressed by already existing services (Mueser et al., 1998; Rose, 1992b).

Another model called clinical case management operates within a similar structure as the broker model but incorporates clinical services (i.e., therapeutic interventions) more explicitly. Kanter (1989) defined this model of case management as providers within the mental health treatment team who are involved in "all aspects of the patient's life in the community" and concerned with both psychiatric stability and community participation (p. 367). The principles of clinical case management outlined include case managers providing a long-term continuity of care for clients, focusing on

the case manager relationship which is described as being relatively directive (analogous to a “travel guide”; p. 362), providing support which is flexible and tailored to the client’s evolving functioning level (e.g., graduated independence), and “facilitating patient resourcefulness” (p. 363) and community connections in a strengths-based manner (Kanter, 1989). Despite these differences, the structure of services in clinical case management are relatively similar to the broker model, including primarily office-based appointments, high caseloads, and largely clinician-directed services (Mueser et al., 1998).

Together, the broker model and clinical model are sometimes referred to as “standard case management” models (Mueser et al., 1998, p.40). Although support for the effectiveness of these models are lacking (Bedell, Cohen, & Sullivan, 2000; Rapp, 1998), these approaches to case management continue to be most pervasive and are sometimes referred to as “mainstream” practice in the field (Bond et al., 2004; Rose, 1992a, p. 74).

While the core principles have largely remained the same, different models of case management have developed alternative approaches to these activities which focus on and promote different client outcomes (Mas-Expósito et al., 2014). These expanded models of case management have begun to incorporate an ecological perspective into this work (Libassi, 1992). For instance, intensive outreach models, which are the foundation for Assertive Community Treatment (ACT) teams, prioritize meeting clients out of the office in the spaces where they “experience everyday life” (Rose, 1992a, p. 75). This model also first introduced individualized plans of care which

incorporated both formal and informal networks of support (e.g., family, friends, faith community). Other approaches, such as the psychiatric rehabilitation model and strengths model of case management, are also focused around client-driven goals, priorities, interests, and strengths (Anthony, Cohen, & Farkas, 1982; Mueser et al., 1998; Rapp, 1998).

A common factor across each of these alternative, more evidence-based models of case management is the ultimate aim of helping clients engage with their communities as much as possible in an effort to support them in living a life of their choosing (Mueser et al., 1998; Rose, 1992b). The focus of these models reflects the broader recovery-oriented direction of the mental health system, which strives to be more centered on clients' lives, rather than mental health symptoms and systems.

Relevance to present study. Although these alternative models of explicitly *recovery-oriented* case management exist, the extent to which elements of these models are incorporated into case management practice, particularly in settings that do not explicitly adhere to one of these approaches, is not well understood. There is also little research on the impact of variation in the attitudes and treatment approaches of those *providing* these services, even within one model or setting. One goal of the present study was to explore ways in which case managers' practices can be more or less recovery-oriented even within standard models of case management and to preliminarily link this variation with client community integration outcomes. Additionally, a notable difference between standard models and explicitly recovery-oriented models of case management is the intensity of services (i.e., frequency of

contact, level of service support; Mueser et al., 1998); therefore a question inherent to this study was whether less intensive models of case management could incorporate issues of community life into services and, if so, how case managers approached this task, given infrequent meetings and being mostly limited to office-based services.

In line with these aims, the present study asked about two dimensions of case management services in order to search for elements of these services that promoted recovery and community participation: (a) perceptions of case managers' roles in the mental health system and in clients' lives and (b) descriptions of activities completed by case managers in working to address issues of community integration with clients. First, little is known about how case managers perceive their roles within the increasingly recovery-oriented mental health system, particularly in systems that have not explicitly adopted recovery-focused models of case management. Numerous concerns of mental health service providers have been cited, including a lack of capacity to incorporate more recovery-focused services into their work (Davidson et al., 2006; Tickle, Brown & Hayward, 2012). This concern seems particularly salient given the very high caseloads of providers within standard models of case management (estimated at 30-50 clients; Mueser et al., 1998) and the resulting limitations on the amount of time case managers can devote to each client. Therefore the present investigation explored how case managers perceived the boundaries of their work: whether as more traditionally limited to brokering across formal service systems or as embracing newer models directly addressing issues of recovery and community integration with clients.

There is also a lack of understanding of the details of the process when case managers do work with clients explicitly on promoting recovery and community integration. Models such as the strengths model of case management paint an image of providers meeting clients out in the community to actively connect them with natural community supports and resources (Marty, Rapp, & Carlson, 2001); however, this practice is not well-defined outside of specific models or when providers are constrained to traditional office settings. Given this gap in literature, the present study worked to describe concrete details of the process of case managers effectively supporting clients in their recovery and community participation goals, from both case manager and client perspectives.

Characteristics of service providers. In order to take a holistic approach to exploring many aspects of case managers' work that promote community integration, the present study investigated whether specific characteristics of providers and their practices were related to client outcomes. The reality that variability in service providers exists and impacts client outcomes has been recognized for decades within the field of psychotherapy. A number of studies have found significant variation in client outcomes (i.e., substance use abstinence, symptom reduction, treatment goal attainment, and treatment drop-out rates) between the most and least effective therapists (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; McLellan, Woody, Luborsky, & Goehl, 1988; Miller, Taylor, & West, 1980; Najavits & Strupp, 1994; Valle, 1981). However, less is known about whether these effects of provider characteristics are found in case management services and, if so, which specific characteristics of case managers might

be critical to such effects. The following review draws from psychotherapy literature on therapist variability, along with literature on primary care providers, psychiatrists, and broadly defined “mental health service providers,” to argue for characteristics of case managers that may be important for promoting positive recovery and community outcomes for clients.

Demographic variables. Factors such as practitioner demographic characteristics (e.g., age, race, gender), treatment orientation, and level of training have been found to have mixed impacts on client outcomes. An early study found a small effect of higher attendance rates for alcohol counselors who were older and female (Rosenberg, Gerrein, Manohar, & Liftik, 1976). More recent investigations have found a positive effect of therapist experience level on client outcomes such as symptom reduction (Huppert et al., 2001; Podell et al., 2013; Powell, Hunter, Beasley, & Vernberg, 2010). There is also evidence that ethnic matching between therapists and clients can have a small positive effect on client outcomes, particularly amongst African American clients (Cabral & Smith, 2011). However, a number of investigations using hierarchical linear modeling failed to find independent therapist effects based on training level, theoretical orientation, gender, age, or therapist race/ethnicity (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Beutler et al., 2004; Okiishi, Lambert, Nielsen, & Ogles, 2003; Okiishi et al., 2006; Owen, Leach, Wampold, & Rodolfa, 2011). Therefore case manager demographic variables such as these were considered in analyses but were not expected to be strongly associated with client outcomes.

Beliefs of mental health recovery. Case managers' beliefs about recovery may also impact clients' attitudes of recovery and community participation. Despite the recent emphasis on recovery-oriented care in community mental health systems, little is known about the extent to which case managers have adopted a recovery orientation themselves. Mixed evidence exists: Borkin et al. (2000) found that mental health professionals (broadly defined) endorsed recovery principles more strongly than mental health clients and family members. Conversely, other researchers have encountered providers as largely resistant to incorporating more recovery-oriented goals into their practice out of concern for both their own service capacity and clients' well-being when making potentially risky life changes (e.g., stress of employment; Davidson et al., 2006; Tickle et al., 2012).

Furthermore, there have been some suggestions that providers' attitudes about recovery are important for impacting client outcomes. Several studies have argued that mental health and rehabilitation providers' beliefs in the reality of recovery for people with severe mental health problems is one of the key elements of helping clients adopt this same sense of recovery for themselves (Corrigan, 2002; Lakeman, 2010; Russinova, 1999; Russinova et al., 2011). Anthony (1993) also emphasized the importance of providers believing in recovery as a holistic process which is facilitated by involvement in "non-mental health activities and organizations" as much as by mental health treatment.

Relevance to present study. Therefore, although not yet empirically explored with case managers specifically, case managers' beliefs in recovery may be associated

with both a similar sense of recovery within clients as well as encouragement of clients' participation in meaningful community roles and activities. The present investigation attempted to address these gaps in the literature in understanding the extent to which case managers endorsed a recovery paradigm in working with their clients and how those attitudes, among other factors, were related to clients' own attitudes toward recovery and actual success living in integrated community settings.

Client-centered care practices. In addition to demographic variables and recovery attitudes, it is thought that case managers' level of client-centeredness in their work may also relate to clients' community outcomes. Carl Rogers (1951) first introduced person-centered approaches to therapy as part of a humanistic orientation which advocated for a holistic, strengths-based approach built upon a strong therapeutic relationship. Current conceptualizations of client-centered care share this focus on providing individualized, humanizing care: Epstein and Street (2011) stated that client-centered care occurs when clients are "known as persons in context of their own social worlds, listened to, informed, respected, and involved in their care—and their wishes are honored (but not mindlessly enacted) during their health care journey" (p. 100). In this approach, services are focused on ensuring that treatment is "built upon respect for the unique preferences, strengths, and dignity of each person" (California Department of Mental Health as cited by Adams & Grieder, 2004, p. 21).

Operational definitions of this concept from physical and mental health care generally share several core principles. First, client-centered care involves the client being given full or at least shared control over his or her own treatment decisions,

within the context of open information-sharing between the provider and client (Adams & Grieder, 2004; Hudon, Fortin, Haggerty, Lambert, & Poitras, 2011). Another core component of client-centered care is incorporating the client's voice, experiences, and understanding of the problem into the provider's own conceptualization of the issue (Stewart et al., 2000). Client-centered assessment also considers the "whole person"—the client's strengths, values, hopes, and interests alongside the struggles—and works to capitalize on client assets in treatment (Adams & Grieder, 2004; Hudon et al., 2011). Finally, models of client-centered care generally emphasize the provider-client relationship as integral to the treatment process (Adams & Grieder, 2004; Hudon et al., 2011; Rose, 1992b; Stewart et al., 2000). Building a true collaborative partnership is viewed as necessary for the other components of shared decision-making and providing humanizing, strengths-based care.

Client-centered care and mental health recovery. The role of client-centered care in promoting client recovery and community integration in mental health services is gaining increasing support from policy makers, consumers, researchers, and mental health practitioners (Hunt & Resnick, 2015). President Bush's New Freedom Commission on Mental Health (PNFCMH) report explicitly stated a need for services that are "consumer and family centered, geared to give consumers real and meaningful choices about treatment options and providers—not oriented to the requirements of bureaucracies" (Hogan, 2003, p. 7). The report also linked the need for client-centered services specifically with the ability of the mental health system to promote client

recovery and community integration (Hogan, 2003). As Adams and Grieder state, “recovery and person-centered care are two tightly linked concepts” (2004, p. 17).

Similarly, interviews with mental health service users have explicitly identified more client-centered services—ones that are flexible to individuals’ specific needs and environments *and* which promote client choice and engagement in decision-making—as core features of services that would help them increase their own level of community integration and recovery (Lester, Tritter, & Sorohan, 2005; Pinfold, 2000).

Despite these important calls and theoretical arguments made for the role of individualized and client-centered mental health care in promoting clients’ independence and integration into community settings, little empirical research has explicitly explored this connection. Below, an argument is made for defining and linking specific components of client-centered care with the potential for more effectively promoting mental health clients’ recovery and community participation.

Aubry and O’Hagan’s (2014) compilation of surveys with key stakeholder groups (e.g., consumers, providers, other experts) identified a number of key elements of recovery-promoting care which aligned with core components of client-centered care described above: (a) the centrality of the client-provider relationship, (b) open information-sharing and shared decision-making, (c) viewing clients as whole people with diverse interests, abilities, and as separate from their symptoms, and (d) individualizing care to the unique needs and capacities of each client (Aubry & O’Hagan, 2014). These specific components of client-centered care are discussed below as they relate to recovery-oriented client outcomes.

Client-case manager relationship. First, client-centered care dictates that clients and their providers must have trusting, open relationships which support collaborative and respectful work. Rose (1992b) made an impassioned argument for collaborative, relationship-based care specific to case management, linking it with case managers' underlying values systems. Using Paulo Freire's (1968) framework of empowerment outlined in *Pedagogy of the Oppressed*, Rose questioned how much of case management practices reflect views of clients as "objects that are known and acted upon" or as "subjects that know and act" (Rose, 1992b). Although many case management models claim values of client empowerment, Rose argued for defining empowering practices as those which engage clients as capable partners with their own goals, values, and contributions—those which are "client-driven" (Rose, 1992b, p. 2). He contrasted these models to case management practices that are "funder-driven" or "provider-driven," which view clients more as "objects" that are known through diagnostic categories and acted upon through enforced compliance to treatment plans (Rose, 1992b). For Rose, the defining characteristic of client-centered care was the extent to which providers are willing to be genuinely collaborative through seeking out their clients' preferences, values, and knowledge of their own experiences.

This relational component of client-centered care, sometimes called the working alliance or therapeutic alliance, has been found to be a particularly important predictor of client outcomes in both therapy and case management services (Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003; Neale & Rosenheck, 1995; Solomon, Draine, & Delaney, 1995). In fact, the client-case manager relationship has been central to case

management theory and practice since its inception (Hollis, 1972; Perlman, 1979). The empirical evidence supporting the importance of the client-case manager relationship in promoting symptom reduction and treatment engagement is generally positive, showing moderate but consistent effects (Priebe & Gruyter, 1993; Howgego et al., 2003). Furthermore, there is also preliminary support for the value of the case manager relationship in increasing social and community outcomes. Solomon et al. (1995) found that the working alliance in case management predicted client treatment satisfaction and quality of life, prompting the authors to suggest that the working alliance “may be particularly useful in improving clients’ subjective experiences of community living” (Solomon et al., 1995, p. 132). Similarly, Coffey (2003) found that connection in the case management relationship predicted clients’ levels of satisfaction with their social lives nine months later.

Shared decision-making. Another a core element of client-centered care is share decision-making between the provider and service recipient, which necessarily takes place within the context of a provider-client relationship described above. This process often involves the provider working to find “common ground” with the client in coming to a shared understanding of the problem and identifying a mutually-acceptable treatment plan (Stewart et al., 2000). It also involves allowing clients to voice their concerns and interests when setting treatment goals and deciding who will be involved in their care (Center for Medicare and Medicaid Services, 2014; Corrigan, 2002). Both the client’s freedom to make health decisions and the client’s perceptions of being heard and valued by medical providers are associated with positive outcomes for mental

health clients and for those with chronic illnesses (Adams & Drake, 2006; Greenfield, Kaplan, & Ware, 1985; Kisthardt, Harris, & Bergman, 1993).

Holistic approach to care. As described above, a key component of client-centered care is viewing clients as “whole people” with concerns, values, and priorities beyond their medical conditions. This element is inherently and critically connected with promoting clients’ community integration simply through increasing the likelihood that providers would view clients’ community lives as an important part of their recovery and a prioritized topic in case management appointments.

Individualized care. The extent to which care is tailored to the needs and preferences of each individual client has been a central component of client-centered care since very early conceptualizations of these models. King, Raynes, and Tizard (1971) developed a framework for defining residential settings as more “resident-oriented” or “institution-oriented” (McCormick, Balla, & Zigler, 1975). They claimed that more resident-oriented practices prioritized clients’ unique needs and preferences in treatment decisions and staff interactions. In contrast, institution-oriented settings were defined as having more rigid schedules, “blocking” clients together for treatment activities, and showing more depersonalization and social distance in staff-client interactions (Goffman, 1961; McCormick et al., 1975). Within this framework, more flexible, resident-oriented practices were found to predict greater client community integration and participation for individuals living in residential psychiatric treatment facilities (Kruzich, 1985).

Relevance to present study. The present study aimed to build upon the calls for client-centered care made by consumers and other stakeholders in exploring the link between elements of client-centered care and client community integration within case management services. It is thought that more client-centered case management services are likely to promote community integration simply because they are guided by clients' holistic values, priorities, concerns, and abilities rather than by systems. Therefore there appears to be a clear conceptual link between case management practices being client-centered and increased client community integration; however, this particular relationship has yet to be explored empirically.

Client functioning level. Another component of the present study's holistic approach to understanding the work of case managers involved considering how the functioning level of clients may impact case managers' roles in promoting community participation. It is possible that the effectiveness of certain case manager practices may vary according to client characteristics like functioning level (Munetz & Frese, 2001). For instance, Adams and Drake (2006) noted that, when asked, not all clients expressed equal preference for shared decision-making with their health care providers. Some clients may prefer to abdicate that responsibility to those who have more professional knowledge and experience; others may want to avoid feeling disappointed if their decisions do not lead to improvements (Adams & Drake, 2006).

Furthermore, Moos and colleagues' research found that higher-functioning clients were more successful in environments with higher expectations for their behavior and when they were given more choice and control in their lives (Moos, King,

Burnett, & Andrassy, 1997; Moos & Lemke, 1994). Conversely, individuals identified as lower-functioning tended to be more engaged in residential programs that were more *structured* in their activities (Moos & Lemke, 1994; Moos et al., 1997). Moos and Lemke suggested this interaction effect could be found because “more competent individuals are likely to be activated by increased opportunities for personal control, whereas personal control policies may be less salient for impaired individuals who are likely to lack the personal resources to take full advantage of such personal control opportunities” (Moos & Lemke, 1994, p. 172).

Specific to case management services, Coffey (2003) found a negative relationship between *autonomy* in the case manager-client relationship and clients’ satisfaction with their social lives, suggesting a more “directive” approach to case management might work better for clients under certain circumstances (p. 33). These findings contribute important nuance to the discussion of case management services and client outcomes and argue for a consideration of person-environment fit over a universal approach to services.

Relevant to present study. Therefore, a critical element to understanding effective case management practices is searching for patterns in how clients of different functioning levels described their experiences with case managers. In the present study, clients’ functioning levels were defined in two ways to allow for consideration of these relationships from multiple perspectives: (a) case manager perspective—as described below, clients were purposively sampled to represent a range of functioning levels as defined by their case managers and (b) client perspective—clients’ community

integration levels were used as a proxy for functioning level in some analyses, particularly because community integration scores took into account indicators of household, social, and vocational functioning.

Summary of conceptual framework. In sum, the present investigation applied findings from literature on community mental health case management to a recovery framework calling for an incorporation of client community integration concerns into services. In particular, recent literature calls for recovery-oriented case management to take a client-centered approach in considering clients as whole people with important interests and needs beyond mental health. Research also suggests that an important element of services is tailoring them to clients' functioning level, needs, and preferences.

In response, the present investigation explored how clients and case managers perceived and described case management services in relation to recovery and community integration. Specifically, the study aimed to describe how case managers can address issues of community integration in recovery-oriented ways, even in settings that do not explicitly implement recovery-oriented models of case management. With this goal, this study explored: (a) how case managers and clients viewed case managers' roles in promoting client recovery and community participation, (b) examples of when clients and case managers perceived issues of community life being addressed in case management services, (c) associations between case manager practices and client outcomes, and (d) potential differences in these patterns based on clients' functioning levels.

Methodological Approach

Naturalistic study of practice. The present study primarily used a paradigm of naturalistic inquiry to describe case managers' existing practice (Lincoln & Guba, 1985). Naturalistic inquiry is defined by two key characteristics: "first, no manipulation on the part of the inquirer is implied, and, second, the inquirer imposes no a priori units on the outcome" (Lincoln & Guba, 1985, p. 8). Within the umbrella of naturalistic inquiry, the present study took a qualitative descriptive methodological approach in attempting to "study something in its natural state" combined with a grounded theory approach aimed at building theory based on those observations (Lincoln & Guba, 1985; Sandelowski, 2000, p. 337). This method allowed the researcher to primarily *describe* participant's experiences and perspectives while also beginning to build hypotheses on the relationships between case manager practices and client outcomes to be further explored in future research. A naturalistic inquiry approach had several key advantages for this specific type of applied research: (a) it did not rely on the challenging process of implementing a new practice, (b) it took a strengths-based approach to identifying naturally-developed effective practices, and (c) it was able to help identify promising components of case management practice across or at the intersections of multiple evidence-based models. Each of these advantages will be further discussed below.

First, there is a significant research-to-practice gap within community mental health which has limited the extent to which recovery-oriented services are broadly and successfully implemented, including evidence-based models of case management (Farkas, Gagne, Anthony, & Chamberlin, 2005; Piat & Polvere, 2014). Among other

barriers, implementation efforts often face resistance from service providers who feel recovery-oriented programs would require too many resources to implement or would raise the level of client risk beyond their comfort levels (Davidson et al., 2006; Tickle et al., 2012). This research-to-practice gap is far from unique to recovery-oriented mental health service systems—it has been identified as a “major concern for scientists, practitioners, and funders” across social issues (Wandersman, 2003, p. 228).

In response to this implementation dilemma, researchers have argued for a strengths-based focus on “indigenous programs,” or those originating in community-based settings, where issues of capacity and values are inherently attended to (Miller & Shinn, 2005; Orford, 2008). In doing so, “social scientists can learn from the ‘ordinary knowledge, skill, and craft’ of front-line service providers (Elmore, 1983) who understand the community contexts within which their interventions take place, and often develop innovative approaches that work” (Miller & Shinn, 2005, p. 176). Research efforts aimed at identifying and expanding effective practices within existing structures like public mental health systems also have the potential to impact the large number of people already engaged in those settings, rather than the relatively limited scope of “boutique” programs originating from research facilities (Miller & Shinn, 2005, p. 175). Following Miller and Shinn’s (2005) suggestions, the present study used a naturalistic approach to identify elements of existing case management practice that were already aligned with recovery principles and that were more strongly linked with client community integration.

Finally, efforts to describe real-world practice are not constrained by the “model mentality” of evidence-based practice (EBP) that often creates relatively arbitrary boundaries between EBP models (Rapp, 1998, p. 365). Some researchers have instead argued for an approach targeting the “core elements or active ingredients” of interventions, including those shared across multiple evidence-based models of case management (Miller & Shinn, 2005, p. 177; Rapp, 1998). Other limitations of traditional randomized control trials are the blurred boundary between “intervention” and “control” groups that may be unaccounted for (Hall & Hord, 2006) and providers’ tendencies to draw skills from multiple evidence-based practices simultaneously to address complex client issues (Orford, 2008). That is, in real-world practice, many service providers inadvertently use skills that may be part of one or multiple EBP models without explicitly implementing those full models or any one model exclusively (Hall & Hord, 2006; Orford, 2008).

By taking an open-ended approach to studying characteristics of providers’ practice rather than a specific treatment model, the present study was able to contribute to the theory around elements of recovery-oriented case management practice, beyond the constraints of any one specific model. Ultimately, identifying these effective components of real-world practice can lead to grounded models of case management care that could potentially be translated more effectively into other community practice settings.

Mixed methods approach. The present study also used a mixed methods design by merging complementary qualitative and quantitative data to gain a fuller

understanding of the phenomena at hand. The mixed method approach was considered valuable for answering the present study's specific research questions because of its ability to capitalize on the strengths of both the exploratory nature of qualitative research to better understand this topic which has very limited previous research and the generalizability of the quantitatively validated outcome constructs of interest, namely recovery attitudes and clients' community integration experiences. In line with this aim, mixed method analyses focused specifically on linking participants' qualitative responses (e.g., priorities in case management) with quantitative outcome measures (e.g., client community integration), as well as using quantitatively defined participant characteristics (e.g., client community integration) to further explore patterns in qualitative responses (e.g., descriptions of topics discussed in appointments). As such, data analyses aligned with the data transformation model put forth by Creswell and Plano Clark (2007) in that the researcher transformed qualitative responses into categories for quantitative comparisons and vice versa, as dictated by the research questions. Specifics of these mixed methods analysis procedures used by the present study are explained below in the Research Design and Data Analysis Procedures sections.

Research Aims and Questions

The focus of this study was defined as exploring the *intersection* of case management services and clients' community experiences. Importantly, the present study acknowledged that there are many factors involved in case management beyond promoting clients' community integration and many factors in clients' lives that impact

community participation beyond case management services. However, the present study intentionally limited itself to the intersection of these experiences and aimed to gather client and case manager perspectives on the questions, *“Does case management play a meaningful role in promoting clients’ community integration?”* and, *“If so, what does that look like in practice?”* The descriptive component of this study was important because there is a lack of research about the current attitudes and practices of case managers and their clients’ experiences of services, especially outside of specific evidence-based programs.

Following from the literature reviewed above, the present investigation described and compared: (a) how case managers and clients perceived the role of case management services in promoting clients’ opportunities for community participation, (b) client- and case manager-reports of specific examples of case managers facilitating or hindering such community participation for clients, (c) whether the way case managers perceived their work was related to differences in their clients’ community integration outcomes, and (d) how participants’ perceptions and descriptions of case management experiences varied by other demographic and personal characteristics, such as one’s endorsement of recovery values or clients’ functioning levels. Particular emphasis in analyses was placed on describing and comparing clusters of similar perspectives and reported practices across participants, as well as using mixed method approaches to link qualitatively reported practices with quantitative measures of participants’ recovery attitudes and clients’ reported community integration experiences.

These overarching research goals were defined in the following research aims:

AIM 1: To describe case managers' and clients' perceptions of the scope, boundaries, barriers, and priorities involved in case management services within a community mental health center. Describing such components of practice was intended to reveal similarities, variability, and clustering in participants' perspectives on case management.

- Qualitative Research Question 1A: In what ways did case managers describe their priorities and core activities in case management practice?
- Qualitative Research Question 1B: How did case managers perceive their roles in promoting participation in community life for their clients, under both ideal and actual circumstances? What were their perceived barriers to fulfilling these ideal roles in practice?
- Qualitative Research Question 1C: In what ways did clients describe their experiences of issues that were typically prioritized and actions that were typically taken in case management?
- Qualitative Research Question 1D: How did clients perceive their case managers' roles in promoting their involvement in community life, under both ideal and actual circumstances?

AIM 2: To describe instances of actions case managers took related to clients' community integration and to compare these efforts when they were defined as successful or unsuccessful. These questions were posed to better understand the specific ways in which case managers facilitated or hindered community integration for clients, as well as when and how clients drew on case managers as resources for

enhancing such community experiences. Essentially, these questions were expected to help operationalize what this connection might “look like” within a case manager-client interaction. Comparisons of extreme examples of “successful” or “unsuccessful” instances were aimed at identifying the circumstances under which case management might be particularly adept at assisting clients with issues of community life and when case managers might face more barriers in addressing these issues.

- Qualitative Research Question 2A: In what ways did case managers describe themselves as addressing issues of community life with clients, and how did these compare with client reports?
- Qualitative Research Question 2B: In what ways did clients describe their case managers facilitating or hindering their integration into community life, and how did these compare with case manager reports?
- Qualitative Research Question 2C: For which kinds of issues did case managers tend to be viewed as “successful” or “ineffective” at addressing with clients? What barriers did participants identify for instances when case managers were viewed as ineffective?

AIM 3: To explore relationships between case managers’ descriptions of their case management practices and their clients’ experiences of community integration. The purpose of these analyses was to explore whether it is possible that case managers’ approaches to their work might ultimately be associated with differences in clients’ community experiences.

- Mixed Method Question 3A: How did average client community integration outcomes vary across case managers who described their *overall priorities* in case management differently?
- Mixed Method Question 3B: How did average client community integration outcomes vary across case managers who described their *roles in promoting community life* for clients differently?

AIM 4: To explore whether participants' descriptions of case managers addressing issues of community life varied based on other personal characteristics. Questions related to this aim sought to identify qualifiers of these relationships, or elements of individuals' experiences which may have changed the ways they described the relationships between case management practice and clients' community integration.

- Mixed Method Question 4A: How did case managers' descriptions of their services vary by the number of years they had been practicing in the mental health field?
- Mixed Method Question 4B: How did case managers' descriptions of their services vary by their level of endorsement of recovery principles?
- Mixed Method Question 4C: How did clients reporting varying levels of community integration differ in the ways they described addressing issues of community life in case management?

CHAPTER 2

METHOD

Research Design

The present research study used a cross-sectional research design with qualitative and limited quantitative interview data to explore these research questions in greater depth than has been previously done. These design elements are further explored below.

Mixed method design. The present study employed a concurrent triangulation mixed method design, which used “‘different but complementary data on the same topic’ to best understand the research problem” (Creswell & Plano Clark, 2007, p. 62). This “QUAL + quant” design, as defined by Creswell and Plano Clark (2007), emphasized qualitative exploration of research questions (Aims 1 and 2) and employed a mixed method data transformation model to explore Research Aims 3 and 4, as further described below and detailed in the Data Analysis Procedures section.

The present study first conducted qualitative analyses in order to address Research Aims 1 and 2: describing and comparing participants’ perceptions of the roles of case managers and their specific experiences with such services. These qualitative analyses were aimed at providing an in-depth understanding of these case manager-

client dynamics and how they impacted clients' experiences. It was believed that, especially due to the lack of previous research on these particular relationships and outcomes within case management services, the open-ended and exploratory approach of qualitative analysis was needed to shed light on these processes. Although the conceptual framework presented above guided the research questions, the researcher aimed to have few a priori assumptions of these phenomena in order to allow for an emergence of findings directly from participant responses, in line with the naturalistic inquiry paradigm (Lincoln & Guba, 1985).

Second, the present study merged quantitative and qualitative data for mixed method analyses using a data transformation model (Creswell & Plano Clark, 2007) to address Research Aims 3 and 4. As described in more detail in the Data Analysis Procedures section, these analyses involved qualitative responses being used to categorize participants for quantitative outcome comparisons and vice versa, depending on the specific research questions outlined in the Research Aims. In combining qualitative exploration with these quantitative variables, the present study had the advantage of being able compare and find patterns within qualitative findings using quantitative data.

Cross-sectional design. Data were collected from all participants at one time point. Although the cross-sectional nature of this design was a limitation in exploring the development of these phenomena over time, it allowed for a "snapshot" of the perspectives of case managers and clients on these issues and helped identify relationships that can later be tested in quantitative or longitudinal designs.

Research Participants

Data collection site. Participants were recruited from one section of an adult outpatient clinic within a public community mental health center. This center was one of 17 mental health centers within a statewide public mental health system in the Southeastern United States. The clinic was the largest outpatient treatment program within this community mental health center system, offering psychiatric medication and nursing services, individual and group therapy, and case management services to close to 1500 individuals in the fiscal year during which data were collected (South Carolina Department of Mental Health, personal communication, April 14, 2016). This adult outpatient clinic was distinct from other “intensive and specialty programs” within the same system which served clients in need of higher levels of outpatient care (e.g., more frequent appointments; SCDMH, 2013). Data were collected only from this one site in order to facilitate the in-depth investigation of case manager relationships needed to answer this study’s exploratory research questions, rather than collecting data for comparison across sites.

The physical layout of this clinic included a lobby area which seated approximately 30 individuals with a mix of chairs and couches. Administrative staff sat behind a large pane of glass in the far corner of the lobby and a small staffed medication closet was located in another corner. Staff offices were located along three locked wings which branched off of the lobby. Staff and client interactions outside of appointments were generally friendly but brief. The clinic operated during normal business hours.

The recent fiscal context of this system was relevant at the time of data collection because it impacted the capacity of the system to hire new staff, the roles that case managers played, and the other supports available to clients to support community integration. Between 2009 and 2012, the state Department of Mental Health endured a budget cut of over 40%, which put the state-wide funding at the same levels as 1987 (SCDMH, 2014). Even as funding increased in the years since 2012, the majority of the funds being restored were through non-recurring funding mechanisms from the state legislature (SCDMH, 2014). This limited the extent to which restored funds could be used for relatively long-term expenses such as new programming or staff hiring. Since this time, however, recurring state appropriations have continued to increase, with the state appropriations estimating between \$175-200 million for the fiscal year during which data were collected (SCDMH, 2016).

Researcher positionality. It should be noted that the principle investigator and sole data collector in this study had been involved in this clinic through various projects and externship experiences throughout her graduate training. She conducted research interviews with clients as part of a larger research study from 2010 to 2012. She had also collaborated with clients and some staff from this clinic (along with other local agencies) on creating a resource guide for promoting client community integration, which involved meeting periodically between 2012 and 2014. Over the course of these projects, the primary researcher developed a professional relationship with the director of this clinic which involved occasional meetings for professional development and allowed her to seek out other training opportunities within this setting.

Most notably, the primary researcher interned four hours per week at this clinic providing individual therapy services to a small caseload of clients for approximately one year before data collection began. During this time, she had regular contact with her clinical supervisor (who was not a case manager) and the administrative staff as well as occasional contact with some of her clients' other providers, including psychiatrists, case managers, and psychiatric nurses. This connection facilitated site entry, participant recruitment, and data collection; potential bias in the data collection process due to this contact was considered but was generally thought to be minor because her contact with most case managers before beginning the present study was minimal. Any former therapy clients were not eligible to be invited to participate in the study; to the best of her knowledge, the researcher did not have prior contact with any of the study's client participants before the interviews.

Personal characteristics of the primary researcher should also be made explicit so that their impact on the research process can be considered. As a White female graduate student in her late-twenties, the principle investigator was younger and privileged by both race and education status when compared to most of the research participants. She was also relatively early in her clinical training (3 years of therapy practicum courses) and had not yet worked as a full-time clinician or case manager, though she had completed two external clinical practicums in community mental health settings. Her exposure to recovery principles was more theoretical than practice-based, which may have impacted how she was perceived by research participants as well as her approach to conducting interviews and analyses. This position of academic privilege is

acknowledged as both an asset which provided the researcher with a relative sense of objectivity and curiosity throughout the research process, as well as a liability by creating a potential for misunderstanding pieces of participants' experiences.

Mental health center case managers. There were seven active case managers within this section of the mental health center at the time of data collection. Not all clients at the site were enrolled in case management services. Case managers typically had caseloads around 80-120 clients, with 15-20 new clients being added to the system each month. Clients were usually identified as needing case management services during the centralized intake process and were assigned to case managers based on provider availability and equal distribution of assignment.

Case managers' official job titles were Human Services Coordinators; however they were almost exclusively referred to as "case managers" by themselves, other staff, and clients. Case managers were required by the agency to have Master's level degrees from counseling or social sciences. Case manager services involved assessing client needs, setting treatment goals, creating and regularly updating client treatment plans as stipulated by insurance billing requirements, and connecting clients with needed services within and beyond the mental health system. Case managers also provided direct clinical services as needed, including leading group therapy sessions or meeting with clients' family members to address issues or build home support.

It should be noted that these case management services were distinct from another program implemented by Medicaid within the past several years called Targeted Case Management. This service was designed to be time-limited and

adjunctive to “direct services” such as the Human Services Coordinator role (SCDHHS, 2015). Targeted Case Management aimed to assist clients with their connection to other social service systems and formal resources; in practice, these providers often helped with some of the more routine aspects of resource connection such as filling out applications for federal benefits programs.

Mental health center clients. Clients within the community mental health system represented a range of ages, racial and ethnic groups, and diagnoses (clinic demographics presented in Results section, Table 3.1). Typically, clients experienced higher levels of impairment, often qualifying for Social Security Disability services and federal health care coverage. Although not exclusively representative, clients within public mental health systems generally have lower levels of financial resources and education and are more likely to be male and African American compared with those accessing mental health care in the private sector (Swartz et al., 1998).

Interview Protocols

Case manager interviews. As shown in Appendix A, case manager interviews were largely comprised of demographic questions and a series of open-ended interview questions. This semi-structured case manager interview explored their perspectives on the primary roles of case managers (both ideal and actual) and any barriers they had experienced to incorporating community-related issues more into their work. Questions also gathered descriptions of actions case managers took in facilitating and, at times, discouraging their clients’ involvement in certain elements of community life and the circumstances under which case managers felt that these efforts were more or less

effective. Case managers were also asked to rate the extent to which various life domains were relevant to case management services generally and to fill out a brief written questionnaire of their endorsement of certain recovery principles (see Quantitative Measures section below for details).

Client interviews. As shown in Appendix B, client interviews included demographic questions of themselves and their service use, followed by a quantitative measure of their community integration and the same set of questions given to case managers which asked clients to rate the extent to which various life domains were relevant to case management services generally (see Quantitative Measures section). Semi-structured interview questions explored clients' perceptions of their case managers' priorities in their appointments and their perspectives on the ideal and actual roles that case management services played in facilitating their community integration. Interview questions also asked clients to describe details of their experiences with case managers related to participation in community life, again focusing on instances of case managers promoting or discouraging such participation and the circumstances under which such efforts were viewed as successful or ineffective. Interviews concluded with the same quantitative measure of recovery attitudes administered to case managers.

Quantitative measures. Three quantitative measures were used to allow for comparisons of client outcomes across qualitatively created categories (Aim 3) and to create categories for further qualitative analysis by demographic characteristics, perceived scope of case management services, recovery attitudes, and clients' level of

community integration (Aim 4). Below is a summary of each quantitative measure used in the present study along with a rationale for its selection and psychometric support.

Scope of case management services. A set of questions created for the present study were included in both case manager and client interviews in order to assess participants' perceptions of the scope of case management services in a systematic and comparable way. Participants were asked to rate the extent to which they believed that various life domains were relevant to case management services *in general* (i.e., not necessarily specific to clients' own work with their case managers). Response options were on a scale of 0-2, with 0 representing "irrelevant," 1 being "mixed/sometimes relevant," and 2 meaning "relevant." Each item was rated independently of the others (i.e., *not* rank-ordered). The ten life domains included were selected to represent issues typically associated with mental health services as well as issues related more to community life (e.g., relationships, recreation/leisure). Total scores were calculated by averaging item responses and also ranged from 0 to 2; higher scores represented a broader scope of case management services (i.e., more domains were rated as more relevant).

Recovery orientation. The Recovery Assessment Questionnaire (RAQ) was selected to measure both provider and client alignment with a recovery orientation of mental illness (Borkin et al., 2000). This seven-item questionnaire asked participants to rate their level of agreement with several claims of recovery which were asserted by Anthony (1993) and have since been upheld as tenets of the recovery movement (e.g., "*People in recovery sometimes have setbacks*" and "*All people with serious mental illness*").

can strive for recovery”). This recovery orientation is thought to be orthogonal to beliefs about the origins of mental illness (e.g., psychosocial, medical; Anthony, 1993). Responses are given on a scale of 1 (“Strongly Disagree”) to 5 (“Strongly Agree”) and total scores were calculated by averaging item responses, with higher scores indicating greater alignment with a recovery orientation.

This measure was selected for its brevity and because it can be administered to both service providers and clients, allowing for their responses to be validly compared (Borkin et al., 2000). It has demonstrated an adequate level of internal consistency (Cronbach $\alpha = .70$) and validity as shown in moderate, positive correlations ($r=.20$) between clients’ RAQ scores and the length of time they perceived themselves as being “in recovery” (Borkin et al., 2000). Therefore, this scale was thought to be a valid way to assess the extent to which providers’ beliefs about recovery were associated with clients’ own beliefs about their personal recovery journeys.

Client community integration. The Community Integration Questionnaire (CIQ) was selected to measure three factors of individuals’ participation in activities related to their household, productive activity, and leisure and social activities (Sander et al., 1999). This measure corresponded with the notion of community integration as “somewhere to live, something to do, and someone to love” (Fraser as quoted by Dunn, 1999). It was originally developed on a population of individuals with traumatic brain injury (TBI) but has been used in studies of those with psychiatric disabilities (Baumgartner & Burns, 2013), due to the similarities in community experiences between these two populations. It has demonstrated validity through significant negative

correlations with measures of disability and impairment and has a validated three-factor structure that is “clinically and theoretically meaningful” (Sander et al., 1999, p. 1308).

Items covered topics including: (a) who generally handles household chores and activities of daily living (e.g., grocery shopping), (b) the frequency of the participant’s involvement in leisure, social, and productive activities (e.g., work, school, volunteering), and (c) the individual’s social involvement with friends with mental illness, friends without mental illness, and family members. This last distinction was supported by research defining differences between individuals with disabilities participating in segregated settings meant exclusively for individuals with disabilities and integrated settings with individuals with and without disabilities (Minnes et al., 2001).

Response options across the 13 items varied, with most responses being associated with 0-, 1-, and 2-point scoring options. For instance, the item *“Who shops for groceries and other necessities in your household?”* had three response options: someone else, yourself and someone else, yourself alone (corresponding with 0-, 1-, and 2-points for scoring, respectively). By contrast, the question *“When you participate in leisure activities, do you usually do this alone or with others?”* had different options: Mostly alone, Mostly with friends who have mental illness OR mostly with family members, Mostly with friends without mental illness OR with a combination of family and friends (again corresponding with 0-, 1-, and 2-points). Scores were summed based on points associated with each response and according to an algorithm for the Productive Activity Scale for a total score on a continuum from 0 to 25 (Sander et al., 1999).

Procedures

The principle investigator worked closely with agency staff from the community mental health center to design recruitment methods which prioritized both respecting clients' confidentiality and using appropriate sampling procedures. The study was approved by Institutional Review Boards through the University of South Carolina and South Carolina Department of Mental Health before beginning recruitment. Data collection occurred between March and June 2015.

Mental health center case manager interviews. All seven case managers within one section of the clinic were invited to participate in a 45-60 minute in-person interview with the principle investigator. Case managers were recruited using agency staff and in-person contacts; monetary incentives for case managers were not permitted due to interviews occurring at the mental health center during normal business hours. Of the seven case managers invited to participate, one declined and the other six were interviewed. Interviews were conducted in case managers' private offices. Informed consent was obtained from all participants before beginning and audio recording the research interview.

Mental health center client interviews. Clients were selected from each case manager's caseload based on purposive sampling from the pool of clients who had been meeting with that case manager for at least three months and had upcoming mental health appointments in the next two months. One case manager was newly hired and had not been working with most of her clients for at least three months by the time of data collection; therefore no clients from her caseload were recruited for interviews.

Purposive sampling was stratified by client functioning level, which allowed for a range of client experiences and perspectives to be represented in this study, in line with previous literature suggesting potential differences in clients' needs across functioning levels. At the end of their interviews, case managers were asked to identify two of their clients they viewed as doing well ("high functioning"), four clients who were doing well in some areas but were struggling in other domains ("mid-functioning"), and two clients who seemed to be currently struggling with their overall functioning ("low functioning"). It should be noted that the researcher intentionally provided case managers with a broad definition of each functioning level in order to allow for flexibility in how case managers defined functioning for their clients. Twice as many clients were "nominated" in each category than were ultimately interviewed (four total per case manager) in order to plan for clients who were not interested in participating in the study or who could not be reached; on several occasions, case managers elected to nominate more clients than were requested.

Clients were randomly selected from these lists (using a random numbers table) to be invited to participate through a letter given to them by their case managers at their next regularly scheduled appointment. In cases when case management appointments were infrequent or had recently passed, the case manager was asked to contact the client by phone to invite him or her to participate. Other "back-up" nominated clients were invited if the first clients were not interested in participating or were unable to be reached.

This process was developed in collaboration with a lead case manager at the site in order to fit the procedural norms and structure of the setting. In most cases, clients were able to be successfully recruited through this procedure. In two cases when all nominated clients were unable to be interviewed (i.e., declined, unable to be reached, no upcoming appointments), case managers were asked to nominate additional clients within the target functioning category.

When contacted about the study, clients had opportunities to ask their case managers questions about participation and, if interested, were asked to do one of the following: (a) provide contact information and consent to be contacted by the researcher to arrange an interview time, (b) agree to the interview after that day's appointment, if interviewer was available (most common), or (c) arrange with the case manager to meet with the interviewer before or after their next appointment. To facilitate the interview process, the principle researcher made every effort to be available for interviews before or after clients' appointments, if clients expressed interest and availability in participating that day. However, case managers always made the first contact with clients and clients only had contact with the researcher after agreeing to do so. Participants who provided the researcher with contact information were contacted by phone by the researcher to schedule an interview, usually before or after their next mental health center appointment. Client participants were offered a \$10 incentive to conduct a 30-40 minute interview with the researcher. Clients continued to be recruited until interviews from each client functioning category (1 high

functioning, 1 low functioning, 2 mid-functioning) had been completed from each participating case manager's caseload.

Of the 48 clients nominated by case managers, 35 were randomly selected to be invited to the study. One of these clients was disqualified due to previous contact with the principle researcher through a previous mental health center project. Nine clients were never invited to the study because they were not able to be reached by phone by their case managers and did not show up to their case manager appointments during the data collection period. Three clients were invited to the study and expressed interest but then were unable to be reached to schedule an interview appointment. Two clients declined participation and the remaining 20 clients consented to the study and completed the interview.

Participants were interviewed in a private office at the community mental health center. Informed consent was obtained from all participants before beginning and audio recording the research interview. Client participants were required to give at least four correct responses on a five-item multiple choice "quiz" about the informed consent process (e.g., *"Is this study voluntary?"*) before being allowed to consent to the study. One client was unable to complete this quiz correctly on the first trial, but was offered a second interview opportunity within two weeks and passed it at the second appointment. The semi-structured research interview was conducted by the principle investigator, along with the administration of quantitative measures of clients' attitudes toward recovery and their community integration experiences.

Data Analysis Procedures

Qualitative analyses. Qualitative descriptive analyses were used to explore Research Aims 1 and 2; all analyses were conducted solely by the primary investigator of the present study in consultation with research advisors. First, responses to qualitative interview questions were transcribed by the principle investigator regularly throughout the data collection process and analyzed using qualitative data analysis software (NVivo 10). A modified grounded theory approach was used: analyses were informed by both research questions and an openness to emerging themes from the data (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Case manager interviews were each coded separately, then important emergent themes were identified. All interviews were then reviewed and re-coded to ensure consistent coding of themes across case manager interviews.

For client interviews, due to the larger number of interviews, an analysis procedure outlined by Kloos et al. (2005) was followed. First, central themes were identified by systematically reading a subset of five randomly selected client interview transcripts and open-coding them for emergent themes within each interview (Strauss & Corbin, 1990). Thematic diagrams were created separately for each interview to outline and organize the concepts identified within each interview. These diagrams were then aggregated into one diagram, with priority given to issues that were present across interviews (see Appendix C). A list of codes and definitions were then created based on this unified diagram which guided targeted coding of all 20 interviews using NVivo 10 (Kloos et al., 2005). Following the first round of coding, themes which emerged

part-way through this coding round were identified, conceptually similar codes were modified to be more conceptually distinct, and unusual patterns of coding were identified (e.g., more frequent coding of nodes in earlier vs. later interviews). A second round of coding was conducted aimed at addressing these issues: recoding similar concepts based on new definitions, coding emergent themes across all interviews, and checking for instances of missed coding (Berg, 2008; Kloos et al., 2005).

A secondary level of coding was also conducted based on emerging research questions, such as whether instances of clients participating in their communities involved “central,” “supportive,” or “no” case manager actions. These secondary nodes were only applied within previously coded groups of nodes rather than to the original interview transcripts. Following the coding and validity checks detailed below, clusters of similar responses across participants were identified and relationships across themes were explored, in line with the research questions identified in Aims 1 and 2 (Strauss & Corbin, 1990).

Validity checks. Qualitative research validity checks were conducted in order to build confidence in the researcher’s findings.

Data auditing and construct check. Each coding node was audited to ensure that coding patterns aligned with expectations. This process involved identifying codes or interviews for which there were fewer coding than expected. Any discrepancies found in this data auditing process were re-examined to explain the lack of coding or to identify any missed content. Broad keyword searches using NVivo10 software were also used to

confirm that the absence of codes represented a true absence of relevant content (Miles, Huberman, & Saldaña, 2013).

A construct check was also conducted in which each node was reviewed to ensure that all coded instances were internally consistent and externally distinct from other codes (Kloos et al., 2005). Conceptually similar or ambiguous nodes were redefined by the researcher and recoded to reflect these refined concepts. One example of conceptually ambiguous nodes were activities case managers *typically* do in their services (i.e., general roles) versus specific instances of actions taken by case managers (i.e., specific experiences). In this case, the context of the interviews were considered in coding decisions about whether the activity being described was more representative of a typical, general pattern or a specific experience.

Drawing conclusions. Intentional efforts were made to present data in the Results section as objectively as possible in order to promote transparency and build confidence in the conclusions drawn in the present study. When possible, all clusters of participant perspectives were presented alongside the number of participants endorsing that perspective (see below for reporting conventions). This was usually possible when findings were more descriptive, such as the number of people describing various case manager actions or the clusters of ways clients defined their case managers' roles in their lives.

For more inferential findings, such as whether a certain group (e.g., clients with high community integration scores) was more or less likely to describe certain types of case manager actions (e.g., central vs. supportive), two steps were taken to increase

confidence in the findings. First, when possible, data were presented directly, either incorporated in the text or in tables, to allow the reader to determine whether the data represented a strong enough pattern to support the claims being made. Second, the researcher searched for disconfirming evidence within these patterns as well as for supportive evidence (Miles et al., 2013). That is, for each claim, data tables were examined with an eye for disproving the claim, asking “Could one argue that there is no pattern or an opposite pattern, given these same coding frequencies across these categories?” Where the answer to this question was affirmative, the claims were removed or qualified to represent a more balanced perspective.

It should also be noted that statements in the following report are not always intended to extend to every participant in a given category. Rather, most of the patterns described here are intended to be broad, hypothesis-building statements that illuminate general trends of experience. For instance, one case manager whose clients had high *average* community integration scores had one client with a very low CIQ score of 5 (out of 25). For this participant, the case manager’s actions were not associated with higher community integration; however, the present study focused instead on the general trend represented by this case manager’s other clients reporting higher community integration. For this reason, ranges are reported along with most group averages to increase transparency in the data which underlies each conclusion. In cases when a participant’s experience is meaningfully counter to the claims being made, these perspectives are also described. Examples include instances when a client described

case management services interfering with parts of his life and the few clients who identified additional roles they would like to see case managers playing in their lives.

Reporting conventions. In order to increase transparency of data during reporting, a few additional reporting conventions are used. First, every statement is accompanied by the number of participants who endorsed that statement out of the number of total participants in that cluster (e.g., 4/6 case managers or 15/20 clients) or the number of coding instances assigned to a given node, as appropriate. Additionally, each quote is accompanied by (a) the participant number (beginning with CM for case managers, CL for clients), (b) basic demographic information for clients only [race/ethnicity (B=Black, W=White, H=Hispanic), gender (F=female, M=male), age, and functioning level (H-F=high-functioning, M-F=mid-functioning, L-F=low-functioning)], and (c) the line numbers in the interview transcripts where each quotation can be found. These reporting patterns are intended to ensure a breadth of representation of participants and to show direct evidence for each conclusion. Demographic information for case managers was chosen to be excluded in order to better protect the identities of these individuals, given the small number of case manager participants in this study.

Mixed method analyses. Mixed method data analyses used a data transformation model to merge qualitative and quantitative responses in various combinations in order to address the research questions outlined in Aims 3 and 4 (Creswell & Plano Clark, 2007). First, qualitative information of how case managers defined their *priorities* in case management was used to create categories (e.g., priorities limited to mental health vs. encompassing overall well-being) for conducting

comparisons of their clients' community integration outcome scores (Research Question 3A). Similar comparisons of client community integration scores were made based on categories of how case managers perceived their *roles in promoting community integration* specifically, in line with Research Question 3B.

Research questions in Aim 4 were addressed through a similar but opposite process. For Research Question 4A, case managers were grouped by their level of mental health provider experience, then qualitative themes identified in Aims 1 and 2 (e.g., priorities in case management, actions taken) were compared across these groups. Similarly, case managers were grouped by their recovery scores (Research Question 4B) and clients were grouped by their community integration scores (Research Question 4C) for drawing comparisons on their perceptions of the roles of case management and their described experiences related to community integration. For instance, clients who reported high, medium, and low participation in activities on quantitative measures were compared in the ways they described their case managers addressing issues of community life with them (4C).

Second-order analyses. Given the present study's aim to identify elements of current case management practice that aligned with models of recovery-oriented care, a second-order level of analysis was conducted specifically to link primary findings with a theory of recovery (Saldaña, 2015). This process involved identifying any elements of case management practice described in the primary findings which appeared particularly useful for demonstrating alignment or divergence from recovery theory. Elements of practice were drawn from across all case manager and client interviews,

regardless of other categorizations of case managers used in the primary analyses (e.g., broad vs. narrow scope of services). That is, these second-order themes identified specific *practices* that were more or less recovery-oriented rather than characteristics of case managers or their general approaches to care. These descriptions of practice were then connected with specific principles of recovery, outlined by SAMHSA (2012), to demonstrate the ways in which they converge or diverge from this frequently-used framework of mental health recovery.

CHAPTER 3

RESULTS

The following chapter details the findings resulting from the qualitative and mixed method analyses described above. First, a basic description of the demographic characteristics of the sample is provided, separately for case manager and client participants. Then research findings are presented according to the research questions outlined at the end of the Introduction. Each broad research aim and specific research question is provided within the text in order to orient the reader to the original research questions guiding each set of findings. When relevant, points of convergence or divergence across analyses are highlighted in order to facilitate identifying broader patterns and themes across the data. Finally, results of a second-order analysis are presented which link broad themes of case manager practices to a theory of recovery.

Description of Sample

Case managers. Six out of the seven case managers within one section of the mental health clinic were interviewed (see Table 3.1). They were all female and most identified as Black/African American. Ages ranged from 39 to 62 years old, with an average of 50 years; experience in the mental health field ranged from 12 to 33 years, with an average of almost 25 years of experience. All case managers reported having at least a Master's Degree, with one provider reporting having a Doctoral Degree. Caseload

sizes ranged from 57 to 148 clients, with an average around 100 clients assigned to each case manager.

Clients. A total of 20 clients were interviewed; four clients were sampled from each of five case managers' caseloads (clients of one newly-hired case manager were not interviewed). As shown in Table 3.1, demographic characteristics of the sample approximately matched the available demographic characteristics of the client population at this clinic during the time of data collection.

Approximately two-thirds of the clients interviewed were female. Sixty percent self-identified as African American, 30% identified themselves as White, one client identified her ethnicity as Hispanic, and one client identified as another (unspecified) race/ethnicity. Client ages ranged from 29 to 62 years old, with an average of approximately 47 years old. Clients had spent anywhere from less than one year to 44 years as clients in the mental health system, with an average of 18 years in the mental health system. Half of clients reported living with family members in a house or apartment (notably, none reported living with a spouse), 30% lived in a group home setting (including recovery houses), and 20% reported living alone in a house or apartment. Per chart review, clients were evenly split between having primary diagnoses of mood disorders or thought disorders, though many had diagnostic qualifiers which indicated symptoms across diagnostic categories (i.e., mood disorder with psychotic features, schizoaffective disorder).

Given the lack of demographic diversity among case managers, the sample of clients was more diverse in terms of gender and race/ethnicity, specifically showing

more representation of male and White perspectives than was represented in the case manager sample. Case manager and client sample groups were similar in terms of average age and tenure in the mental health system, with case managers averaging slightly older with more mental health experience and clients representing wider ranges of both categories.

Descriptive Statistics. Table 3.2 details the descriptive statistics (mean, median, range) of the quantitative measures used in analyses, divided by case managers and clients. Clients' and case managers' average scores on the measure of scope of case management services were similar; however, clients' responses spanned a significantly wider range than case managers' responses. Scores on the Recovery Assessment Questionnaire revealed that case managers tended to endorse more recovery principles than clients did on average. Client scores on the Community Integration Questionnaire revealed a wide range of responses with the mean and median both falling in the center of the response range.

Research Aim 1 Results

Research Aim 1 was to describe case managers' and clients' perceptions of the scope, boundaries, barriers, and priorities involved in case management services within a community mental health center. A summary of key themes identified within this research aim are provided in Table 3.3.

Question 1A: In what ways did case managers describe their priorities and core activities in case management practice? When asked about their primary goals in working with clients, case manager responses tended to cluster in two core groups: (a)

focused more narrowly on meeting basic needs or mental health stability, and (b) looking more holistically at clients' lives in the community.

Those case managers (2/6) who talked about their top goals as helping clients get their basic needs met focused on housing, food, and health care. Primary activities involved guiding clients to prioritize these needs and linking them to appropriate community resources: *"[My job involves] helping them have balance, making sure the priorities are right. We're looking at housing before we're looking at a car"* (CM03, 9-10). Case managers with a similar perspective (2/6) emphasized the goal of clients becoming stable in their mental health, including improving treatment compliance and reducing symptoms: *"If we can increase compliance and they become more stable, that means that they're less decompensating symptoms, which can include psychosis, hospitalizations, and things of that nature"* (CM05, 10-12). Primary activities for these case managers included helping clients engage in mental health services, take medication, and prove their readiness for higher levels of independence by progressively meeting goals in more structured settings.

A second cluster of case managers (2/6) described their primary goals more broadly as helping clients improve their lives in the community or helping them *"get [their] life back...as full as I can give it back to [them]"* (CM04, 36-38). One case manager described discharge planning from her first meeting with clients in order to decrease reliance on the mental health system and promote clients developing natural supports (e.g., family, friends, neighbors, faith communities). This case manager also had a sign in her office stating, *"Know me as a person, not by my illness"* (field notes, lines 32-33).

Another case manager discussed her efforts to educate clients on the realities of recovery from mental illness and to combat stigmatizing attitudes of mental illness that might prevent clients from asking for services they needed or pursuing life goals: “[I] treat them as a person—not stigmatizing them, but just as another person needing any help” (CM06, 47). She also emphasized the importance of promoting a client’s holistic sense of self and development of activities beyond mental health appointments: “It keeps them in a certain state if [mental health] is all they focus on—just coming here and going there and, you know, going back home and then coming here. It’s more to life than mental health—coming here to the clinic. You know, it’s so much more.” (CM06, 124-126).

Notably, one case manager’s priorities spanned these two groups. Her main priorities were on treatment compliance and stability, but she viewed these goals as serving the larger purpose of promoting clients’ quality of life. She described mental health stability more as a short-term goal in service of the ultimate goal of promoting clients’ well-being, which also included involvement in meaningful activities and community participation.

Question 1B: How did case managers perceive their roles in promoting participation in community life for their clients? Case managers discussed four aspects of their roles in clients’ lives: the *functional* aspects of “what” case managers did to help their clients, the *relational* aspects of their roles in terms of “how” case managers approached their work with clients, the *contextualized* aspects of “where” case management services fit into clients’ lives in relation to other concerns or priorities, and

the *scope* of their roles in clients' lives which determined "when" or "about which issues" case managers would enact these roles. As described below, there was a relative degree of agreement among case managers about the functional aspects of their roles, but they appeared divided on how to approach the relational, contextual, and scope dimensions of their work with clients.

Functional aspects. Case managers largely agreed on their functional roles in supporting clients' community integration, which took three forms: as a *connector* helping clients address external barriers (5/6), as an *encourager* helping clients overcome internal barriers (3/6), and as a *clinician* focused on mental health issues (6/6).

The role of *connector* involved helping clients overcome logistical barriers to community participation by connecting them with helpful resources to increase access to social activities, address housing concerns, or meet other community needs. Typically, this involved either directly referring clients to social programs (e.g., senior center, church day programs, psychosocial clubhouse) or linking them with resources that would help them work around specific barriers to participation, such as helping them find transportation, federal benefits programs (income), or social contacts at those settings.

Case managers also described their roles as being *encouragers* who worked to address internal issues like symptoms or internalized stigma which sometimes led clients to feel unable to or unworthy of participating in community activities. Actions related to this role included providing encouragement, psychoeducation, and

connection to supportive community spaces like local advocacy groups (e.g., National Alliance on Mental Illness).

Finally, all case managers identified themselves as *clinicians* who carried out other tasks such as assessing client needs and providing psychotherapy services as regular parts of their practices.

Relational aspects. Case managers tended to describe the relational aspects of their roles in two main ways, as a parent or as a coach. *Parent-like* approaches involved case managers playing a directive role in clients' lives whereas *coach-like* approaches were viewed as secondary to primarily client-led processes. These two approaches differed primarily in how case managers perceived themselves relative to clients' own actions and responsibilities.

Half of case managers (3/6) viewed themselves in the more parental, directive role. These case managers tended to help clients through more clinician-led efforts, such as directly connecting them to social resources and settings where the case manager had established relationships and viewed as safe for clients:

"I put them at [the food bank]—the lower-functioning, well some of the higher-functionings like to do that too. But I put the ones I know that can do that; [the food bank staff] will use them because they're used to working with mentally ill people." (CM03, 342-344)

One case manager in this group explicitly described herself in this parental role: *"Playing the role as if I'm Mom: Well this medicine—you've got to take it. Take it this time. No you can't get \$10 or you're spending too much money"* (CM01, 339-340). This case manager acknowledged her clients' choices in their lives but also felt she had a

strong responsibility to provide them guidance and instruction: *“It’s not that you’re in control, but you’re trying to help mold them to be productive adults”* (CM01, 346-347).

Case managers in the coach-like role (2/6) viewed the guidance they provided as secondary to the clients’ own preferences, beliefs, and actions. These case managers described their roles as providing feedback, encouragement, and suggestions to help clients create and follow their own plans for community participation. These case managers tended to describe connecting clients to resources by providing information and encouraging clients to connect with resource themselves:

“[We support clients’ community lives because] what goes on in a session or how we plan out their goal...makes them get connected to some other areas outside in the community. They can go out and join a club or join a leisure club or participate in some activity. They can do that, when it’s not just minimized to just coming here. When we let them know of the resources out there or ...everything that’s available to them that they didn’t know they could have access to they could participate in.” (CM06, 114-119)

One case manager within this grouping actually reacted strongly to the idea of case managers playing the more parental roles described above, stating that she believed this approach limited clients’ recovery in some ways: *“We hinder patients here. The doctors do it, the staff [do it]: ‘that’s my patient, that’s my...’ I don’t claim any of them. Don’t call me mama, don’t think I’m your sister—I’m none of those things”* (CM04, 174-175). Instead, she advocated for an approach in which clients were asked to identify goals themselves and she offered feedback, which she believed was more effective for promoting clients’ sense of ownership over their goals: *“So you [the client] got to tell me what you’re willing to do, then I’ll say, ‘That sounds good—you got a good plan, you got*

a good strategy. I'm on board with that.' So they grasp the concept that a goal is not me, a goal is you and how you're going to fix it" (CM04, 148-150).

These seemingly divergent approaches to case manager roles were brought together in how one case manager described her role in clients' lives as dependent on the client's functioning level. At lower levels of functioning, she described her role as "*coordinating*" her clients' activities through creating plans and referring to services (more like the parental role; CM02, 146). Once clients became more stable, such as living independently, working consistently, and being compliant with treatment, this case manager viewed her role as shifting to more of "*a support*" in helping clients manage their own care and stability (more like the coach role; CM02, 147).

Contextualized aspects. Case managers' perspectives on "where" their services fit within the broader contexts of clients' community lives were generally divided as either being a *central* part of clients' lives or being more *supplemental* to other relationships and resources available to clients.

Most case managers (4/6) described themselves as a "*key component*" (CM01, 131) or "*vital part in [clients'] mental health*" (CM05, 79). In practice, they were more likely to use mental health services and treatment compliance as a marker of stability and of readiness for increased privileges or independence.

A less common perspective (2/6) was for case managers to view themselves as one of many resources that clients can access when seeking to increase their community integration. One case manager explicitly saw her role as a 'back-up' for clients, rather than as their primary source of support: "*I think our clients have more resources than*

they let on because then, if that doesn't work, then you got us as a back-up" (CM04, 223-224). Within this perspective, clients' non-compliance to services was sometimes interpreted as a sign that their needs were being met in other ways or that they had other concerns in their lives that felt more pressing to the client than mental health treatment.

Scope of case managers' roles. A final aspect of case managers' roles identified here was the scope of their services—the extent to which they viewed various areas of clients' lives as relevant to their work. This dimension was measured quantitatively by participants rating (on a scale of 0-2) the extent to which they viewed case management as relevant to various domains of clients' lives. The majority of case managers (4/6) indicated that most domains of clients' lives were relevant to their work, with ratings averaging between 1.7 and 1.9 (out of possible score range 0-2). Two case managers reported markedly smaller scopes of services with average scores of 1.2 and 1.3 (out of 0-2). Therefore case managers clearly clustered into two groups on this *scope* dimension, endorsing broader and narrower scopes of their services. These differences will be further explored in subsequent analyses, specifically related to how these perspectives aligned with other case manager characteristics and client outcomes.

The life domains of basic needs, social support, and finances were each rated as very relevant to their work by every case manager, highlighting the strong support these domains had for being addressed in case management services. Mental health was ranked as very relevant by the majority of providers (4/6) but a few case managers viewed it as "sometimes relevant" due to feeling that clients' mental health problems

can be exaggerated or may resolve on their own once they are able to get their other needs met (e.g., access to benefits, housing). Physical health, family relationships, employment, and spirituality also tended to be rated as either very relevant or somewhat relevant. Legal problems were rated least relevant on average, but were still viewed as sometimes relevant by most case managers (5/6).

Convergence across analyses. Data were also explored for patterns of convergence between the various aspects of case managers' defined roles and their priorities in case management. Interestingly, case managers' ratings of the scope of their services tended to converge with other ways they described their practices. Specifically, the two case managers with notably smaller average scope scores tended to describe their roles as more parental and identified "stability" (mental health or basic needs) as their top priorities in services. Moreover, case managers' overall approaches to case management were related to their ratings of how relevant recreation or leisure activities were to their services. The three providers who included clients' quality of life in the community as a central goal in their work also rated recreation/leisure as very important to their work; other case managers (3/6) indicated it was sometimes or not at all relevant. These patterns indicate that the ways in which case managers described their priorities and relational dynamics within their services may be related—at least in some cases—to the types of community issues they viewed as important to discuss with clients.

Ideal roles. When asked about their ideal roles in clients' lives, all case managers had a desire to be able to help their clients more effectively, but they had different

approaches to what these ideal roles would look like. A few case managers preferred expanded roles (2/6) in that they wanted to be able to provide a wider range of services related to getting clients connected with community resources and working with many aspects of their lives—from medication to transportation to patient advocacy. On the other hand, one case manager said she would ideally play a more supportive, ‘backseat’ role in empowering clients toward their own actions:

“It depends a lot on how [clients] see themselves. No matter what we do, they got to see themselves as the one that can do it... We can help empower them to do it and let them know—give them an open mind about the illness and what they can do.” (CM06, 178-182)

This case manager also concluded her research interview by articulating a memorable vision for her work with clients and specifically for her ideal role in helping clients grasp their self-worth and potential for recovery:

“I wish there was more I could do to make [my job] successful work and put [clients] in the community. Because you want them to understand that they can continue to move on regardless of how they’re feeling because of the mental condition. You want them to know that this earth, we have everything right here for them anyway and they can still take advantage of it anyway, even though they might not see themselves as worthy. Everything is still available to them just like it’s available to one of us.” (CM06, 322-327)

Half of case managers had difficulty defining differences between their actual and ideal roles in promoting community integration for their clients. They either felt that their actual and ideal roles were similar or focused more on systems-wide changes:

“In an ideal world, we’d have a mall—a strip mall. One stop shopping. If you need meds, you go right there” (CM04, 298-299). After some discussion, all case managers were able

to identify barriers and challenges they encountered in their work, discussed below, even if they were not able to explicitly describe their ideal types of practice.

What were the perceived barriers for case managers to fulfilling their defined roles in practice? Case managers mostly discussed system-level barriers as interfering with their work, including high caseloads and certain center policies that constrained their activities. High caseloads were attributed to two main root causes: (a) a lack of resources within the mental health system to have adequate staffing to serve the high number of clients needing services (4/6) and (b) a sense of being a “catch-all” service within the system that receives many clients who were not appropriate for their services or level of care (3/6). Clients viewed as inappropriate for this clinic ranged from those who were older adults, had intellectual disabilities, had primary substance use concerns, or needed a more acute level of mental health care. Case managers described these cases as requiring more time and energy in order to either treat these high-demand clients or to re-refer clients to more appropriate services. Two case managers said that this high caseload was the biggest barrier to meeting clients in the community and doing home visits, rather than center policies prohibiting this type of work. Other case managers specifically linked the high caseload with less frequent meetings, less time for therapy, and less energy to devote to helping clients integrate into their communities.

Notably, one case manager acknowledged the constraints of her high caseload and relative restriction to office-based services but also explicitly described ways she was able to work within these constraints to support clients in their community lives. In

fact, she found that for many clients, this level of care was more appropriate than more intensive community-based approaches which she had previously used in other positions.

Mental health center policies were also identified as constraining case managers' activities such as HIPAA restrictions making it difficult to coordinate with community-based settings (e.g., when attempting to link a client with a specific contact person at a local church; 3/6) or limiting providers' abilities to engage with clients outside of the mental health center (2/6). Billing restrictions were also identified by one case manager as creating a barrier to spending appointment time making sure that clients had all of the necessary information (e.g., directions, phone numbers) to follow through on a referral. This case manager further stated that the creation of Targeted Case Management services made it more difficult to justify spending time on these more traditional case management tasks.

Although a few case managers noted client-level issues that impacted their ability to effectively promote community integration in their services (e.g., limited client resources, client motivation), these issues were deemed to be more relevant for the discussion of barriers to *successful service outcomes*, discussed in Question 2C, rather than barriers to case managers fulfilling their *roles*.

In sum, case managers described the functional aspects of their roles in clients' lives as connecting them with resources, helping them cope with internal barriers to community participation through encouragement and psychoeducation, and providing more traditional clinical services like assessment and therapy. Relational dimensions of

case managers' roles tended to be described as either a parental role providing strong direction to services or a coach role offering more supplemental guidance for clients. Contextual dimensions varied in the extent to which case managers viewed mental health services as central to client's lives or supplemental to their other community supports. Most case managers defined the scope of their roles relatively broadly, viewing most areas of clients' lives as relevant to their services. Barriers to case managers playing these roles included high caseloads, inefficient referral systems, and privacy policies which limited the extent to which case managers could reach beyond formal service systems in their work. Next, findings are presented from client interviews exploring similar topics.

Question 1C: In what ways did clients describe their experiences of issues that were typically prioritized and actions that were typically taken in case management?

Most clients felt they were able to influence what was discussed in their case management appointments—usually prioritizing issues of mental health and basic needs—and described getting help from their case managers through connecting them with resources, providing encouragement, and offering other types of support.

For many clients (12/20), issues discussed in case management appointments were based on their concerns, preferences, or current issues that they brought to their sessions, rather than topics dictated by their providers. Common case management topics included clients' mental health and sobriety (11/20), obtaining independent housing (10/20), applying for benefits (9/20), navigating important relationships (9/20), and employment or school issues (9/20).

A few clients explicitly described how issues were prioritized during appointments, which usually involved focusing on mental health and basic needs before pursuing other life goals. Two clients reported addressing their mental health issues first with community life becoming more of a focus once they were more stable: *“I feel like she cares [about my life outside of mental health] but I don’t feel like I’ve got that far yet with our relationship, you know. I feel like we’ve focused on mental health”* (CL05, B/F/59/M-F, 242-243). Two others described their own preferences for beginning with a more basic need (e.g., employment, housing) before addressing other areas of community life such as social activities: *“I definitely know that the reason for [not yet discussing dating relationships] is because I was concerned about employment. But now that I’m employed, it’s time to move to the next step”* (CL07, B/F/33/H-F, 121-122).

Question 1D: How did clients perceive their case managers’ roles in promoting their involvement in community life, under both ideal and actual circumstances? As above, client’s perceptions of case managers’ roles can also be described according to functional, relational, contextualized, and scope dimensions.

Functional roles. The most common functional aspects of case manager roles described by clients were as *connectors* to resources (14/20) and *encouragers* through providing them emotional support during appointments (11/20). Case managers were also described as being *supporters* in a variety of other ways that were often more tangible than offering general emotional support (i.e., distinct from *encourager* role). Actions within the *supporter* role included offering guidance and advice to meet goals or handle issues (8/20), helping clients build important skills like planning and social skills

(8/20), and holding clients accountable to goals or actions they committed to during appointments (7/20).

Relational roles. When clients discussed the relational dynamics of their work with case managers, most described very positive, collaborative relationships. All clients except one reported enjoying their work with their case managers and described them as caring, trustworthy, and supportive. Consistent with collaborative approaches to services, most clients (19/20) also reported that they had at least some level of involvement in setting treatment goals and deciding what issues would be discussed in appointments.

On the other hand, about a quarter of clients (5/20) *also* described experiences which highlighted uneven power dynamics within the client-case manager relationship. These clients talked about case managers being *enforcers* of court mandates, stipulations on independence, and rules of behavior. They described their case managers as determining whether they needed to be hospitalized, whether they were fit to live independently, whether they were behaving appropriately in other settings (e.g., psychosocial clubhouse staff made “reports” to case manager about client’s behavior), and whether they were ready to be discharged from court-mandated services. This *enforcer* role sometimes led clients (2/20) to withhold information from their case managers: *“That [involuntary hospitalization] kind of made me skeptical about saying anything that would come to my mind and how I feel”* (CL01, B/F/29/M-F, 99-100). Other clients (2/20) reported feeling pressure to do whatever they needed to do in

order to keep their case managers satisfied with their compliance: *“If I don’t make her happy, then the longer I’ll have to come”* (CL10, W/M/31/M-F, 164).

Convergence across analyses. Notably, clients’ and case managers’ descriptions of the relational dynamics of their work together showed preliminary evidence of aligning with another other. Specifically, clients who reported their case managers as playing the *enforcer* role were exclusively clients of case managers who themselves described taking more *parental* and directive approaches to their work, at least some of the time. Put another way, none of the case managers who described taking collaborative, *coach-like* approaches to their work had clients who reported uneven power dynamics or case manager roles as *enforcer* of rules.

Contextualized roles. From the clients’ perspectives, one of the most important aspects of the case manager role was how case managers fit within the context of the rest of clients’ lives (e.g., family, work, housing, daily activities). Clients varied in the ways they described this aspect of how their case managers related to their community lives, with four main perspectives emerging: (a) being *central* to clients’ lives, (b) providing support that was *supplemental* or secondary to client’s actions, (c) *facilitating* clients’ integration by assisting with mental health stability, or (d) being largely *separate* or *unrelated*.

One client perspective (8/20) viewed case managers as being an important source of resources, skills, and support to promote their community participation: *“If I need somebody to help, she can help me with it or she know who to go [to] that might can help,”* (CL16, B/F/53/M-F, 193-194) and *“It’s important for her to give me advice*

about my relationships in the community and what to talk to people about and what not to talk to them about” (CL15, W/F/61/M-F, 171-173). A different perspective (5/20) described case managers as relevant to their community lives, but in more of a supplemental or supportive role: “She’s there to be like—not approver—but the person with logic and rationale to help guide me to make a more concrete decision rather than just dart out there and do something impulsively” (CL07, B/F/33/H-F, 176-178).

A third subset of clients (3/20) viewed case managers’ roles as facilitating community integration by helping them with their mental health so that they can improve their community lives themselves: *“To see her and deal with my issues is a big part of me being healthy and being sane and being somewhat back to...you know, not way out there” (CL09, B/F/54/M-F, 185-186). For a final group of clients (4/20), case managers were viewed as generally separate from their lives in the community: “I don’t see much interaction with [my case manager] about my life too much. Except for when I come here—it’s a part of my life. When I leave, it’s my life” (CL02, W/F/43/L-F, 187-188). Only one client described a potentially problematic impact that his mental health appointments may have on his community life through taking time away from other activities like employment, though he was careful to state that “it’s not to [the point] where it’s a hindrance to me” (CL11, B/M/33/M-F, 278).*

Limits to the role of the case manager in their lives were also discussed by clients (5/20). These “boundaries” varied greatly across clients with no real consensus emerging; as such, they are best characterized as specific client preferences rather than broader trends of which life domains clients tended to view as relevant or irrelevant to

their case management services (explored further below). Areas that some clients defined as *not* related to their case managers' work included finding and keeping a job, applying for disability benefits, family relationships, sobriety, and planning social activities; each of these areas was only discussed by a single client.

Scope of case manager roles. When asked about how relevant clients viewed various life domains to mental health case management services *in general* (i.e., for all mental health clients, not specific to their experiences), most clients reported having relatively broad ideas about the scope of services. The majority of clients (15/20) reported an average scope score of 1.5 or higher (out of 2), with most of those participants indicating every life domain was relevant to services at least sometimes. Mental health (18/20) and basic needs (18/20) emerged as two domains that were overwhelmingly viewed as very relevant to case management. Family relationships (17/20) and employment (15/20) were also viewed as highly relevant by most clients while other domains (physical health needs, recreation/leisure activities, social support, finances, and spirituality) were generally deemed relevant but showed more variability in responses. Legal support was least likely to be viewed as relevant to case management, with about half of clients (11/20) rating it as relevant to services only sometimes or not at all.

Comparing case manager and client responses. A few notable comparisons can be made between how clients and case managers viewed the scope of mental health case management services. Basic needs and mental health were most consistently rated by both case managers and clients as areas that should be addressed in case

management services. Legal support was most often viewed as less relevant to these services. The most notable discrepancies between case manager and client reports were around finances and social support, both of which case managers viewed as very important to their services and clients generally rated as less relevant to case managers' work.

Ideal roles. When asked about the *ideal* role that case managers may play in their community lives, about one-third of clients denied wanting any specific changes (7/20) and others simply restated what they appreciated most about their case managers (4/20). These latter responses emphasized the importance of having their case manager be a source of resources, support, and non-judgmental listening that helped them in their mental health and community experiences. Only three clients identified specific changes they would like to see in their case management services: become more involved in a specific issue (getting custody of child), facilitate community participation indirectly through providing money to buy nicer clothes, and directly provide or re-refer the client to vocational support that was more tailored to her skills and needs than the services she found through vocational rehabilitation.

Summary of Research Aim 1. The findings presented above are briefly summarized in Table 3.3. Case managers and clients perceived case managers' roles in clients' community lives in a few key ways. Case managers tended to either prioritize client stability in their work or take a more holistic perspective considering clients' quality of life as the ultimate goal of their work. Clients most often reported mental

health and basic needs as the focus of their work with case managers; about half also discussed relationships or work/school regularly with their case managers.

Functionally, both case managers and clients described case managers as helping clients most often through connecting them with resources and offering support and encouragement. Case managers described clinical services as a key part of their roles whereas clients perceived more supportive activities like skill-building, planning, and accountability as central to case managers' roles.

Case managers' relational descriptions of their work with clients was generally divided into parent-like and coach-like roles. Clients almost unanimously described their relationships with case managers positively; however, a subset of clients also expressed frustration that their case managers enforced rules and service mandates onto them.

The contextual roles of case managers within clients' broader community lives were mostly defined as either central to helping clients directly manage their lives or offering secondary support for clients' efforts in the community (supplemental). Other client perspectives included case managers providing an initial level of support focused on mental health stability which then allowed them to pursue other goals on their own (facilitative) or being largely separate from clients' community lives.

Most clients and case managers endorsed a relatively broad scope of case management, with many life domains being relevant to these services. Case managers mostly identified system-level barriers to fulfilling their perceived roles, including high caseloads and healthcare privacy policies.

Research Aim 2 Results

Research Aim 2 described instances of actions case managers took related to clients' community integration and compared these efforts when they were defined as successful or unsuccessful. Summaries of themes generated from this research aim are included in Tables 3.4 and 3.5.

Question 2A: In what ways did case managers describe themselves as addressing issues of community life with clients? The most common action described by case managers in facilitating their clients' community integration was linking them with community resources (6/6). This "linking" took many forms, including directly referring clients to other formal services (e.g., clubhouse, supported housing), case managers calling businesses or community groups on behalf of clients (e.g., setting up cable, linking with church program or volunteer opportunities), and providing clients with information to use themselves (e.g., library, homeless shelter, senior center, local festivals). Case managers (4/6) also described efforts to problem-solve issues that arose with these efforts, such as having to refer clients to several different places to address a single issue and problem-solving with clients any barriers to accessing the resource (e.g., transportation, cultural concerns). Several case managers (4/6) described using their community contacts developed over the course of their careers to facilitate connections to certain resources (e.g., job services). One case manager also described helping clients overcome their anxiety about going to a new setting by identifying a specific contact person who the client can connect with: *"I like to connect them to people—people. ...I*

have a contact person that if I call and say this person wants to come and be a part of the singles group, who can I tell them to meet with?" (CM03, 222-225).

A second major action case managers reported taking was simply encouraging their clients to participate more in community activities or take advantage of available resources (5/6). Notably, this action was much more likely to be implicitly included in case managers' examples of their work with clients than to be explicitly identified as a typical part of their role (described above). For one case manager, providing encouragement involved talking with her clients about problematic patterns of isolation and encouraging them towards more social activity: *"We were talking about, 'You continue to isolate yourself, so depression sets in. You have to change your routine and your environment. You have to get outside of the house and get some fresh air'"* (CM02, 287-289). For others, this encouragement was more about helping clients to overcome their fears and negative beliefs about themselves and their mental illness: *"I always tell people—not only just clients—it'll be a failure if they don't try but if you try, at least you know that you tried, whether it fails,"* (CM05, 140-142) and *"We can help empower them to do it and let them know—give them an open mind about the illness and what they can do"* (CM06, 181-182). Several case managers (4/6) also described providing their clients with new ideas for doing community activities like window shopping or giving them small "challenges" like going to the library to find a certain book or going to a certain number of stores in the mall. Clients would then be asked to report back to the case manager about their experiences at the next appointment.

Many other support activities were also described by case managers for promoting clients' community activities, including helping clients problem-solve current issues (e.g., where to buy groceries; 3/6), building clients' independent living skills (e.g., budgeting, social skills; 3/6), setting goals and creating a plan for achieving them (3/6), and collaborating with other members of the treatment team when needed (3/6). Often these other types of actions were discussed in the context of filling in gaps between other services like using personal resources and connections to provide clients with appropriate clothing or transportation (2/6), acting as a liaison to problem-solves issues with employers (2/6), giving advice about when and how to disclose mental illness (1/6), and escorting clients to court or the hospital to provide advocacy and support in these contexts (2/6). Most case managers (5/6) spoke about the need to intentionally tailor the nature and level of these supports to clients' current needs, abilities, age, cultural concerns, and financial resources, which further emphasized the variability and necessary flexibility of these support activities.

Discouraging activities. Sometimes case managers reported discouraging their clients from engaging in certain areas of community life (4/6), but they did not always communicate this discouragement in the same ways. Choices—like pursuing a job, living independently, or online dating—were sometimes discouraged out of a sense of protection for clients who case managers felt were not able to handle that level of responsibility or risk at their current level of functioning (2/6):

“She wouldn’t have lasted five minutes on a job. So I didn’t want her to be disappointed. And also...like if she wanted to go to the clubhouse, I had to stop that from happening...My main goal with anybody is [to be] medically stable—

whether it be psychiatric or medical. So you know, if they're not, then all that stuff—I'm setting them up to fail.” (CM03, 428-431)

In some of these instances, activities were only discouraged by case managers until clients demonstrated a consistent pattern of graduated responsibility:

“You need to get involved in a day program so that other people can observe you and they can see your level of responsibility...you have to make your appointments, you have to take your medicine. And you have to arrange your own transportation.” (CM02, 250-254)

Other times, case managers were more apt to discourage an activity altogether such as drinking alcohol or dating and instead offered alternative activities such as attending a mental health clubhouse or exploring other activities (e.g., library, park).

Alternatively, a more collaborative approach was described by two other case managers in which discouraging activities occurred in the context of helping their clients evaluate their decisions in situations that had proven risky in the past. Examples included attending a family party that may have resulted in an altercation due to contentious family relationships, spending time in settings that offered alcohol for clients with substance abuse histories, or deciding how to respond in an abusive relationship.

Question 2B: In what ways did clients describe their case managers facilitating or hindering their integration into community life? Similar to case managers above, clients also identified a variety of specific ways in which case managers performed their main tasks of connecting clients to resources, encouraging clients' participation in community life, and supporting them in reaching their goals. Connecting clients to resources was identified most often by clients as a main way their case managers

supported their community integration (14/20). Almost equal numbers of clients described these connections involving direct referrals to a service by their case manager (8/20) versus being given information about a resource that they pursued themselves (7/20). Problem-solving issues that arose with connecting to certain resources (e.g., sorting through delays in moving into supported housing) was reported by a few clients (3/20). Others described their case managers coordinating their care on their behalf (3/20): *“[My case manager] worked with the [community care home] administrator to get me to the dentist—set everything up”* (CL02, W/F/43/L-F, 254).

Encouragement in many forms—ranging from encouraging clients’ general capabilities to their use of specific community resources—was described by about half of clients (11/20): *“She let you decide...what you want to work toward and she encourage you to do it,”* (CL09, B/F/54/M-F, 298-300) and *“She said that if I wanted, I could join the day program and I ride on the van...and she just reassured me”* (CL17, W/F/51/L-F, 212-213). Similarly, simple check-ins by case managers about clients’ recent experiences, mental health, and general well-being at their appointments were also reported by many clients (10/20) as helpful for supporting their community lives: *“She asks me about how is work going and stuff like that and I tell her about my coworkers,”* (CL06, L/F/34/H-F, 132) and *“When I sit down...she say, ‘Well how was your day? Well how was your weekend? Did you have any bad experiences?’ She asks me those things, which I think she’s asking the right questions”* (CL20, B/F/56/L-F, 248-250).

Clients also identified their case managers as providing support through a host of other actions. Giving advice about how to handle difficult situations (8/20) and holding

clients accountable for following through on their goals (7/20) were identified as additional ways case managers promoted community involvement: *“I told her what I’m doing in my life and she listens and gives me advice,”* (CL08, B/M/49/H-F, 140-141) and *“I feel like that really helped me because she held me accountable...so I was like, ‘OK, I’m going to do it.’ Well if I said I was going to do it on my own, then I wouldn’t have her to say, ‘Well did you do it?’”* (CL07, B/F/33/H-F, 248-250). Other actions described as important for supporting successful community living included: teaching clients specific skills for independent living (e.g., budgeting, interpersonal communication, adaptive coping, social skills; 8/20), correcting maladaptive behaviors (e.g., poor grooming, inappropriate behavior, paranoid or impulsive behavior; 6/20), offering a listening ear when needed (5/20), and helping them identify and plan out their goals (4/20): *“She helped me with my goals and that was very important because I had limited goals at first and now I have a goal of being independent”* (CL13, B/M/58/H-F, 361-362). Two clients described their case managers providing them some type of community-based service: going shopping for new clothes and bringing house supplies when moving into a new apartment.

Discouraging activities. The majority of clients were not able to identify a time when their case manager actively discouraged their participation in the community (13/20). The examples that were given followed two patterns: they either represented an apparent clash in client and case manager perspectives or they demonstrated instances when case managers helped to reinforce clients’ difficult yet values-consistent actions.

First, a few clients described being discouraged from seeking independent housing or mainstream employment due to case managers' preferences for them to take more gradual steps toward independence and first engage in mental health-based settings (e.g., mental health clubhouse, supported housing; 3/20). Additional instances included a case manager refusing to make arrangements for a clients' boyfriend to stay over with her at her community care home (1/20) and discouraging clients from making changes they wanted to their medications (e.g., discontinue due to side effects, switch from injection to pill administration; 2/20). On the other hand, other examples of discouraging activities appeared to be in line with what the client wanted and felt was beneficial for them, including discouraging quitting a job before planning for the change financially (1/20), setting appropriate boundaries in relationships (1/20), and discouraging violent or paranoid behavior in clients or those around them (2/20).

How did case manager and client responses compare with each other? Case managers' and clients' descriptions of the ways in which case managers supported clients' community integration largely aligned with one another (see Table 3.4). Both groups identified case managers connecting clients with resources as the most common mechanism of support, which involved a combination of case manager-directed referrals, information provided to clients to use themselves, and problem-solving issues with these resources and the referral process. Encouraging more community activity also emerged as a particularly valuable action case managers took on a regular basis. This encouragement often involved case managers helping to build clients' confidence in their abilities to pursue community activities and motivating them toward action. Clients

and case managers also both described case managers helping clients build skills they needed to engage in community life (e.g., budgeting, social skills), assisting clients with goal-setting and creating a plan to reach those goals, and problem-solving issues as they arose.

A notable difference between client and case manager responses was that clients identified a wider variety of actions case managers took within appointments that helped support clients' community lives. These appointment-based actions included checking-in with clients about current issues that may need to be addressed, listening and giving clients advice about handling these issues, holding clients accountable for following through on their goals, and correcting maladaptive behaviors when necessary. On the other hand, case managers were more likely to provide examples of actions taken outside of appointments, such as seeking out resources for clients (e.g., clothes, toiletries), acting as liaisons with employers and community groups, and providing advocacy in community-based settings when needed.

Another major difference between client and case manager responses was around case managers' tendencies to *discourage* clients from certain community-based actions. The proportion of case managers who discussed this as an integral part of their work (4/6) was much higher than the proportion of clients who were able to provide an example of this in their work with their case managers (7/20). However, it seems that when examples were given, they were categorized in one of two ways across both samples: either as a means of case managers protecting clients from taking risks around independence or as a more collaborative effort in which case managers and clients

openly discussed consequences and benefits of certain actions (e.g., relationships, spending time in certain environments) and came to an agreement about what might be best for the client.

Question 2C: For which kinds of issues did case managers tend to be viewed as “successful” or “ineffective” at addressing with clients? What barriers did participants identify for instances when case managers were viewed as ineffective?

Successful actions. Across clients and case managers, the majority of examples given as “successful” instances of case managers supporting clients’ community activities involved connecting clients with resources (14/26). Most often, these resources were other “formal” social services within the community, such as mental health clubhouses, supported housing, housing shelters, mental health-based vocational assistance, Targeted Case Management services, or government benefits programs for income or transportation. The informal resources mentioned were usually ones that case managers tended to refer clients to often, such as specific church-based programs with transportation, senior centers, or non-mental health housing programs. Occasionally, service referrals included ones to other community resources that were relevant to specific client issues, such as a doctor, dentist, and a computer repair shop (needed for online classes).

Notably, in some instances, clients (4/20) reported examples of being connected to resources which they viewed as “successful” but, once described, were actually not yet resolved, either because their case manager had just given them the information at that day’s appointment or because they were waiting for other steps of the process to

be completed. Other times, clients (3/20) described examples of “successful” instances of case manager referrals which were successful at helping them get connected to the resource but were not successful at getting their original problem resolved. Examples included a client being referred to a dentist who was not able to complete the denture work she needed and a client who was referred to and accepted at a supported housing facility but turned it down due to his preference for independent housing instead. These examples revealed a potential discrepancy for some clients between actions that were *perceived* as successful and those that actually helped the client meet his or her goals.

Other successful case manager actions, besides resource connection, were identified by participants (8/26). These examples included providing useful relationship advice, talking through fears about going on a vacation, working with a clients’ employer to address problematic symptoms, providing specific skills or material resources to support independent living (e.g., budgeting, providing kitchen supplies), and helping a client plan out long-term goals.

In sum, there was great variety in the types of issues for which clients and case managers identified successful instances; however, it appears that case managers were particularly successful at addressing problems around housing, employment, socialization, and basic needs that could be resolved through referrals to other service agencies. Other actions within appointments like providing encouragement, advice, or planning skills were also viewed as important for helping clients successfully meet their goals.

Ineffective actions. Across case managers and clients, the instances of actions that were viewed as “ineffective” were more varied and differed significantly more across case manager and client perspectives (see Table 3.5 for summary of themes).

Case manager responses. Case managers cited issues related to service systems, service providers, and clients as reasons for their work sometimes being ineffective at helping their clients meet their community goals. Two of the examples given by case managers of actions they viewed as “ineffective” centered on systems-level barriers encountered when referring clients to resources. One example involved a case manager finding that the resources available in the community were not sufficient for meeting the client’s need (obtaining disability benefits) and feeling she, as the case manager, was not able to provide other kinds of assistance besides making these referrals. The other example involved a case manager facing a number of logistical barriers (e.g., program eligibility requirements) when attempting to refer a client to a needed treatment service not available in other places.

One case manager cited case management practices as a barrier to helping clients become more integrated into communities. This case manager was critical of her fellow service providers (psychiatrists, nurses, and case managers) in observing their tendencies to create client dependencies on the system and to “hold” them in services even after their needs were met. She cited examples of case managers and other providers making certain client goals (e.g., disability check, medications) contingent on their compliance with specific service requirements (e.g., making appointments): *“We’re holding them here, we’re trapping them because if you don’t come, your check’s going to*

be cut off. If you don't come, you can't get your medicine here. If you don't come, you can't see the doctor here" (CM04, 151-153). From her perspective, this culture of fostering client dependence on the system significantly limited case managers' efforts to help clients build their own, full lives in the community.

Client-level issues, including clients' personal resources, motivation, and symptoms, were more often identified as creating barriers to case managers being effective in their work. Most case managers (5/6) reported their work was sometimes constrained by clients' access to resources such as adequate finances and transportation. They described having difficulty finding social resources and activities that included transportation services or were free of cost. Others discussed being limited in where they could refer clients based on income requirements or needing to prioritize getting clients linked up to benefits as the first part of their work together.

Clients' internal resources—including low motivation and difficulty coping with symptoms—were also identified as problematic at times (4/6). Low motivation was most often described as not following through on case managers' suggestions for engaging in community activities or specific treatment recommendations, but not all case managers interpreted this low motivation in the same way. One case manager described clients' difficulty engaging in the community as a *"disappointing"* part of her work and viewed it as a failure on her part when she was not able to help clients overcome this motivation barrier (CM02, 141). Conversely, another case manager said she had accepted motivation issues as a reality for a portion of her clients: *"No matter how much you encourage or support them as far as compliance as well as trying to*

increase their stabilization, there's some that's still resistant to treatment" (CM05, 117-119).

Ongoing mental health symptoms and substance abuse problems posed their own challenges in working with clients. One case manager expressed frustration when a client's substance use issues prevented him from fully engaging in an employment opportunity that the case manager had created specifically for that client. Another case manager described the barrier of clients' own senses of disempowerment and self-perceived limitations due to mental illness.

The *topics* of these "ineffective" examples were not dissimilar from the "successful" examples (e.g., social activity, employment) but included more examples around clients' compliance with mental health treatment and concerns for clients' overall well-being rather than specific problem areas. Overall, many of these examples reflected a pattern of case managers feeling most limited in their work during instances when connecting a client to resources was insufficient for solving the problem or meeting the goal. Both system- and client-level issues complicated this process; in some cases, case managers were able to overcome these barriers (e.g., persisting through incompatible systems, tailoring referrals to clients' level of resources) whereas other times they felt the problem was beyond the scope of their services (e.g., client's resistance to treatment).

Client responses. It proved difficult for many clients (9/20) to identify an instance in which they viewed case managers as being "ineffective" at helping them reach a goal in the community. For clients who did identify examples, ineffective instances were

related to service referrals (e.g., specialized treatment program, housing, employment; 4/20) or disagreements about their mental health treatment (e.g., medication management; 3/20). Other examples of case manager ineffectiveness involved case managers struggling to help clients address interpersonal issues (2/20), not sufficiently responding to a client's concerns about safety outside of office hours (1/20), and clients initially being reluctant to open up to case managers, which improved over time (2/20).

Clients were most likely to attribute case managers' ineffectiveness to case managers failing to follow-through on a referral or other request (6/20). Other reasons given included three clients blaming themselves for making it difficult for case managers to do their work successfully (e.g., not opening up or being ready to change) and two clients expressing general dissatisfaction with the treatment provided by their entire treatment team (e.g., trouble finding appropriate medications): *"When I first got sick, it took them 5 years to find the right combination of medication to work. Nothing would work. And [my case manager] was hitting a brick wall and I was hitting a brick wall"* (CL12, W/F/58/H-F, 197-198).

A notable theme across client interviews echoed case managers' observations about their relative restriction to the role of "referrer" to other resources and to office-based actions. Specifically, clients cited instances when *referring* to a service was not sufficient for *engaging* in that service, such as when there were significant wait lists for housing programs (3/20). In these instances, clients generally described not having those needs met or case managers continuing to follow-up with the same referral, rather than case managers and clients exploring other options.

Relatedly, another client concern (3/20) was the disconnection or “wall” that clients perceived between their case manager appointments and their lives in the community. These clients expressed feeling that they were not always able to continue the progress made in the office once they were in the community: *“I mean I could talk to you and still can go outside and still feel bad but it just make me feel good when I’m here, but when I go outside, it just comes back to normal,”* (CL04, B/M/42/M-F, 166-168) and *“In here, I can, I am self-directed but out there it’s like, ‘Oh my gosh, I’m scared!’ So it’s like she’s there with me and when I leave, I’m going to freeze up a little bit”* (CL07, B/F/33/H-F, 212-213). Two other clients gave examples of needing case management supports outside of office hours but not being able to access those services at that time.

Although the present study was not able to directly compare case manager and client perspectives on single issues or instances, these findings suggested a potential disconnection in how case managers and clients “defined the problem” when case management services failed to promote clients’ community integration. Case managers were more likely to attribute the failure to clients’ motivation and symptoms whereas clients tended to view the issue as a lack of sufficient support for implementing these changes in their lives.

Summary of Research Aim 2. Connecting clients to resources was a central theme across clients’ and case managers’ descriptions of their work together, but it took different forms depending on the client and goal. Examples varied in the types of resources clients were connected to (i.e., formal vs. informal services) as well as how these connections were made (i.e., direct referrals, case manager-led actions, providing

information to client). Case managers were reported as most effective (though not exclusively so) when making referrals to formal service systems around issues of employment, housing, basic needs, and structured social activity. Case managers also problem-solved issues with connecting clients to resources, including both systems-level issues (e.g., incompatible systems, waitlists) and client-level issues (e.g., symptoms, motivation). Some case managers reported strategies to overcome these barriers such as using personal connections to facilitate cross-system referrals or connecting clients to specific people in new settings to decrease anxiety; in other cases, case managers reported being unable to overcome the barriers (e.g., client resistance to treatment).

A second major task for case managers was encouraging clients to participate more in community life. This included providing psychoeducation and setting small challenges for clients to complete between sessions. Case managers also provided additional services as needed, including planning, skill-building, advocacy, and accountability for clients. When case managers felt the need to discourage clients, they often did so through either authoritative, protective approaches or more collaboratively alongside clients.

Clients and case managers identified a broad range of issues about which case managers' actions were viewed as ineffective, including more issues around clients' mental health treatment, safety, and trust than in the "successful" examples. Case managers tended to attribute the ineffectiveness to clients' low motivation or symptoms and, to a lesser extent, systems issues while clients tended to attribute the ineffectiveness to case managers—either to a lack of following through on requests or

to inherent limitations of their office-based work. Less often, clients also acknowledged themselves or other treatment providers as the reasons for failing to meet certain goals.

Research Aim 3 Results

The goal of Research Aim 3 was to use mixed method analyses to explore relationships between case managers' descriptions of their case management practices and their clients' experiences of community integration.

Question 3A: How did average client community integration outcomes vary across case managers who described their *overall priorities* in case management differently? The primary researcher categorized case managers into three groups based on a combination of factors: (a) responses to the question of what their primary goal was with clients in case management, (b) what they viewed as their clients' biggest needs in case management, and (c) their perceived scope of case management services. Two case managers described their primary goals as promoting their clients' "stability" in the community, through either helping clients get basic needs met or by helping to decrease symptoms and hospitalizations. These two providers also had markedly lower average scores on the "scope" questions (1.2, 1.3 out of 0-2), suggesting that they viewed more life domains as irrelevant or only sometimes relevant to case management services than other case managers did. On the other side of the spectrum, two case managers described their primary goals with clients more holistically with a focus on helping improve their clients' lives in the community through changing how clients viewed themselves or helping them return to meaningful activities and relationships. These two providers had average "scope" question scores of 1.7 and 1.9 (out of 0-2),

suggesting that they viewed most life domains as relevant to case management services. The final two case managers described their roles as encompassing parts of both of these perspectives—focusing on clients’ basic needs and “stability” as well as their social lives and overall quality of life in the community. Their average “scope” scores were also high (both 1.8 out of 0-2), indicating they also had a broad conceptualization of their roles as case managers.

When comparing clients’ average community integration scores across these three groups of case managers, patterns emerged between these categories and clients’ experiences in the community (see Figure 3.1). For the one case manager who focused more on clients’ stability for whom client data is available (no client data collected for the other case manager due to recently starting in this position at the site), the average across her clients’ CIQ scores was 8 (range 3-19). This contrasts with the case managers with a mix of mental health and community-based goals whose average client CIQ scores were 11.5 (range 7-16) and 12 (range 6-17). The two case managers with more holistic perspectives on their work had clients with the highest average CIQ scores at 15.25 (range 5-21) and 15.5 (range 11-23). Interestingly, scores indicated a relatively similar *range* across case managers, but the average CIQ scores showed an emerging pattern of differences corresponding with these groups of case managers. Overall, higher average CIQ scores were found for clients of case managers who prioritized a broader range of client issues, especially when the focus was on clients’ overall well-being and quality of life in the community.

Question 3B: How did average client community integration outcomes vary across case managers who described their *roles in promoting community life for clients differently*? As described above, case managers described their roles in their clients' community lives very differently and with a relatively high level of complexity depending on the client's functioning, the issue at hand, and other resources available in the community. For the purposes of these analyses, the role dimensions which showed the clearest differences between case managers—the relational and contextual aspects—were used to explore links between how case managers approached their work and their clients' outcomes. Therefore responses were clustered according to the extent to which case managers viewed their roles and guidance in clients' lives as *central* to clients' community integration (also aligned with parental role) or as more *supplemental* to clients' ongoing activities, ideas, and supports (aligned with coach role).

As shown in Figure 3.2, half of case managers viewed themselves in this parental role and as more central to clients' community lives, describing themselves as strongly guiding clients in their decisions. Case managers in this category tended to have average client CIQ scores that were slightly lower (8, 11.5, no data for one CM's clients). One case manager described varying her role in clients' lives based on their functioning level—being a stronger source of guidance for those at lower functioning and more of a hands-off support once the client proved higher functioning capabilities. The average CIQ scores for her clients was 12. The last two case managers tended to view themselves more as coaches providing additional, supplemental supports for clients when needed. They described their roles more as providing information,

encouragement, and feedback on client-led ideas and actions. Clients of these two case managers tended to have higher average CIQ scores (15.25, 15.5).

These findings reflected a pattern in which case managers who described their roles as more central to clients' community integration and as providing stronger guidance to clients (more parental role) tended to have slightly lower average client CIQ scores. On the other hand, average CIQ scores were higher for clients of case managers who acknowledged clients' larger sets of resources and who viewed themselves in coach-like roles with clients being more actively involved in connecting themselves to community resources.

Summary of Research Aim 3. Clients' CIQ scores varied by case manager with higher average client CIQ scores corresponding with case managers who tended to view the focus of their work more holistically and as a supplement to clients' own abilities, preferences, and actions (coach role). Lower CIQ scores were associated with case managers who tended to focus more narrowly on mental health and basic needs and who viewed their roles in clients' lives as central to clients' successful living in the community (parental role). These trends suggest that more holistic, supplemental, and coach-like approaches to case management may be related to more positive client outcomes, such as greater integration into community life.

Research Aim 4 Results

Research Aim 4 explored how participants' descriptions of case managers addressing issues of community life varied based on other personal characteristics of case managers and clients.

Question 4A: How did case managers' descriptions of their services vary by the number of years they had been practicing in the mental health field? The two case managers who were both younger in age and had fewer years of experience in the field (12, 17 years) tended to define the scope of case management services more narrowly than the four older, more experienced case managers (25-33 years of experience). That is, younger case managers were more likely to say various domains of life were "sometimes" or "not at all" relevant to case management services (scope scores = 1.2-1.3), whereas older case managers took more inclusive views, rating most domains as very relevant to their work (scope scores = 1.7-1.9). These younger case managers were also among the case managers who tended to discuss their primary goals in case management as "stabilizing" their clients and focused more on basic needs and mental health symptoms.

Overall, case managers with more experience tended to report a wider variety of strategies used to work with clients to promote their community engagement. Specifically, of the ten strategies identified across case manager interviews (e.g., using personal community connections when making referrals, giving clients community activity assignments or challenges, providing clients with alternative options when discouraging activities), less experienced case managers mentioned using three to four of them, whereas more experienced case managers talked about anywhere from five to nine of the strategies.

It was more complicated to identify whether the use of any specific strategies varied across more and less experienced providers; only a few trends emerged from

these analyses. Case managers with more experience tended to endorse *discouraging* clients' activities more (average of 4 instances mentioned per case manager; range of 2-6) than less experienced providers (0-1 instance mentioned per case manager). There was also a slight trend of older case managers using more strategies to help *engage* clients, particularly in the initial treatment planning phase of their work (e.g., rewording questions around treatment goals) with older case managers averaging 2.5 instances (range: 0-6) mentioned per case manager and younger case managers again mentioning this strategy once or not at all. There were no apparent differences between younger and older case managers in how they described barriers to promoting community integration in their work.

A few trends emerged when analyzing differences in the ways in which *clients* described their case managers' actions according to case managers' experience levels; however, it should be noted that these analyses are limited by comparing clients of four "more experienced" case managers with those of only one "less experienced" provider due to not having client data for one case manager. Clients of more experienced providers tended to describe receiving more skill-building (2-8 vs. 0 instances), correction of inappropriate behavior (1-4 vs. 0 instances), and general encouragement (3-5 vs. 1 instances) from their case managers. These trends supported the same notion that more experienced providers may use a wider range of strategies (e.g., correcting behavior *and* encouragement) in their work with clients.

Question 4B: How did case managers' descriptions of their services vary by their level of endorsement of recovery principles? Generally speaking, case managers'

endorsement of recovery principles, as defined by RAQ scores did not align with many of the ways in which case managers were grouped together in other analyses, such as case managers' primary goals or roles as case managers, their actions and strategies taken with clients, the barriers they faced in their work, or their experience levels. The only notable association found between recovery scores and case manager actions was that case managers with the highest RAQ scores were the only ones with clients who talked about their case managers providing community-based services for them (i.e., delivering house supplies to client's new apartment, going shopping with client). Case manager RAQ scores also did not align with the average RAQ scores of their clients.

Question 4C: How did clients reporting varying levels of community integration differ in the ways they described addressing issues of community life in case management? Clients were divided into three groups based on CIQ total scores with 6 clients in the "low community integration (L-CI)" group (CIQ scores: 3-7), 6 clients deemed "mid-community integration (M-CI)" (CIQ scores: 11-13), and 8 clients deemed "high community integration (H-CI)" (CIQ scores: 15-23). Groups were uneven due to prioritizing natural breaks in the score distribution; this approach was used in an attempt to yield more meaningfully different groups. Notably, these groups loosely aligned with case manager-identified functioning levels. That is, the L-CI group was completely comprised of clients identified by case managers as either mid- or low-functioning (in equal numbers), the H-CI group was entirely mid- and high-functioning clients, and the mid-CI group was equal numbers of low-, mid-, and high-functioning clients (2 from each group).

Case manager roles. When asked to describe the roles their case managers played in the *contexts* of their community lives, differences emerged in the extent to which clients across community integration levels described their case managers playing central, supplemental, facilitative, and separate roles in their lives (see Table 3.6; Note: a few clients described multiple types of roles across different points in their interviews. Category determinations were made based on a holistic view of how they talked about their work with case managers across the interview; to the extent possible, these categorizations were made without consideration for the participant's community integration level).

Specifically, H-CI clients were equally likely to describe their case managers in each of these roles. M-CI clients tended to view their case managers as more relevant to their lives, in either central or supplemental roles. L-CI clients were most mixed in the ways they perceived their case managers fitting into their community lives: they tended to either describe case managers as very central or completely separate from their community lives. Similarly, when asked to rate the extent to which various life domains were relevant to case managers' services generally (i.e., *scope* of services), L-CI clients had the lowest average ratings at 1.35 (Note: L-CI group average includes an outlier of .3; without outlier, average is 1.56). The H-CI group's average rating was 1.61 and M-CI clients had the highest average rating at 1.78, corresponding with viewing many life domains as very relevant to case managers' work in general. These findings supported a pattern of M-CI clients perceiving the most overlap between their community lives and

case management services, while L-CI clients showed the most diverse views on this relationship.

Clients' descriptions of how they viewed the *functional* roles that case managers played in their lives were relatively similar across these three groups (e.g., connection to resources, emotional support, skill-building) with one exception: H-CI clients were more likely to identify "guidance" as a key way that case managers assisted them in their community lives (H-CI: 7 instances; M-CI: 2 instances; L-CI: 1 instance). For some clients, this support was viewed as useful even when general case management services were not seen as needed. One H-CI client stated she only attended appointments due to a court mandate and did not feel that she needed to continue seeing her case manager; however, she also described benefiting from the accountability, check-ins, and ongoing support provided by her case manager to help her maintain healthy relationships and sobriety. Other clients described similarly feeling that they did not *need* to meet with their case managers but found the support helpful. Most of these individuals described a more *coach-like* type of support, such as providing advice or encouragement or giving the client information about a resource to pursue him- or herself.

Case example. In an effort to demonstrate the complexity of the relationship between case management services and clients' community integration levels, a brief case example is presented. This client issue highlights the challenge of supporting clients as their functioning levels and needs change over time:

One client interviewed was recently discharged from case management and transferred to Medication Management Only services due to demonstrating significant

progress in his mental health and being deemed sufficiently stable to step down his level of care. Also because of this improvement in functioning, he was seeking to move out of a group home into independent housing at the same time. However, because he was discharged from case management, he was left without formal supports to help him search for housing or smoothly transition into this new living situation. Fortunately, this individual had a strong network of supports through his family (niece was a social worker who was assisting him in looking for housing) and his church congregation. This example is helpful to illustrate that the role of case managers in clients' lives depends on many factors, including clients' preferences, case managers' perceptions of clients' needs, and the mental health system's capacity to continue supporting clients who are relatively stable in their mental health.

Convergence with case manager perspective. A noteworthy perspective that was held by one case manager supported the findings above that clients at a mid-level of functioning may be at greatest need for case manager intervention:

"I have quite a few [clients] that work, that have full-time jobs and so those are not the ones I worry about...If they're high-functioning, they have a car and they can drive to and from, they usually have families and they do a lot of things with families. And then if they're low-functioning...they're usually the ones that's in the day program. It's the ones that's in the middle...that usually get lost." (CM02, 212-216)

In sum, clients with mid-levels of community integration appeared to be more likely to see their case managers as more relevant to their community lives, either directly or in a supportive role. This finding matched at least one case manager's perspective that they may be at highest need for case managers' support due to not

having as many formal or informal supports as clients typically have at other functioning levels. H-CI and L-CI clients were both more mixed in how they viewed their case managers, but when case managers were viewed as relevant, H-CI clients saw them largely as supplemental supports offering guidance.

Case manager actions. When asked to describe specific ways in which case managers assisted clients with their community lives, H-CI clients identified the most actions taken by case managers and M-CI clients identified the fewest (see Table 3.7). H-CI clients were more likely to identify case managers as keeping them accountable, offering advice, helping them plan, helping them build specific skills (e.g., budgeting, social skills) and encouraging them in their activities than L-CI or M-CI clients. By contrast, L-CI clients were more likely to describe their case managers as helping them by simply checking-in with how they were doing or listening to them when they had a problem. Specific to resource connections, H-CI clients were slightly more likely to describe their case managers as connecting them with resources by providing *them* with the information to use rather than the case manager contacting or referring them to a service. Other clients were more likely to describe being connected with services directly by the case manager.

Comparisons were also made across CI groups of clients' reports of instances when case managers' support was deemed "central" to the activity (e.g., case manager connected them directly with a service), "supportive" to an activity (e.g., case manager provided a suggestion or encouragement), or was not at all involved in an activity (e.g., client received information from neighbor), as shown in Table 3.8 and Figure 3.3.

Notably, these descriptions were used to label case manager *actions* here, which is distinct from the section above which uses similar terms to describe case managers' *contextual roles* in clients' lives. It should also be noted that clients were not directly asked to identify these instances in the interviews and these data were coded from clients' spontaneous interview responses. H-CI clients reported more instances of activities with only supportive actions from their case managers and slightly fewer instances of central actions than the other two groups, who reported these instances at approximately similar rates. Notably, no clients identified as L-CI reported instances of doing activities without any case manager support, whereas M-CI and H-CI groups described these instances at similar rates.

Topics in case management appointments. The topics that clients reported discussing with case managers during appointments were compared across client community integration groups (see Table 3.9 and Figure 3.4). A pattern emerged in which L-CI clients tended to report discussing more basic needs and mental health-related issues with their case managers (i.e., problematic behavior, mental health and sobriety, medical/physical health, and basic housing needs) than other clients. Highly integrated clients, on the other hand, reported more instances of discussing issues of community life, including independent housing, work, current issues, and general self-improvement, during case management appointments. Topics of relationships and religion were approximately equal across the three community integration groups.

Few patterns emerged when comparing the topics clients reported discussing in case management appointments across their assigned case managers. Clients of case

managers from more holistic perspectives reported slightly less discussion around correcting clients' behaviors (0 vs. 2-3 instances) and slightly more discussion of independent housing options (3-4 vs. 1-2 instances). Otherwise, the topics which clients reported discussing in case management appointments appeared to be relatively similar across case managers and any differences found appeared to be randomly distributed across case managers. These data could be helpful in guiding future research which more directly assesses the relationships between case managers' approaches to their work, their clients' functioning levels, and the issues they focus on during appointments.

Summary of Research Aim 4. Case managers' years of experience in mental health were associated with differences in the ways they discussed their work as case managers, with more experienced providers viewing their roles in clients' lives as broader and describing a wider range of strategies they employed to help clients reach their goals. On the other hand, the ways in which case managers described their work did not vary by their reported endorsement of some of the core principles of recovery.

A number of differences emerged in how clients described their case managers supporting their community lives across clients' self-reported levels of community integration. Clients with higher levels of community integration tended to describe their case managers playing more supplementary roles in their community lives (if at all), reported actions that were consistent with this role (i.e., a wide variety of "support" roles their case managers played), and reported higher rates of discussing community-based issues with case managers during appointments. A few clients with lower levels of community integration paradoxically viewed their case managers as less relevant to

their community lives but also did not discuss instances when they engaged in community life without their case managers' support (though, importantly, clients were not asked for these examples directly). These clients were also more likely to describe their case management appointments as focused on mental health and basic needs. Clients at mid-levels of community integration tended to view their case managers as important in their community lives and reported approximately equal numbers of instances when their case managers played large, small, and no roles in facilitating their community participation.

Second Order Data Themes

In an effort to bring more clarity to some of the key findings reviewed above and to connect them with recovery practice, the following section presents themes drawn from across the primary data analyses and links them with theory around mental health recovery. These second-order themes (Saldaña, 2013) focus specifically on the extent to which various case management perspectives and practices described above align with SAMHSA's principles of recovery (SAMHSA, 2012). When appropriate, these themes are also linked to other literature, which is then expanded upon in the Discussion section. These second-order themes aim to highlight an important strength of the present study: its ability to identify elements of case management practice that are recovery-oriented and supportive of community inclusion even within more traditional, office-based case management services. Table 3.10 summarizes these second-order themes; several of these topics were selected to be discussed in more detail below.

Role in clients' lives. One example of variability in alignment with recovery principles within the case management services studied here was in how case managers viewed their contextual roles in clients' lives. More recovery-oriented approaches to case management involved seeing mental health services as one component of clients' lives, rather than as a central focus for clients. Some case managers explicitly acknowledged the range of resources that many clients had access to—within their families, churches, neighborhoods, and social networks—and were satisfied as being a “back-up” resource for clients when needed. One case manager was actually critical of the mental health system for making clients more dependent on itself through encouraging a central focus on mental health services rather than naturally-occurring supports and other activities. This case manager appeared to take a client-centered approach to care in viewing services as only valuable insofar as they can provide necessary support for clients living the lives of their choosing and not burdening clients with additional time constraints or requirements.

This perspective embodied a number of recovery principles in emphasizing the naturally-occurring strengths and resources available in clients' existing communities and working to minimize clients' over-reliance on the mental health system. It also acknowledged clients' multifaceted concerns about many issues in their lives (e.g., work, relationships, spirituality) beyond mental health. Finally, this approach necessitated taking an individualized, person-driven approach to care because each clients' concerns, resources, and strengths are unique to the contexts of their lives.

This more recovery-oriented perspective is in contrast to other case managers who seemed to believe that mental health care should be clients' top priority at that time and described using compliance with mental health appointments and treatment plans as a measure of the client's overall functioning and readiness for independence. Although a clear case can be made that keeping appointments and commitments is an important part of being responsible for one's own healthcare, this approach is inherently system-centered and does not allow for flexibility in what may be viewed as helpful or valuable for a client's recovery beyond formal services. It also uses treatment compliance as the benchmark of success, rather than using clients' goals and community functioning as the ultimate marker of effective treatment. Put another way, the difference in these perspectives may be succinctly captured by whether case managers viewed treatment as more of a *means* to an end (i.e., clients' goals) or as an *end goal* in and of itself.

Connection to resources. All case managers also identified connecting clients to resources as a central action taken in their work, but the ways in which they approached this task seemed to vary in the extent to which they promoted recovery principles. On the less recovery-oriented end of the spectrum, case managers described themselves identifying a need *for* clients (e.g., loneliness) and choosing from a selection of community resources to which they often referred clients (e.g., church day program for seniors, supported housing programs, psychosocial clubhouse). These types of referrals were often very useful for clients as well as more efficient for case managers. They usually had established referral processes and fewer barriers to clients due to free cost

(e.g., billed through Medicaid) and providing transportation (e.g., van, Medicaid transportation). However, generally speaking, if these types of referrals are used exclusively, they result in clients spending most of their time in these relatively segregated settings and limit the extent to which clients become genuinely integrated into their broader communities (Bond et al., 2004; Minnes et al., 2001). Furthermore, making referrals on clients' behalfs is a large part of the case manager role but also, if done exclusively, potentially limits the extent to which clients develop the skills to seek out and connect with community resources themselves.

More recovery-oriented examples of connections to resources involved case managers problem-solving issues alongside clients (e.g., internet search for computer repair facilities, brainstorming sources for scholarships) and providing clients with information they could use to follow-up. Some case managers also described providing clients with a range of options of "generic community resources" (e.g., library, senior center activities) that might fit their needs and interests (Trainor, Pomeroy, Pape, & Dewar, 2004). These examples also often involved case managers working creatively to overcome potential barriers to clients' participation, including using their own personal connections to get clients into a new setting. Another strategy described by a case manager was working to connect clients to specific *people* within community settings (e.g., churches) to facilitate clients' comfort and connection to a new place. In these instances, case managers were aligning their work with recovery principles in helping to empower clients to take action and responsibility for their own lives, recognizing the

holistic nature of recovery, and drawing on the strengths and resources available in the client's community.

Notably, there were no examples from clients or case managers in this study of case managers acting as supports for connecting clients with community-based hobbies or leisure groups (e.g., social clubs, book club, gardening group). This type of individualized support aimed at helping clients connect with informal community groups based on personal interests is emerging as a new model of "supported socialization" which can be helpful for supporting clients' engagement in integrated social and recreational settings (Rowe, 2015).

Risk management. In many cases, providing case management in more recovery-oriented ways was less about doing or not doing specific actions and more about the *process by which* actions were taken. In the case of risk management, almost all case managers described discouraging clients from pursuing certain activities at various times, but some instances were described in ways more consistent with a recovery paradigm. These more recovery-consistent actions involved approaching these decisions as collaborative discussions between clients and case managers about the pros and cons of certain actions based on previous experiences (e.g., attending party with alcohol for those with substance abuse histories). Some case managers also described encouraging and even challenging their clients to take risks in their lives (e.g., going on vacation, change jobs).

Important to this process was case managers seeing their level of support as flexible based on clients' needs. In some cases, clients were supported in transitioning

to lower levels of care with the understanding that if they needed more intensive support, they would be able to return to regular meetings with their case managers. These examples embodied a spirit of recovery by respecting clients' autonomy and self-direction, acknowledging clients as capable of making their own decisions, offering support for clients in this process as allies, and viewing recovery as a non-linear, individualized process that sometimes involved a need for increased support interspersed with or alongside greater independence. By contrast, less-oriented examples of risk management included instances of case managers viewing themselves in parent-like, protective roles and discouraging clients from taking risks in their lives (e.g., working, dating) based on a fear of failure and disappointment.

In sum, there were elements of more and less recovery-oriented practices integrated throughout participants' descriptions of their case management experiences. These themes highlighted some of the ways in which case managers' practices aligned with recovery-oriented care and offer a theoretical perspective on how the principles of recovery can be enacted within community mental health care settings.

Table 3.1. Demographic characteristics of sample compared with total client population of clinic.

	Research Participants		
	Case managers (n=6)	Clients (n=20)	Clinic population (n≈1500)
Gender	100% Female	65% Female (13) 35% Male (7)	62% Female 38% Male
Race/Ethnicity	66% Black (4) 17% White (1) [1 declined response]	60% Black (12) 30% White (6) 5% Hispanic (1) 5% Other (1)	63% Black 34% White <1% Hispanic 2% Other
Age (years)	Average: 50 Range: 39 – 62	Average: 46.7 Range: 29 – 62	
Education Level	83% Master’s degree (5) 17% Doctoral degree (1)		
Mental Health Experience (years)	[As service provider] Average: 24.5 Range: 12 – 33	[As client] Average: 18 Range: <1 – 44	
Housing		50% house/apt, with family (10) 30% group home (6) 20% house/apt, alone (4)	
Primary Diagnosis		50% Mood disorder (10) 50% Thought disorder (10)	51% Mood disorder 42% Thought disorder 7% Other disorders (e.g., anxiety, PTSD)

Table 3.2. Descriptive statistics of quantitative measures.

Measure (score range)	Mean	Median	Range
Scope of services (0-2)			
Case Managers	1.6	1.8	1.2 - 1.9
Clients	1.6	1.8	0.3 - 2.0
Recovery Assessment Questionnaire (1-5)			
Case Managers	4.4	4.4	4.0 - 4.9
Clients	4.1	4.0	3.0 - 4.9
Community Integration Questionnaire (0-25)			
Clients	12.5	12.5	3.0 - 23.0

Table 3.3. Summary of findings from Research Aim 1: Exploring the priorities and roles of case managers.

Themes		Participant Perspective		
		Case managers	Clients	
Primary goals		Mental health stability <i>[OR]</i> Quality of life in community	Mental health first, then community goals (<i>when discussed</i>)	
Dimensions of case manager roles in promoting community integration	Functional role	Connector	Connector	
		Encourager	Encourager	
		Clinician	--	
		--	Supporter	
	Contextual role	Central	Central	
		Supplemental	Supplemental	
		--	Facilitative	
		--	Separate	
	Relational role	Coach, secondary <i>[OR]</i> Parent, directive	Positive, collaborative <i>[AND sometimes]</i> Enforcer	
		Scope of services	Broader Narrower Most relevant: Mental health, basic needs, social support, finances	Mostly broad -- Most relevant: Mental health, basic needs, family, employment
	Barriers to roles		High caseloads Policies (e.g., HIPAA)	-- --

Table 3.4. Summary of case manager actions related to community integration from case manager and client perspectives.

	Participant Perspective		
	Case Manager	Shared	Client
Connect with resources		Direct referral Case manager-led action Provide info. to client Problem-solve	
Encourage activities	Set “challenges”	Provide reassurance	Regularly “check-in”
Miscellaneous support	Problem-solve issues Work with treatment team Advocacy Liaison to community sites (housing, job) Pursue new resources Use personal contacts	Teach skills Set goals & create plans Offer advice	Accountability Correct behavior Supportive listening
Discourage activities		CM-directed process Shared decision	

Table 3.5. Summary of themes identified as reasons for services being viewed as ineffective at promoting community integration.

Themes	Participant Perspective		
	Case Manager	Shared	Client
Systems issues	Insufficient services available in community Incompatible systems (referrals)		Limited to office setting (“wall”)
Case manager-related issues	Tendency to foster client dependence	Limited to referring to formal services	Lack of follow-through
Client-related issues	Resources Motivation Substance use	Symptoms	Lack of trust

Table 3.6. Comparison of number of clients endorsing each type of case manager *contextual role* grouped by client community integration level.

	Community Integration Level		
	High (n=8)	Medium (n=6)	Low (n=6)
Central	2	3	3
Supplemental	2	2	1
Facilitative	2	1	0
Separate	2	0	2

Table 3.7. Comparison of frequencies of client-reported instances of case managers' actions supporting community integration grouped by client community integration level.

Case Manager Actions		Community Integration Level		
		High (n=8)	Medium (n=6)	Low (n=6)
Resource Referral	Direct resource referral	4	6	7
	Case manager call resource	2	1	1
	Give client resource info	5	3	2
In-session Actions	Accountability	6	1	1
	Check-in	4	3	9
	Advice	8	4	2
	Psychoeducation	1	0	0
	Planning	4	0	1
	Skill-building	6	3	2
	Correction	4	1	2
	Encouragement	8	4	2
	Listening	2	2	4
Work with treatment team		1	2	0
Community-based action		1	0	1

Table 3.8. Comparison of frequencies of client-reported instances of case managers providing central, supportive, or no actions for clients' community integration grouped by client community integration level.

	Community Integration Level		
	High (n=8)	Medium (n=6)	Low (n=6)
Central CM action	6	6	7
Supportive CM action	14	5	5
No CM action	10	7	0

Table 3.9. Comparison of frequencies of client-reported instances of topics discussed during appointments grouped by client community integration level.

Topic Discussed	Community Integration Level		
	High (n=8)	Medium (n=6)	Low (n=6)
Mental Health or Sobriety	5	2	9
Medical or Physical Health	0	0	3
Problematic Behavior	2	2	3
Finances and Benefits	6	5	2
Basic Housing	1	0	1
Independent Housing	5	3	3
Work/School	7	3	3
Relationships	5	4	3
Religion	1	1	1
Recreation	1	1	1
Current Issues	8	5	4
Processing Experiences	2	0	1
Self-Improvement	4	0	0

Table 3.10. Summary of second-order themes describing case manager practices aligning or conflicting with recovery principles.

Theme	Less recovery-oriented	More recovery-oriented	Recovery principles
Case manager’s primary goal	Limited to mental health and stability	Broadly consider clients’ community lives, quality of life, relationships, self-esteem	Holistic, draws on personal and community strengths, relationship-focused, self-respect
Role in clients’ community lives	Parental, central	Coach-like, secondary; one of many resources; negotiated with client	Holistic, draws on personal and community strengths, person-driven
Connection to resources	Direct referral to formal resources only; primarily case manager-led actions	Individualized; facilitate connects to formal and informal resources; look beyond mental health; connect to <i>people</i> ; give information to clients to use when possible	Holistic, draws on personal and community strengths
Facilitating community activities	Limited to referrals	Set between-session challenges for clients; address self-stigma	Supported by allies, self-respect
Supplemental support actions	Prioritize issues for clients; direct meeting agendas	Fill in the gaps between services; encouragement and support in many ways; tailored to client needs, culture, income, etc.	Supported by allies, person-driven, culturally-informed, promotes hope
Managing risk	Protective; focused on avoiding failure; encourage graduated steps or safe environments; discourage activities based on functioning level	Collaborative; reframe failure as “trying”; assist with planning; discuss pros/cons of decisions; respect autonomy; flexible levels of support according to needs; discourage based on past experiences	Supported by allies, person-driven, draws on personal strengths, occurs via many pathways

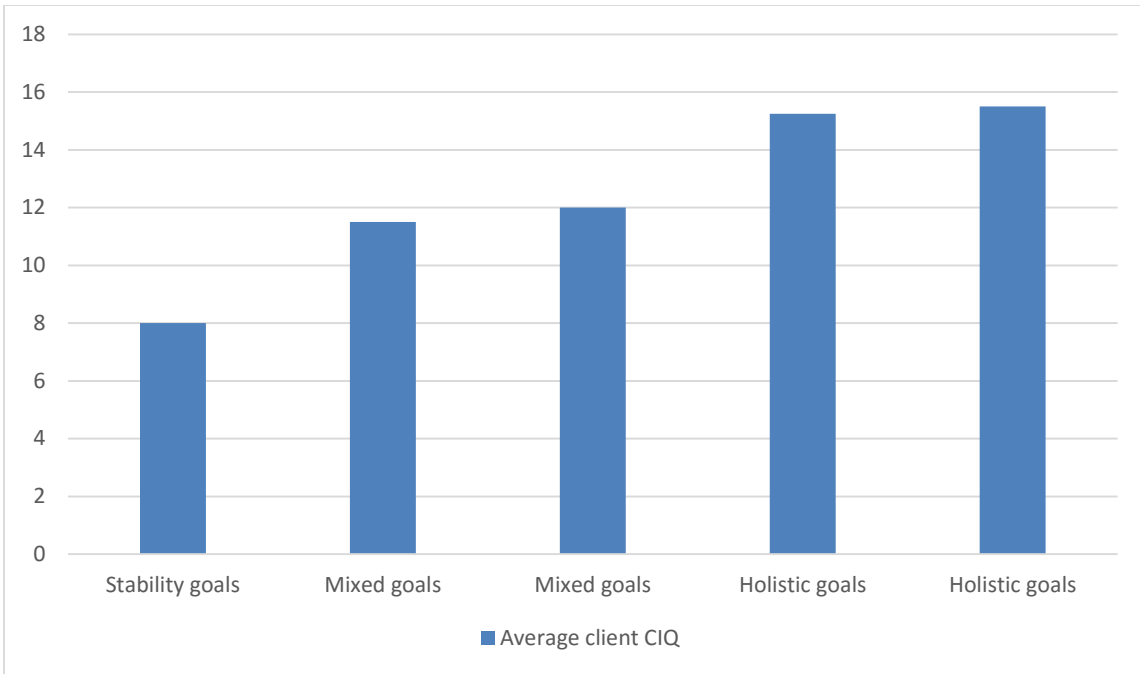


Figure 3.1. Average client community integration scores of case managers with different primary goals in case management.

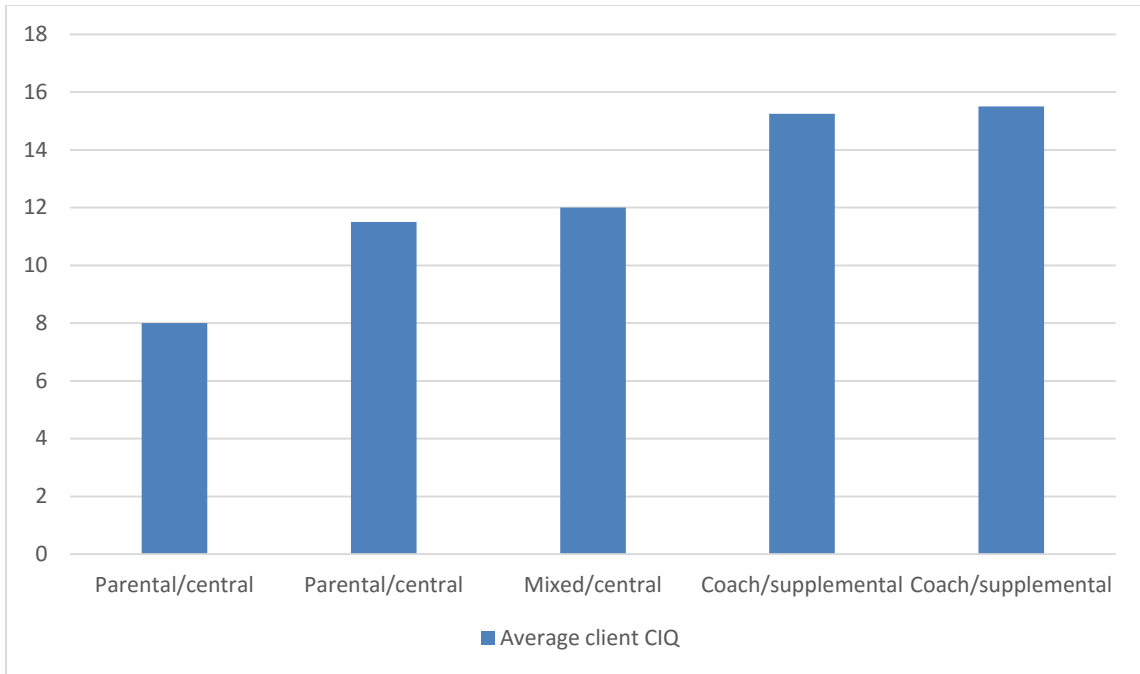


Figure 3.2. Average client community integration scores of case managers with different descriptions of their *relational* and *contextual* roles in case management.

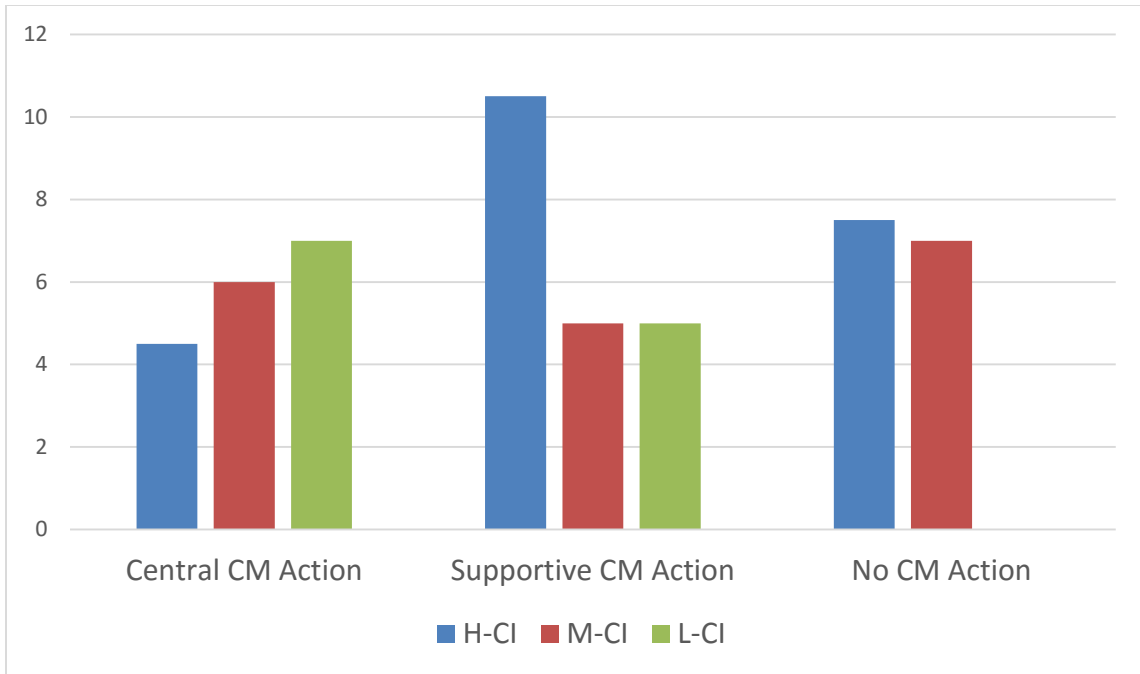


Figure 3.3. Comparison of frequencies of client-reported instances of case managers providing central, supportive, or no actions for clients' community integration grouped by client community integration level. Note: Numbers were adjusted to correct for unequal group sizes in order to allow for direct visual comparison.

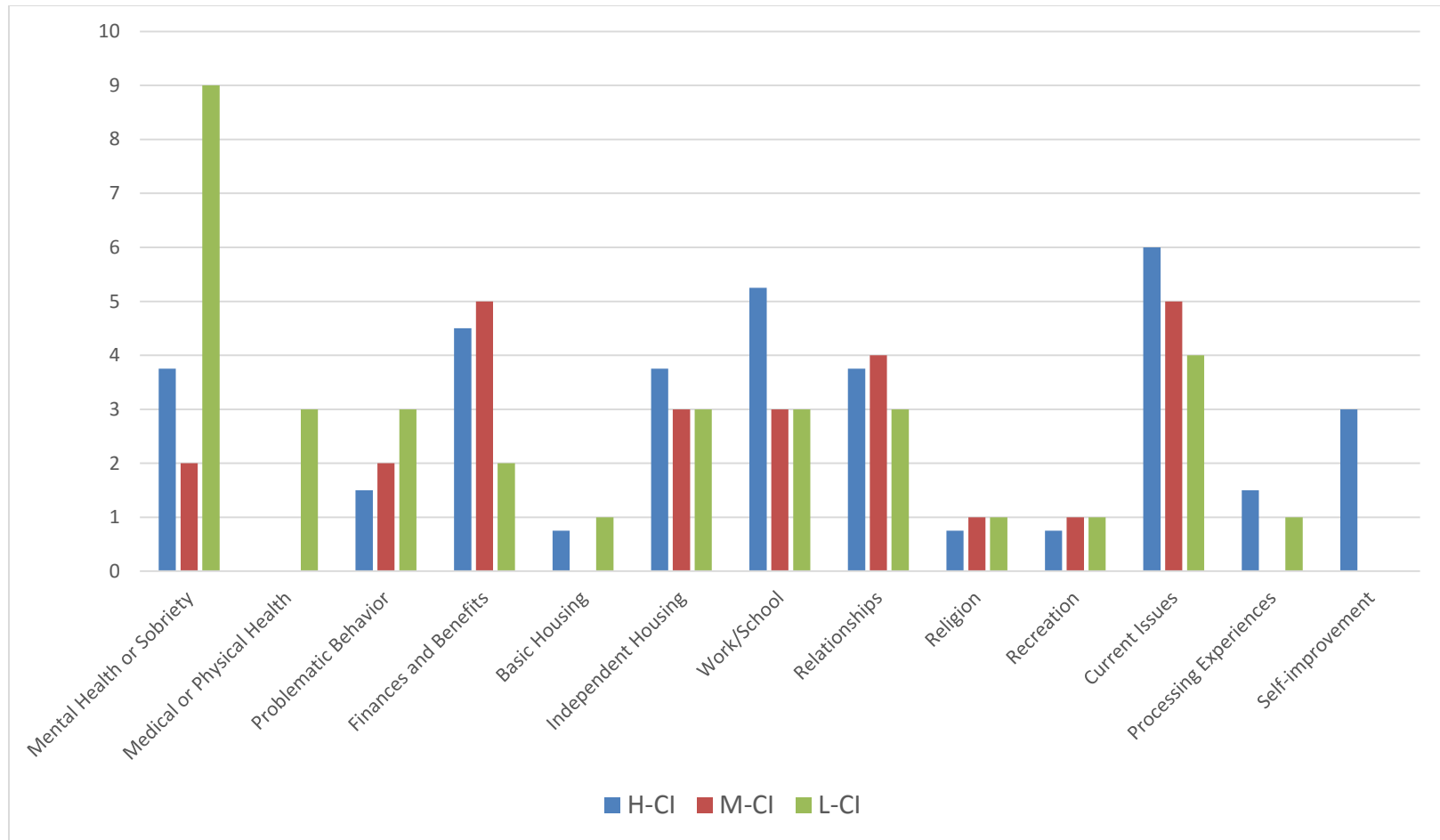


Figure 3.4. Comparison of frequencies of client-reported instances of topics discussed during appointments grouped by client community integration level. Note: Numbers were adjusted to correct for unequal group sizes in order to allow for direct visual comparison.

CHAPTER 4

DISCUSSION

This hypothesis-generating study explored the ways in which community mental health center case managers supported their clients' integration into community life. Case management practices that were more holistically-focused, client-led, and collaborative were linked with higher client community integration outcomes. These approaches to case management reflected an attitude expressed by one case manager and captured in this report's title that there's *"more to life than mental health [and] coming here to the clinic."* From this perspective, the case manager's role was to help clients build a fuller life beyond mental health services, out in their communities. As described below, the practices that these case managers used in working towards this goal with clients also aligned with principles of recovery and client-centered care, and showed promise in being able to inform how standard models of case management can be practiced in recovery-promoting ways.

The present study also brought a new perspective to considering case managers' roles in clients' community lives by outlining four facets of these roles: relational, contextual, functional, and scope dimensions. Relationally, case managers either described themselves as taking on parental roles through using directive approaches to

services or playing a coach role in providing supplemental support and feedback to clients when needed. These patterns were consistent with reports by a subset of clients who discussed their case managers enforcing rules and treatment decisions on them, while other clients described more collaborative relationships.

The ways in which participants described case managers fitting in with clients' broader community contexts fell into four categories: as a central part of their support networks, as providing supplemental or secondary support to their own actions, as facilitating integration through assisting first with mental health stability, and as generally separate from their community lives. Clients across functioning levels defined their case managers' support relating to their community lives in slightly different ways. Clients who reported moderate levels of community integration were more likely to view their case managers as very relevant to their community lives. Highly integrated clients described more supportive roles from their case managers, and those with the lowest level of community integration had a wider range of perspectives in viewing case managers as either central to or separate from their community lives.

Functionally, case managers primarily supported clients' community integration through connecting them to resources, providing encouragement and other support (e.g., skill-building, planning) for community participation, and offering traditional clinical services. Case managers were described as most effective at addressing issues of community life through making connections to established resources and less effective when referrals were insufficient for getting needs met (e.g., low client motivation to follow-through, appropriate services unavailable). The scope of services was most often

defined by participants relatively broadly, with most life domains being considered relevant to case management services for at least some clients.

Below, the discussion turns to four central themes which were drawn from these findings. First, the model of case management described in the present study is connected with the broader literature on case management in order to discuss the strengths and limitations of this approach to services. Next, the characteristics of case management services which were linked with higher client community integration are explored. This section gives particular attention to the principles of client-centered care and the historical context of case management training which may account for differences in practice by experience level. Third, the barriers to effectively promoting clients' community integration which were detailed above are framed as various types of disconnection between systems, case managers, and clients. The final theme focuses on differences in case management experiences by client community integration level and explores these findings within the context of broader literature on client functioning. Following a discussion of these central themes, the limitations of the present study are acknowledged and then potential implications of the present findings for future research are discussed. This section gives special consideration to some of the hypotheses which were generated through this study. Finally, recommendations for clinical practice are presented.

Alignment with Models of Case Management

Based on the models of case management outlined by Kim Mueser and colleagues (1998), the type of case management described in this study fell squarely

within the two models categorized as “standard case management”: the broker model and clinical case management model. High staff-to-client ratios, infrequent outreach to clients, interactions being limited to the mental health center during regular business hours, relatively infrequent office visits (e.g., every 1-2 months), and low-to-moderate levels of direct clinical service provision all confirmed the alignment with these models of practice (Mueser et al., 1998). The specific roles of case managers outlined within these models which were most discussed in the present study were referral to resources, providing general support and encouragement around issues of community life, and providing miscellaneous other supportive tasks such as planning, skill-building, and giving advice (Mueser et al., 1998). The roles of case managers in assessing client needs, advocating for clients within systems, and working with clients’ families and other community supports—all components of standard approaches to case management described by Mueser et al. (1998)—were mentioned but less emphasized by participants interviewed here.

Between the two types of case management comprising these “standard approaches” (i.e., broker model and clinical case management), the elements of practice described in the present study pulled from both models, with participants describing actions consistent with either model at various points in the interviews. For instance, case managers who reported a broader scope of services viewed themselves as being involved in “all aspects of the patient’s life in the community,” and several others reported tailoring their approaches to clients’ changing functioning levels (Kanter, 1989,

p. 367). Both of these practices are consistent with Kanter's (1989) definition of clinical case management.

Others aligned more with the broker model in emphasizing mental health symptoms over other issues of community life. Examples included case managers who viewed their services as *central* to clients' community lives and their tendencies to connect clients to formal services or resources to which case managers already had established connections (e.g., supported housing, mental health clubhouses). These approaches were more consistent with the broker model designed to bridge formal systems. As such, some of the approaches to case management described in this study may be vulnerable to a common critique of standard models of case management as being more "provider-driven" and systems-focused rather than client-centered (Rose, 1992b); however, the present study was also able to highlight elements of practice within these same settings which were more strengths-based, collaborative, and client-centered, as explored below.

Case Manager Characteristics and Client Community Integration Outcomes

The value of the mixed method analyses in the present study was in providing preliminary evidence for linking specific characteristics of case managers with their clients' outcomes. As discussed below, case managers who described their work in ways more consistent with client-centered care, but not necessarily those who endorsed more recovery principles on a quantitative scale, tended to have clients with higher community integration outcomes. These case managers also tended to be older with more experience. These findings align with literature showing that certain traits of

service providers predicted better mental health outcomes for clients in individual therapy (Najavits & Strupp, 1994; Najavits & Weiss, 1994). The present study provided promising evidence that this relationship may translate to case managers and clients' community integration outcomes.

Client-centered care. The practice of client-centered care has been said to be well-aligned with the principles of recovery (Hunt & Resnick, 2015), so it is unsurprising that the characteristics found to be associated with higher average community integration scores in this study were in line with the core principles of this approach. The principles which varied most across case managers included viewing the aims of case management holistically, being collaborative in allowing services to be primarily client-led, and the extent to which client-case manager power dynamics impacted the relationship. The dimension of individualization of support seemed to be relatively consistent across providers.

Whole person approach. The two case managers with highest average client community integration scores both tended to talk about their work with clients in more holistic, humanizing ways than other case managers. They were more likely to acknowledge the interactions between the broader context of their clients' community lives and mental health treatment. Examples included resources clients had outside of mental health that may have aided in their recovery, clients' concerns and values beyond mental health, and the ways in which mental health concerns impacted clients' views of themselves and willingness to try new activities (i.e., importance of addressing

internalized stigma). These case managers explicitly stated the importance of viewing their clients as people first, with struggles and capabilities like everyone else.

Other case managers tended to view mental health as a central concern (or as something that “should” be a primary concern) for many of their clients. They discussed using mental health treatment compliance as an important indicator of clients’ readiness to integrate into the community, which is more aligned with “system-driven” rather than “person-driven” approaches to care (Rose, 1992b).

The difference in these approaches also reflects a larger tension between recovery-oriented care and more traditional (i.e., medical model) approaches to services, which is sometimes labeled the “service paradigm.” The service paradigm is defined as an approach to mental health care which “assumes that the only model of action in helping people with mental health problems is to make them clients and provide services” (Trainor, Shepherd, Boydell, Leff, & Crawford, 1997, p. 134). As an alternative, Trainor et al. (2004) proposed a more holistic Framework for Support which included a model of many types of community resources available to help individuals with psychiatric disabilities in their recovery (Community Resource Base model). This model conceptualized mental health services as one of several types of resources that were important for clients’ community participation and recovery.

In this Community Resource Base model, the person in recovery is in the center and is surrounded by self-help/consumer organizations, friends and family, generic (i.e., not mental health-specific) community services and groups, and mental health services (Trainor et al., 2004). Stated another way, “recovery requires reframing the treatment

enterprise from the professional's perspective to the person's perspective," leading to questions about "what role treatment plays in recovery" rather than vice versa (Davidson et al., 2006, p. 643). Case managers in the present study who identified their roles as *supplemental* to the broader context of client's lives were aligned with this model. They conceptualized their roles as mental health case managers in this more holistic, recovery-oriented way as one of many resources and interests which clients could consider when making decisions in their lives. It is possible that this perspective allowed these case managers to better facilitate their clients' connections with and use of naturally occurring resources, which could contribute to a fuller network of community supports available to clients. More research is needed to test this hypothesis and further explore details and mechanisms of this pattern found in the present findings.

Shared decision-making. Case managers with higher average client community integration scores also described their interactions with clients as being more coach-like and collaborative, with more open discussion and shared decision-making with the client. This difference became particularly salient when describing the ways in which case managers discouraged their clients from certain activities. Some case managers approached these issues from a more parental perspective of protecting clients from potentially risky decisions. Other case managers reported respecting clients' rights to make these decisions and offered support through open discussions with clients about the pros and cons of certain decisions (e.g., quitting a job, attending a party with alcohol).

This latter approach, reported more by case managers with higher client community integration outcomes, reflected the sentiment of client-centered care put forth by Epstein and Street (2011) in which clients' "wishes [are] honored (but not mindlessly enacted)" (p. 100). This perspective also aligned with a core tenet of recovery which respects clients' choices even when they may be risky. Within a recovery framework, this respect for autonomy reinforces "the dignity of risk" and "the right to fail" in clients' lives as ways of growing and learning from their own experiences (Deegan, 1993; Davidson et al., 2006, p. 644).

Case managers with higher average client community integration scores also reported viewing their roles with clients as secondary to clients' own actions and desires, which inherently made the relationship more collaborative. By contrast, other case managers viewed themselves as a necessarily central part of clients' functioning at that time. The differences in these perspectives aligns with the different ways in which Rose (1992b) described case management approaches based on Paolo Friere's framework. The former approach reflects a way of working with clients which views them as "subjects that know and act"—they are given both choice and responsibility for their lives and engagement in treatment; the case manager is present to offer support and guidance. The latter approach reflects a view of clients more as "objects that are known and acted upon" in which providers take on more of the burden of care and protection of the client. These differences in approaches to care also relate to the previously discussed variation in how case managers discouraged activities and managed risk in mental health care. Generally, if clients are viewed as being ultimately

responsible for their choices, then mental health case managers may be more apt to support them in pursuing even risky goals such as working or living independently; if case managers assume more of the burden of care and protection, then discouragement of such risks is more likely.

Shared problem definition. An important component of shared decision-making within models of client-centered care is being able to reach “common ground” about problems and solutions (Stewart et al., 2000). This elements of client-centered care was generally found to be lacking in the present study, specifically related to how clients and case managers viewed challenges or roadblocks in their work together. In this study, there appeared to be differences in the ways in which clients and case managers sometimes understood instances when case managers were not successful at helping a client meet a goal. Though not directly asked in these interviews, neither clients nor case managers reported openly discussing these problems in appointments, which likely led to continued difficulty meeting clients’ needs.

Relationship. Shared decision-making is necessarily built on the foundation of an open and collaborative working relationship; however, this dimension of client-centered care is difficult to interpret in the present study’s findings. On one hand, clients consistently reported having positive relationships with their case managers and identified this relationship as a central way in which case managers supported their recovery. On the other hand, there was a subset of clients who *also* described uneven power dynamics with their case managers, such as case managers enforcing rules, court mandates, or other treatment decisions on them. This dynamic impacted some clients’

willingness to be as open with case managers about their struggles or led clients to work towards appeasing their case managers rather than toward their own goals. Notably, this power dynamic was *not* reported by clients of case managers who tended to describe more collaborative approaches to care.

Therefore, the present study provided somewhat mixed support for the notion that clients' relationships with their case managers may be related to their community integration outcomes. Based on these findings, however, it is possible that having a genuinely collaborative client-case manager relationship which minimizes power differentials is more important for promoting community integration than clients' general, positive impressions of their case managers as being caring and supportive.

Individualized care. Almost all case managers described their work as being tailored to individual clients—either through the resources they referred clients to, the level of support they provided (e.g., meeting frequency, etc.), or the specific issues they addressed in appointments. However, there also seemed to be relatively few examples across both case manager and clients interviews of case managers identifying resources specifically for a single client; more often, referrals were made to other formal systems (e.g., vocational rehabilitation, psychosocial clubhouse) or resources that case managers referred many clients to (e.g., church programs for seniors). Therefore the extent to which care was truly tailored to each individual was unclear in this study.

Individualization of care is an important component of many of the evidence-based models of recovery-oriented mental health services which have been developed over the last several decades, such as Housing First for supported housing and Individual

Placement and Support for supported employment (Drake & Becker, 1996; Stefancic, Tsemberis, Messeri, Drake, & Goering, 2013). Similar approaches are beginning to be applied to other types of community participation, including social and recreational activities. This “supported socialization” can be beneficial for providing clients with the support needed to integrate more fully into their neighborhoods, social clubs, and other informal spaces in their communities (Rowe, 2015). However, this type of service is also more resource-intensive than connecting clients within formal service systems and likely goes beyond the scope and capacity of case managers within overburdened systems such as the one in this study.

In sum, the present study provides preliminary support for the notion that when providers approached their work in more client-centered ways, their clients tended to report better community-based outcomes. The elements of client-centered care captured here included having a more holistic and humanizing approach to case management and providing more supplemental support which naturally capitalized on client’s strengths and capabilities. Other elements of client-centered care, particularly the extent to which care was individually-tailored and incorporated clients’ views of their problems, were identified as potential areas for growth in the case management services studied here.

Recovery attitudes. The finding that scores on the Recovery Attitudes Questionnaire *were not* associated with client outcomes suggests clients’ experiences in case management may be more influenced by the ways in which case managers approached their specific roles as service providers rather than their global attitudes

about recovery. This finding potentially highlights differences between recovery-consistent *attitudes* and recovery-promoting *behaviors* from case managers, which may include some of the actions outlined in Table 3.10 or finding ways of enacting principles of client-centered care, as described above (Hunt & Resnick, 2015). It should be noted, however, that recovery is often considered to be particularly difficult to measure quantitatively due to divergent operational definitions and a “lack of clarity about what the term ‘recovery’ means in practice” (Burgess, Pirkis, Coombs, & Rosen, 2010, p. 27). Furthermore, the RAQ specifically, though valuable for its brevity and ability to directly compare client and provider perspectives, does not have consistent reliability across all samples, partially due to its brevity (Jaeger, Konrad, Rueegg, & Rabenschlag, 2013).

Case manager experience level. A trend emerged from the data suggesting that more- and less-experienced case managers varied in the ways they viewed their case manager roles, the strategies they used with clients, and, to some extent, the average community integration scores of their clients. It should be noted that all case managers in this study had relatively high levels of experience (minimum of 12 years), so the labels of “more” and “less” experienced are only meaningful in their comparison to each other; by other standards, all case managers in this study would likely be considered very experienced. Nevertheless, these findings converge with the results of some psychotherapy studies which found more experienced therapists to have better client outcomes (i.e., symptom reduction; Huppert et al., 2001; Podell et al., 2013; Powell, Hunter, Beasley, & Vernberg, 2010). The present study’s results suggest these relationships may translate to case managers’ work and community integration

outcomes. Furthermore, a value of the present study is its ability to identify differences in the ways that more- and less-experienced case managers tended to approach their work, rather than simply comparing client outcomes, to better illuminate potential pathways through which age or experience may have contributed to different client experiences.

First, analyses suggested that clinicians with more experience (both age and years in the field) reported a broader scope to their services. A potential explanation for this finding is that case managers may have found over time that clients did not experience mental health problems in isolation but rather in conjunction with many other life stressors (e.g., homelessness, family stress, etc.) and that effective case management required addressing a full range of issues beyond mental health.

This difference may also be a result of historical factors impacting the social climate of the United States during the time of case managers' training. Specifically, the older generation of providers, ranging from 25 to 33 years of experience, underwent most of their clinical training during the 1980s, during times of significant expansion of the community mental health movement (Drake & Latimer, 2012; Geller, 2000). The National Institute of Mental Health's Community Support Program was implemented in the late 1970s and new models of case management which helped support clients' rehabilitation and reintegration into their communities were being innovated and emphasized throughout the 1980s and into the 1990s (Geller, 2000). By the 2000s, when the younger case managers in the present study were trained, the mental health system was "dominated by attempts to control costs" (Drake & Latimer, 2012, p. 49),

resulting in more constricted services that were necessarily more focused on acute mental health issues due to billing constraints and limited resources. Therefore it is possible that case managers' differences in how they perceived their roles in clients' lives may have been as much a cohort effect based on the historical context during formative training years as it was attributable to age or experience itself.

Case managers with more experience paradoxically reported more instances of discouraging their clients and using specific strategies to engage their clients more in services. Likewise, clients of these providers reported more instances of their case managers providing encouragement but also correction of inappropriate behaviors. It is possible that over time case managers became more comfortable enacting a wider range of actions—both encouraging and discouraging clients' activities—and built a fuller set of strategies that they had found to be successful in the past. Alternatively, older case managers may have simply been more articulate at defining the specific ways in which they worked with clients or were more comfortable openly discussing ways in which they discouraged clients from pursuing certain goals or activities.

More experienced case managers also tended to have clients with higher community integration scores, but this finding should be interpreted with great caution as it was based on comparisons with only one younger case managers' clients. Future research is needed to determine whether this effect—that older and more experienced case managers were associated with greater client community integration—generalizes beyond the current sample.

Following from this discussion of characteristics that may support case managers in promoting recovery and community integration for their clients, the discussion now turns to barriers case managers faced in this process as well as strategies they used to overcome these barriers.

Barriers to Case Managers Promoting Community Integration

A unifying theme across the barriers identified in promoting community integration within case management was disconnection, in many forms: clients talked about a disconnect between office meetings with case managers and their community lives, case managers discussed frustration around disconnections between what they were able to do and what clients often needed, and analyses highlighted a disconnect between where providers and clients sometimes attributed blame for failed actions. Lastly, the risk-averse nature of the mental health system will be discussed as a barrier which implicitly emerged from analyses, though it was not mentioned directly by participants.

First, a few clients described feeling a “wall” between their meetings with their case managers and their lives in the community which limited the extent to which their work with their case managers could truly impact their everyday lives. For these participants, more intensive community-based support, such as the type of support provided in other models of case management like Assertive Community Treatment or Strengths Case Management, would have allowed them to more successfully implement some of the suggestions made in case management appointments. At the same time, clients also described a wide range of ways in which case managers provided support for

community life during appointments, including helping with goal-setting and planning, holding clients accountable, and providing advice. Therefore although more community-based support might have been helpful for overcoming some barriers in the community, this office-based model did not prevent case managers from supporting their clients' community lives altogether.

Similarly, at times, case managers described a tension between what clients needed and what they were able to provide, and they identified barriers both within and outside of the mental health system as problematic. Internal to the mental health system, case managers discussed the referral system—which they perceived as being inefficient by referring many inappropriate clients to their services—as limiting the time they were able to spend with clients who were appropriate for their services. They also expressed frustration at feeling their actions were limited by what they could bill for during appointments. One key example was case managers feeling that they could not help clients with logistics of community referrals because those services were supposed to be referred out to another specialized service, Targeted Case Management.

At the same time, at least one case manager recognized the value of her role being clearly defined as providing general outpatient case management services to individuals who needed less intense levels of community support. She strove to find ways of providing helpful support within her limited appointments and busy schedule. In this case, it appeared that case managers' frustration at the limitations of their roles could be balanced by recognizing the value of the specific ways in which they serve clients as one piece of a broader system.

Case managers' actions were also described as being constrained by issues outside of the mental health system, particularly the limitations of existing community resources. Often available resources were not sufficient for getting a client's needs met, such as in the case of long supported housing waitlists or a lack of the appropriate services available in the community, and case managers had few solutions to these types of problems.

The final theme of disconnection arose from an observation that case managers often identified major barriers to clients' community integration as clients' motivation for change, their access to resources like transportation and finances, and their mental health or substance use symptoms. Clients, on the other hand, more often described the biggest barriers to community participation as a lack of community-based support, as described above, or case managers not following through on referrals. Therefore it appears that there was, at least among some case manager-client dyads, a conflict in the ways in which each person defined the problem of why a goal was not being reached. These conflicts may partially explain why clients and case managers sometimes differed in their goals, such as case managers strongly recommending mental health-based resources (e.g., clubhouse, supported housing program) based on the "problem" of needing symptom stability and clients preferring a more mainstream setting (e.g., employment, open market housing) based on the "problem" of not having enough income or independence and needing support to make this transition. This finding speaks to the critical importance of case managers and clients openly discussing their goals as well as their thoughts on what barriers are preventing a goal from being

reached and mutually agreeing on how to address the underlying issue. However, this recommendation requires clients to feel empowered to express their own ideas of barriers, which often takes time and courage to build within this historically disempowered population (World Health Organization, 2010).

Risk-averse mental health system. This last example of times when clients and case managers had different goals in mind for the client (e.g., case manager favors mental health setting) also speaks to another barrier to supporting client community integration which was not explicitly discussed by clients but observed throughout the interviews: a risk-averse mental health system (Davidson et al., 2006). As described above, not all providers espoused a protective or risk-averse mentality with their clients—some outright encouraged their clients to face failure in the interest of trying something new. However, the mentality that it is “setting [clients] up to fail” if case managers encourage too much community activity before a client demonstrates a significant period of symptom stability was a theme across both client and case manager interviews.

This theme is not unique to this study. The risk aversion of the current mental health system is a common complaint among service users and promoting greater client choice, even for risky decisions, is a recurrent issue addressed by calls to transform the mental health into a more recovery-oriented system of care (Hogan et al., 2003; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002; WHO, 2010). One potential reason for this risk aversion is because clients often present as more work for case managers if they have set-backs. Keeping clients stable, even at the expense of potentially greater

independence, may then be the default choice for many overworked case managers. As one of Onken et al.'s (2002) participants stated, "We [mental health consumers] lose that ability to have the courage to take a step in a direction where it is just a little bit risky and the system is all too willing to say... 'It's OK we'll take care of you'" (p. 51). Finding ways to overcome the inertia of a risk-averse system in order to promote greater community integration and independence continues to be a significant challenge for these systems (Onken et al., 2002).

Next, the discussion turns to the ways in which clients' functioning levels may impact their perspectives on, needs for, and uses of case management services.

Client Functioning Level

In a general outpatient clinic like the one studied here, case managers must be prepared to work with a full range of client functioning levels—clients range from living in community care homes to living with family or completely independently. A central theme in these interviews was finding ways to tailor one's strategies to each clients' needs and abilities, as well as tailoring strategies to the same client over time as functioning waxes and wanes. The following discussion begins with findings from mid-functioning clients who, in some ways, appeared to see the greatest need for case management services in their lives.

Mid-functioning clients. When exploring differences by functioning level in how clients described their work with case managers, clients with a medium level of community integration were most likely to describe case management as relevant to many areas of clients' lives generally and to their community experiences in particular.

As one case manager suggested, it may be that clients at this functioning level lacked the supports often used by other types of clients, such as those in higher levels of formal services (e.g., psychosocial clubhouse) or with more naturally-occurring supports (e.g., work, friends, family). This finding is particularly interesting given that there is a lack of literature exploring the experiences of mid-functioning clients and whether their service needs may differ from those who need less support or already have more formal supports in place.

Higher-functioning clients. Many clients on the higher end of the functioning spectrum expressed getting help from case managers in more supportive ways which were secondary to their own activities. Interestingly, even higher functioning individuals who believed they had little need for case management services at this time still expressed benefitting from case managers' ongoing support and accountability. One particularly complex question for this population arose from the present findings: How do providers balance minimizing individuals' long-term use and reliance on the mental health system with ensuring that they have the appropriate supports in place to handle important and often stressful transitions like moving to independent housing?

Lower-functioning clients. Prior research and conventional approaches to treatment support the notion that individuals at lower levels of functioning may benefit from more structured settings with more formalized support (Coffey, 2003; Moos & Lemke, 1994; Moos et al., 1997). For several clients in the present study, this appeared to be the case: they rated their case managers as highly relevant to many life domains, they offered many examples of case managers providing them direct support for their

community lives (e.g., connecting them with a psychosocial clubhouse, working with housing managers to coordinate care), and they did not describe any instances of pursuing community activities on their own without formal support.

However, other clients with low levels of community integration viewed their case managers as separate from their community lives. They were not interested in talking with their case managers about ways to increase their social activities or explore new experiences beyond structured mental health settings, despite, in some cases, recognizing the relative paucity of community activities in their lives. It is unclear, based on this study, how to best serve these individuals. Future research should explore more closely the needs, preferences, and perspectives of these lower-functioning individuals specifically related to case management and community integration. It is clear, however, that this finding speaks to the importance of individualized care and of talking openly with each client about his or her specific preferences and needs in case management. Given the wide variety of ways in which case managers supported their clients' community lives in this study, it seems vital for providers to gain a clear understanding of the unique ways in which each client views case management as being most helpful for him or her at that time.

Study Limitations

The exploratory nature of this study, which aimed to build hypotheses that can be tested using larger, more elaborate research designs in the future, inherently has several key limitations that should be acknowledged and considered when interpreting findings. First, the present study used a cross-sectional design which allowed for an in-

depth exploration of relationships at one time point but limited the ability of the present study to define the directions of relationships. For instance, differences found in case management practices across more and less integrated clients may have been due to differences in how case managers worked with these clients or in how clients tended to use and describe their case managers as resources. The observational (rather than experimental) nature of the present study also resulted in an inability to isolate specific causal mechanisms or eliminate other potentially confounding variables in these relationships.

One significant confounding factor was the reliance of the present study on case manager nominations to identify and recruit clients, which introduced sampling bias into the study. Case managers' characteristics, such as their approaches to working with clients or level of understanding of the goals of the present study, may have impacted the types of clients they chose to nominate for the study (e.g., those who lived independently, etc.). The present study attempted to minimize this limitation by explicitly requesting clients across functioning levels and by introducing an element of randomization into participant selection by having case managers nominate more clients than needed for the study.

Other potential biases may have resulted from factors inherent to the data collection process. Clients were partially recruited based on their appointment times (i.e., clients with upcoming appointments were prioritized), which may have led to clients with more frequent appointments being more likely to be interviewed than those with less frequent mental health appointments. Furthermore, clients were often

interviewed before or after mental health appointments, so sampling favored individuals who attended mental health appointments. The extent to which these factors may have biased this study's results is unclear. Although they likely limited generalizability of results to only clients who are engaged in mental health services, this limitation was not necessarily problematic because mental health center clients were the predefined population of focus for this study.

Another significant limitation was the small sample size of the present study and the constriction of collecting data from a single mental health center. The case managers interviewed here represented a majority of the case managers within this section of clinic, but the extent to which their perspectives may be representative of case managers across other community mental health centers is unclear based on the present study. For instance, a major theme across case managers was that their work is restricted by their role in the system as a "catch-all" service which limited their time to focus on working with clients they deemed as most appropriate for their services. It is unknown from this study how common this problem is across similarly-sized and resourced community mental health centers or in what ways case managers' services would be different in settings that more efficiently funneled clients into appropriate services. Moreover, all case managers in this sample had longer tenures in community mental health than the average found in other studies (American Case Management Association, 2013; Paris & Hoge, 2010; Salyers, Rollins, Kelly, Lysaker, Williams, 2013). Given the high burnout rates in this field (Salyers et al., 2013), it is likely that the providers in this sample possess unique sets of skills and personal characteristics that

have allowed them to remain engaged in this line of work for many years. Therefore the extent to which their experiences can be generalized to case managers with less experience may be limited.

Furthermore, only four clients from each caseload were interviewed, which limited the extent to which responses may be generalized to all clients on that provider's caseload, at this community mental health center, or across the state or country. The limited sample size also magnified the impact that each participant had on the findings, increasing the likelihood that findings may have been skewed by a few extreme perspectives. Given these limitations, findings in the present study are viewed as hypotheses to be considered and further tested, rather than conclusive statements in their own respects.

It should also be noted that the distinctions between case managers may be somewhat exaggerated in analyses due to the natural process of clustering individuals based on certain criteria. Case managers may have described their roles generally in one way used in analyses but then given contradictory examples when asked for details. For instance, even case managers who were identified as being focused on symptoms and stability discussed the importance of clients' social lives at other points in their interviews. Conversely, at least one of the providers who was identified as being more client-centered was described by a client as directly countering his wishes for independent housing. This limitation is difficult to avoid, given the complex nature of human relationships, but should be considered in the interpretation of findings nonetheless. Concern over this study limitation was also one reason why data were

analyzed from several different approaches, such as by case manager clusters, client perspectives, and secondary themes of case manager practices (regardless of other case manager characteristics).

Future Directions for Research

The present study was intended to be a first look at the ways in which case managers can support clients' community integration. As such, a target outcome of the study was to generate hypotheses about these relationships which can be further explored and tested in future investigations. This section first discusses some of the most promising hypotheses that emerged from the present study's findings, followed by other considerations for future research. It is important to note that these are hypotheses to be tested for future research, which sometimes include propositions of causal statements, even though the present study was only able to determine non-causal associations.

Emerging hypotheses. A key hypothesis generated from the present study was that case managers who demonstrated more client-centered care will be more effective at promoting clients' community integration. The specific elements of client-centered care which are proposed to contribute most to this relationship, based on the present findings, are case managers' holistic and collaborative approaches to their work with clients. In particular, case managers may be more effective at promoting community integration when they: (a) practice genuinely collaborative decision-making with clients, (b) view clients' quality of life in the community as their ultimate service goal, (c) consider their roles to be more coach-like and secondary to a primarily client-led

process, and (d) acknowledge the wide range of concerns, resources, and interests clients have beyond mental health.

Future research could test these relationships quantitatively and longitudinally to explore whether these characteristics of case managers' practice contribute to changes in clients' recovery and community integration outcomes over time. Intervention studies of case manager trainings on client-centered approaches to case management could offer opportunities for experimental or quasi-experimental approaches to studying this topic. Specific mechanisms of these relationships could also be explored. For example, the present study leads to questions around whether differences in case managers' enacted roles (e.g., parental vs. coach-like, central vs. supplemental) contribute to differences in clients' sense of empowerment, confidence, or skills to explore new community activities or interests on their own. Alternately, the amount of time spent during sessions talking about certain topics (e.g., mental health, relationships, community activities) could be another mediating variable in exploring how services affect clients' community lives.

A second promising hypothesis generated from this study is that clients functioning at different levels may use and benefit from case management services in different ways, especially related to their community integration experiences. Specifically, the present findings suggest that clients at mid-levels of functioning may have the biggest need for the moderate level of support provided by outpatient case management services. These clients may be lacking support from the other formal services (e.g., psychosocial day programs) that lower functioning clients often use but

also not have the informal supports (e.g., work, family) in place often available to higher functioning clients. Therefore there is potential for case management services to be particularly beneficial for clients within this category.

A related hypothesis is that case manager-client interactions vary according to clients' functioning levels, with lower functioning clients receiving more structured care (e.g., service referrals) and higher functioning clients benefitting most from supplemental support (e.g., encouragement, information). Future research could explore whether these case manager actions truly are most effective for supporting community integration for clients at various levels of functioning. Another area for exploration is how to best serve clients at low levels of functioning who prefer to not have case managers involved in their community lives, as some clients expressed in this study.

A final hypothesis which emerged from the present study is that it is important for case managers and clients to openly discuss and agree on each clients' preferred role for case management services. This proposition was not directly implicated in the present findings, but is suggested to be important due to (a) the many ways that both case managers and clients described case managers' roles in client's lives and (b) the differences found in how case managers and clients tended to define problems that arose in these services. The present findings suggest that the two aspects of case managers' roles that would be particularly helpful to discuss are the contextual role (*Where do case management services fit with your other concerns, goals, and resources in the community?*) and the scope of services (*What issues are relevant or not relevant*

to services?). These role dimensions varied most across client perspectives. Future research is needed to explore whether explicitly discussing and agreeing on these components of service might improve case managers' effectiveness, clients' satisfaction with services, and, ultimately, clients' community outcomes.

Other recommendations for research. Future research into the real-world practice of standard models of case management is needed to test whether the actions taken by case managers in the present sample are representative of clinical case managers in other settings. It is not known to what extent services would vary for case managers who operate within similar models but with smaller caseloads or more flexibility to provide community-based services. There is also great potential for using participatory research approaches to collaborate with service providers and clients in building upon these findings and identifying new ways in which standard models of case management may be implemented in more recovery-oriented manners.

Another natural extension of the present study would be to test many of the findings presented here in more structured quantitative ways, in larger samples, longitudinally, and across a diversity of settings. There is potential to use the findings here to generate a more structured approach to evaluating case manager and client perspectives on providers' roles and actions. For instance, future studies could have participants select from a list of choices (e.g., actions, roles, ideal roles) rather than spontaneously generate opinions and examples. There is also a need for measure development around these issues, such as assessing the extent to which individuals

align with various dimensions of case managers' roles described by participants in this study (e.g., parent vs. coach relational role; broad vs. narrow scope).

Implications for Practice

Although the primary purpose of the study was to generate empirically-informed hypotheses for a program of research about how case management can promote community integration, there are some implications of these findings for practice. Specifically, the present findings were able to begin identifying ways in which traditional models of case management (broker model, clinical case management model) can be implemented in recovery-oriented ways which may ultimately promote clients' participation in community life. The elements of practice identified here as related to positive client outcomes aligned with previous research on the benefits of holistically-focused, client-centered care (Aubry & O'Hagan, 2014; Hunt & Resnick, 2015). However, the present study also highlighted numerous challenges to these recovery-oriented approaches to care which are inherent in many healthcare systems (e.g., high caseloads). Finding realistic, experience-based ways of tweaking current practice to be more aligned with recovery principles has potential for a practical and far-reaching impact in mental health systems that are often slow to change and too under-resourced to implement entirely new models of care.

Below is a list of promising practices for both case managers and clients which are based on the patterns observed in the present study; further research is needed to determine empirical support for these recommendations.

Case manager interventions. Specific practice recommendations for case management practice which emerged from the present study's findings include bolstering case managers' abilities to:

- (1) view their case manager role more holistically, both in terms of the ultimate goals they have for clients (i.e., promoting greater quality of life versus treatment compliance or stability) and acknowledging themselves as one element within clients' broader network of relationships, resources, and concerns,
- (2) explicitly discuss with each client various elements of case managers' roles, including the scope of services (i.e., which life domains should or should not be part of case management) and the kind of support that may be most helpful for the client (e.g., directive versus supportive/supplemental),
- (3) intentionally incorporate more *support* activities (e.g., planning, goal-setting, encouragement, accountability, checking-in) into their client meetings,
- (4) strategically tailor actions to clients' needs, preferences, and functioning levels,
- (5) assess for and incorporate naturally occurring resources available to clients into treatment plans, and
- (6) provide support for clients in a manner in which clients are encouraged and supported in taking their own actions in the community.

It is also clear from this study that case managers have developed many strategies for working with clients, but there was very little mention of case managers

sharing these strategies with one another. Therefore a system-level recommendation for supporting case managers would be to develop a peer consultation model in which systematic sharing of strategies and resources are facilitated and encouraged through regular group discussion or similar meetings. This approach may be effective in helping case managers feel appreciated for their own abilities and contributions to the group discussion and is also potentially a more sustainable form of intervention than staff trainings (Shera & Page, 1996). Peer consultation models have been found to be useful in other mental health professions (e.g., school counselors, private practitioners; Benschoff & Paisley, 1996; Lewis, Greenburg, & Hatch, 1988; Logan, 1997; Richard & Rodway, 1992) but have not been extensively applied to case management practice.

Client interventions. Another point of intervention could be training or educating clients in how to best use mental health case management services to improve their community lives (Lammers & Hapell, 2003). A number of existing organizations, including the National Mental Health Self-Help Clearing House, the National Empowerment Center, and Mental Health America offer educational materials for mental health clients on general topics such as recovery and self-advocacy, which serve to help clients become more active in their recovery and service use (Morris & Stuart, 2002). Expanding these trainings into case management, and community integration specifically, could be valuable. This training could include helping clients to identify the roles that they prefer for case managers to play in their community lives and develop skills in advocating for getting the kind of help they see as most needed.

Conclusion

Ultimately, the value of the present study lies in exploring the real-world practices of case managers and the ways in which they managed to work within the constraints of their mental health system to promote clients' community integration. This study included case managers who largely represented the status quo of tightly managed risk, medicalization of mental illness, and a system-centered approach to mental health care. Because of this population of focus, this study was able to fruitfully explore instances—present among some case managers more than others—of viewing clients as people first, of recognizing the barriers to community life from a client's perspective, and of finding creative ways of bending the system's resources to meet the unique needs of each client. These are the stories that should be highlighted, built upon, cultivated, and searched for in other providers, mental health systems, and service settings.

In our attempt to create more recovery-oriented systems of care which are integrated into existing systems rather than parallel to them, it should be a priority to partner not only with consumers but also with front-line practitioners—particularly those who already have priorities and goals aligned with recovery principles—to find ways of building on their practical knowledge and existing practices (Floersch, 2002). Providing mental health centers with more information about what works for increasing clients' involvement in community life may allow them to boost these components of their case management programs and incorporate community integration promotion more effectively into their daily practices.

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APPENDIX A

CASE MANAGER INTERVIEW PROTOCOL

Demographic Information

1. How old are you? _____ years

2. How do you identify your race and ethnicity? [circle all that apply]
 - American Indian/Alaskan Native
 - Asian/Pacific Islander
 - Black/African American
 - Hispanic/Latino
 - Middle East/North Africa
 - White
 - Other

3. How do you identify your gender?
 - Male
 - Female
 - Transgender

4. What is your highest level of education?
 - High school diploma or GED
 - Associates Degree or some college
 - Bachelor's Degree
 - Master's Degree
 - Doctoral Degree

5. How long have you been practicing in the mental health field? _____ yrs/mo

6. How long have you been practicing at [this site]? _____ yrs/mo

7. Approximately how many clients are on your current caseload? _____ clients

Perceived Purpose of Case Management

1. What do you see as the primary purpose(s) of case management?
 - a. How do you define your role as a case manager within the overall mental health system?
 - b. What is your primary goal with clients?
 - c. What do you see as your client’s biggest needs in case management?

2. Which of these areas do you see as more or less relevant to your work in mental health case management? (0 – irrelevant; 1 – mixed/sometimes; 2 – relevant)
 - a. Basic needs, benefits access _____
 - b. mental health _____
 - c. physical health _____
 - d. Family _____
 - e. Education, employment, volunteer work _____
 - f. Recreation, leisure _____
 - g. Legal assistance _____
 - h. Social supports, relationships _____
 - i. Spiritual life _____
 - j. Financial management _____

3. Generally, how involved are clients in setting their own treatment goals?
 - a. When clients are involved, how does this change your work together?

Now I have several questions about how you, as a case manager, view your work relating to clients’ “community activities”. When I use this term, I mean anything that clients do outside of their homes, either for fun (going to the movies, taking a walk, going to community festivals), as part of their day-to-day life (work/school/volunteering, visiting the library, grocery shopping, going to the convenience store), or social activities or relationships (going out to eat with others, dating, visiting friends/family, talking with neighbors or others they meet out).I’m interested in anything related to these experiences—stigma, feeling a sense of belonging, transportation issues, overcoming symptom barriers, etc.

4. In general, how do you see your work as a case manager fitting in with your clients’ overall experiences in the community?
 - a. *Prompt if needed:* Does it feel relevant to your work together? Largely outside of your realm or covered by other services? Relevant but a lower priority? Not relevant until client is very stable in other areas?
 - b. Thinking about all of the factors that impact clients’ participation in the community (finances, transportation, motivation, stigma, friendships,

functioning), where do you think case management fits *ideally*? *In actual practice*?

5. What kinds of barriers keep you from addressing these issues of community life more with clients?
 - a. *Prompt if needed*: time, billing limitations, training/skills/experience/knowledge, discouraged by supervisor/outside of role, not sure client could handle challenge/too risky
 - b. Can you describe a specific example?

6. Tell me about a specific time when you felt *successful* at helping a client do something outside of their home that they wanted to do.
 - a. What was the issue, problem, or goal?
 - b. How was this conversation initiated?
 - c. What did you do or say?
 - d. What happened after you talked about it?

7. Tell me about a specific time when you felt *ineffective* at helping a client do something outside of their home that they wanted to do.
 - e. What was the issue, problem, or goal?
 - f. What did you do or say?
 - g. What happened after you talked about it?
 - h. What do you think prevented your efforts from being effective?

8. Tell me about a specific time when it felt like you needed to *discourage or prevent* a client from doing something in the community that they wanted to do.
 - a. What was the issue, problem, or goal?
 - c. How was this conversation initiated?
 - d. What did you do or say? Did you offer an alternative activity?
 - e. What happened after you talked about it?

9. How much do these examples reflect what *normally* happens in your case management appointments or how you typically approach your work with clients?
 - a. How so or why not?

10. Is there anything else that you want to tell me about your work with clients around their lives in the community?

<i>Recovery Assessment Questionnaire</i>	1 – Strongly Disagree 2 – Disagree 3 – Neutral 4 – Agree 5 – Strongly Agree
1. People in recovery sometimes have setbacks.	1 2 3 4 5
2. To recover requires faith.	1 2 3 4 5
3. Stigma associated with mental illness can slow down the recovery process.	1 2 3 4 5
4. Recovery can occur even if symptoms of mental illness are present.	1 2 3 4 5
5. Recovering from mental illness is possible no matter what you think may cause it.	1 2 3 4 5
6. All people with serious mental illnesses can strive for recovery.	1 2 3 4 5
7. People differ in the way they recover from a mental illness.	1 2 3 4 5

Nominating Client Participants

High functioning: Clients who seem to be doing well in most areas of their lives

- 1.
- 2.

Mid-functioning: Clients who seem to be doing well in some areas or struggling in others

- 1.
- 2.
- 3.
- 4.

Lower functioning: Clients who seem to be currently struggling with their overall functioning

- 1.
- 2.

APPENDIX B

CLIENT INTERVIEW PROTOCOL

Demographic Information

1. How old are you? _____ years

2. How do you identify your race and ethnicity? [circle all that apply]
 - American Indian/Alaskan Native
 - Asian/Pacific Islander
 - Black/African American
 - Hispanic/Latino
 - Middle East/North Africa
 - White
 - Other

3. How do you identify your gender?
 - Female
 - Male
 - Transgender

4. How old were you when you began mental health services? _____ years

5. How long have you been seeing this case manager? _____ years/months

6. How often do you typically see your case manager?
 - Every 1-2 weeks
 - Every 3-4 weeks
 - Every 2-3 months
 - Less than every 3 months

7. What type of residence do you live in? _____
 - a. With whom (if anyone)? _____

Community Integration Questionnaire

ITEM			
1. Who shops for groceries and other necessities in your household?	Someone else	Yourself and someone else	Yourself alone
2. Who usually prepares meals in your household?	Someone else	Yourself and someone else	Yourself alone
3. Who usually does normal everyday housework?	Someone else	Yourself and someone else	Yourself alone
4. Who usually looks after your personal finances, such as banking and paying bills?	Someone else	Yourself and someone else	Yourself alone
5. Who usually plans social arrangements such as get-togethers with family and friends?	Someone else	Yourself and someone else	Yourself alone
How many times per month do you participate in the following activities outside of your home?			
6. Leisure activities (movies, sports, restaurants)	Never	1-4 times	5+ times
7. Visiting friends or relatives	Never	1-4 times	5+ times
8. When you participate in leisure activities, do you usually do this alone or with others?	Mostly alone	Mostly with friends who have MI Mostly with family members	Mostly with friends w/o MI With a combination of family and friends
9. Do you have a best friend, other than a family member, in whom you confide? <i>Where did you first meet that person?</i>	No		Yes
10. How often do you travel outside the home?	Seldom/never (less than once/week)	Almost every week	Almost every day
11. Please choose the answer below that best corresponds to your current work situation in the past month:	Not working, not looking Retired or N/A	Part time Not working but looking	Full time (>20 hours/week)

12. Please choose the answer that best corresponds to your current school or training program situation in the past month:	Not attending school/training program	Part time	Full time
13. In the past month, how often did you engage in volunteer activities?	Never	1-4 times	5+ times

Perceived Purpose of Case Management

1. What is your relationship like with your case manager?
2. What kinds of issues do you and your case manager typically focus on most when you meet?
 - a. *Prompts if needed:* mental health symptoms/problems, medication, other MH programs like group therapy, referring to other programs like voc rehab, relationships, finances, housing situation
3. Is there anything you don't talk about with your case manager that you wish you could?
 - a. Why do you think you two don't usually talk about that?
4. Which of these areas do you see as more or less relevant to what you view mental health case management services being about *in general*? (0 – irrelevant; 1 – mixed/sometimes; 2 – relevant)
 - a. Basic needs, benefits access _____
 - b. mental health _____
 - c. physical health _____
 - d. Family _____
 - e. Education, employment, volunteer work _____
 - f. Recreation, leisure _____
 - g. Legal assistance _____
 - h. Social supports, relationships _____
 - i. Spiritual life _____
 - j. Financial management _____
11. Generally, how involved are you in setting your own treatment goals?
 - a. How does (*or would*) this change your work with your case manager?

Now I have several questions about how you view your case manager as impacting your "life in the community" or "community activities". When I use these terms, I mean anything that you do outside of your home, either for fun (going to the movies, taking a

walk, going to community festivals), as part of your day-to-day life (work/school/volunteering, visiting the library, grocery shopping, going to the convenience store), or social activities or relationships (going out to eat with others, dating, visiting friends/family, talking with neighbors or others you meet out). I'm interested in anything related to these experiences—stigma, feeling a sense of belonging, transportation issues, overcoming symptom barriers, etc.

5. In general, how do you see your work with your case manager fitting in with your overall life in the community?
 - a. *Prompt if needed:* Do you view him/her as a resource for helping you do more activities or make more friends or does your work with him/her feel separate from all of that?
 - b. How much do you feel like your case manager cares about or understands your life outside of mental health?
 - c. Thinking about all of the factors that impact your activities in the community (finances, transportation, motivation, friendships), where do you think case management fits *ideally*? In *reality*?

6. Tell me about a specific time when you felt like your case manager was *successful* at helping you do something outside of your home you wanted to do.
 - a. What was the issue, problem, or goal?
 - b. How was the conversation initiated?
 - c. What did your case manager do or say?
 - d. What happened after you talked about it?

7. Tell me about a specific time when you felt like your case manager was *ineffective* at helping you do something outside of your home that you wanted to do.
 - a. What was the issue, problem, or goal?
 - b. What did your case manager do or say?
 - c. What happened after you talked about it?
 - d. Why do you think that instance was unsuccessful?

8. Tell me about a specific time when it felt like your case manager discouraged or prevented you from doing something outside of your home you wanted to do.
 - a. What was the issue, problem, or goal?
 - b. How was the conversation initiated?
 - c. What did your case manager do or say? Did you discuss alternative activities?
 - d. What happened after you talked about it?

9. How much do these examples reflect what *normally* happens in your case management appointments? How so or why not?

10. Is there anything else that you want to tell me about how your interactions with your case manager affect your life?

<i>Recovery Assessment Questionnaire</i>	1 – Strongly Disagree 2 – Disagree 3 – Neutral 4 – Agree 5 – Strongly Agree
1. People in recovery sometimes have setbacks.	1 2 3 4 5
2. To recover requires faith.	1 2 3 4 5
3. Stigma associated with mental illness can slow down the recovery process.	1 2 3 4 5
4. Recovery can occur even if symptoms of mental illness are present.	1 2 3 4 5
5. Recovering from mental illness is possible no matter what you think may cause it.	1 2 3 4 5
6. All people with serious mental illnesses can strive for recovery.	1 2 3 4 5
7. People differ in the way they recover from a mental illness.	1 2 3 4 5

APPENDIX C

AGGREGATED CODING DIAGRAM

[Client interviews only]

1. Activities

- a. Want more activities
- b. Done alone
- c. Done with others
- d. community-based
 - i. daily living
 - ii. recreation/leisure
 - iii. done with support
 - iv. work/school
 - v. done independently
- e. Mental health-based
 - i. Support groups
 - ii. Appointments
 - iii. Psychosocial clubhouse
- f. Home-based
- g. no activities

2. Relationships with others

- a. Lacking or lost relationships
- b. Helping others
- c. Family
 - i. Positive
 - ii. Negative
- d. Friends
 - i. Mental health
 - ii. Non-mental health
- e. Support

- i. Emotional
- ii. Tangible
- f. Interpersonal problems
- g. MH staff (non-Case manager) relationships
- h. Role of relationships in recovery

3. Case manager relationship

- a. Collaborative
- b. Positive
 - i. Open
 - ii. Persistent
 - iii. Cares
 - iv. “down to earth”
- c. Uses humor/funny
- d. Power dynamic (in control)
 - i. “pushy”
- e. Trust issues

4. Case manager role (broad)

- a. accountability
- b. guidance/feedback
- c. money management
- d. emotional support/encouragement
- e. planning
- f. resource for getting more info/resources
 - i. housing
 - ii. work
 - iii. Client brings resources to CM to discuss
- g. therapist
- h. NOT part of role
- i. Ideal
 - i. No difference between actual and ideal

5. Case manager actions (specific)

- a. Strategies CMs use
 - i. Use stories
 - ii. Increase support in high need times
 - iii. Tailor work to client needs/abilities
- b. Documentation of services
- c. Community-based actions
- d. Connect with resources

- i. Provide information
 - ii. Help with applications
 - iii. CM calls places
- e. Discussion
 - i. Check-in
 - ii. Accountability
 - iii. Advice
 - iv. Aid client in problem-solving
 - v. Encouraging
- f. Skill-building
 - i. Planning
 - ii. Assertiveness
- g. Collaborate with treatment team
- h. Limits to actions
 - i. Waitlists to services
 - ii. Not in community (enough) to know client lives

6. Case manager work examples

- a. Successful
- b. Unsuccessful
- c. Discouraging activities

7. Topics in case management

- a. Finances
- b. Basic needs
- c. Current issues for client
- d. Housing
- e. Family relationships
- f. Meds
- g. Medical/physical health
- h. Work
- i. Self-confidence

8. Treatment goals

- a. Content of goals
 - i. Independent housing
 - ii. Discharge from case management
 - iii. Improve hygiene
 - iv. Maintain sobriety
- b. Process of setting goals
 - i. Collaborative

- ii. Client-initiated
- iii. Not client-initiated

9. Mental health

- a. Symptoms
 - i. Interfering/disruptive
- b. building non-MH Identity
- c. medications
- d. accepting limits of mental illness
- e. things that promote recovery
 - i. spirituality
 - ii. follow service provider guidance
 - iii. avoid old environments
 - iv. relationships/support

10. CM-client interactions

- a. Client expectations of CM
- b. Client perceptions of difficult CM experiences
- c. Role of choice
 - i. Preferred
 - ii. Not preferred
 - iii. Defer in emergency
- d. CM vs. client goals