**Substance Abuse and Mental Health Services Administration**

*Center for Substance Abuse Treatment*

**Co prehensive Case anage ent for Substance Abuse Treat ent**

*Treatment Improvement Protocol (TIP) Series*

*�* **Substance Abuse and Mental Health Services Administration**

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**Comprehensive Case anagement for Substance Abuse Treatment**

*Treatment Improvement Protocol (TIP) Series*

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment

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## What Is a TIP?

reatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration

(SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts of various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at [http://store.samhsa.gov.](http://store.samhsa.gov/)

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided. When no citation is provided, the information is based on the collective clinical knowledge and experience of the consensus panel.

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#### Foreword

he Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health

and Human Services that leads public health efforts to advance the behavioral health of the nation.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities by providing evidence-based and best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-

Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. Field reviewers then review and critique this panel's work.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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# Executive Su111111ary

ase management has been variously classified as a skill group, a core function, service coordination, or a

network of "friendly neighbors." Although it defies precise definition, case management generally can be described as a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals. The Consensus Panel that developed this TIP believes that case management lends itself to the treatment of substance abuse, particularly for clients with other disorders and conditions who require multiple services over extended periods of time and who face difficulty in gaining access to those services. This document details the

and service coordination to address multiple aspects of a client's life. Comprehensive substance abuse treatment often requires that clients move to different levels of care or systems; case management facilitates such movement.

Any definition of case management will be contextual, depending on who is implementing the program. Perhaps a more helpful way to understand it is to examine the functions that generally comprise case management: (1) assessment, (2) planning, (3) linkage, (4) monitoring, and (5) advocacy.

##### Case Management and Substance Abuse

**Treatment**

factors that programs should consider as they

decide to implement case management or modify their current case management activities. This summary is excerpted from the main text, in which references to the research appear.

Research suggests two reasons why case management is effective as an adjunct to substance abuse treatment. First, retention in treatment is associated with better outcomes, and a principal goal of case management is to keep clients engaged in treatment and moving toward recovery. Second, treatment may be more likely to succeed when a client's other problems are addressed concurrently with substance abuse. Case management focuses on the whole individual and stresses comprehensive assessment, service planning,

When implemented to its fullest, case management will enhance the scope of addictions treatment and the recovery continuum. A treatment professional utilizing case management will

* Provide the client a single point of contact for multiple health and social services systems
* Advocate for the client
* Be flexible, community-based, and client­ oriented
* Assist the client with needs generally

thought to be outside the realm of substance abuse treatment

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*Executive Summary*

To provide optimal services for clients, a treatment professional should possess particular knowledge, skills, and attitudes including

* Understanding various models and theories of addiction and other problems related to substance abuse
* Ability to describe the philosophies,

practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems

* Ability to recognize the importance of family,

social networks, community systems, and self-help groups in the treatment and recovery process

* Understanding the variety of insurance and

health maintenance options available and the importance of helping clients access those benefits

* Understanding diverse cultures and

incorporating the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice

* Understanding the value of an

interdisciplinary approach to addiction treatment

In addition to the above competencies, treatment professionals must have skills relating to interagency functioning, negotiating, and advocacy. CSAT's Addiction Technology Transfer Centers classify referral and service coordination-basic case management functions-as core competencies for substance abuse treatment providers.

The Substance Abuse Treatment Continuum and Functions of Case Management

The continuum of substance abuse treatment ranges from case finding and pretreatment to primary treatment to aftercare. Although there

are distinct goals and treatment activities at each point on the continuum, rarely do clients' needs fit neatly into any one area at a given time; case management serves to span client needs and program structure. Substance abuse treatment and case management functions differ in that treatment involves activities that help substance abusers recognize their problems, acquire the motivation and tools to stay abstinent, and use the acquired tools; case management focuses on helping the substance abuser acquire needed resources. Case management supports a client as he moves through the recovery continuum and reinforces treatment goals.

##### lnteragency Case Management

The goal of interagency case management is to expand the network of services available to clients. All organizations have boundaries to what they can do, and case managers or "boundary spanners" transcend them to facilitate interactions among agencies. In the field of substance abuse, three interagency models have been identified. In the *single agency* model, the case manager personally establishes a series of distinct relationships on an as-needed basis with counterparts in other agencies. In the *informal partnership* model, staff members from several agencies work as a collaborative team, often constituted case by case; *the formal consortium* binds case managers and service providers through formal written agreements.

Clearly defined roles are essential to all three models to ensure that services are coordinated and relevant gaps addressed.

Although informal exchange or "social service bartering" among different agencies is intrinsic to case management, a more formalized connection among agencies sometimes may be required. Examples include memoranda of understanding and interagency agreements and contracts; each of these methods for formalizing

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*Executive Summary*

expectations can be used in single agency models, informal partnerships, and formal consortia.

To be successful, a case management plan must thoroughly and critically examine community resources to determine what forms of assistance are available and how case management efforts can help clients attain necessary assistance. Many communities have published directories of social, health, welfare, housing, vocational, and other service organizations to help case management programs identify resources, possible provider linkages, and potential gaps in services for their clients. Although such directories are a good starting point, it is important to follow up on the listings to ensure they are still accurate and will be of use to the client.

**The Environmental Assessment**

Exploring the environment in which an agency operates is crucial to determining the feasibility of an interagency effort. Analysis of the community environment will enhance understanding of the changes that occur among clients, within the program, and in the community. Case management takes place within a dynamic social service environment in which agencies are in constant flux. Programs considering interagency efforts must devise strategies to respond to change while providing continuity for the client. Regular reevaluation helps ensure continued relevance; community service provider networks or consortia are particularly effective in sharing information about changes and developments.

**Potential Conflicts**

Whenever agencies or service providers work together, the potential for conflict exists. Areas of tension may be present from the very onset of the collaboration. For example, a new project may be viewed by established social service agencies as competition for scarce resources.

Sometimes social pressures or the need to maximize resources can force public agencies into joint ventures even if they do not mesh well or have a history of being service competitors.

Tensions can also develop in the course of delivering services; for example, interagency collaboration may result in a client having two case managers. Recognizing potential triggers for conflict is a necessary first step in developing a system to handle them. When problems do arise, case managers and other agency personnel can use both informal and formal communication to clarify issues, regain perspective, and refocus the interagency case management process.

##### Evaluation and Quality Assurance of Case Management Services

Substance abuse treatment programs, including those that receive public funding, are increasingly operating in a managed care environment. In such an environment, policy and clinical decisionmaking rely on outcome data that traditionally describe the impact of case management and substance abuse treatment interventions in the context of services used and money spent. An additional demand for data comes from public and private payers who want services linked to specific outcomes.

To gauge the effectiveness of case

management, indicators of "success" must be defined by the substance abuse program and its stakeholders (including funding and regulatory agencies). In documenting a case management effort, it is necessary to establish *benchmarks* to measure the case management process, for example, recording how often a client shows up at treatment. Once the benchmarks are defined in measurable terms, the next step is to develop and implement a method for measuring practice; that is, to answer the questions, "What are case managers doing, and how does their

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*Executive Summary*

practice conform to the benchmarks?" Methods of such documentation include

* Maintenance of a simple staff log procedure that measures case managers' activities by contact
* Reviews of case manager client records to

evaluate how service planning and referrals adhere to benchmarks

* Interviews or surveys of case managers or

clients and their family members to collect information on activities in which case managers engage, to identify how clients' and case managers' views of case management activities differ

* Analysis of data from the agency's

management information system (to examine patterns on type, number, and duration of case manager contacts with different target populations).

Measuring System Outcomes

System outcomes are particularly important in a managed care environment, where overall use of expensive services such as hospitalization and residential treatment is strictly monitored.

System outcomes can measure cost savings and quality of care: For example, continuity of care is an appropriate measure for a client at risk for relapse after detoxification and before entry into outpatient treatment. Tracking clients within a comprehensive service agency or analyzing data on costs and encounters within a network of agencies are two methods for measuring system outcomes. For such analyses, a computerized management information system (MIS) is essential.

Measuring Client Outcomes

Although "evaluation" is generally considered worthwhile, there is little agreement about the measurement and documentation of specific outcomes for individual clients. Some view a single measure such as sobriety to be the only meaningful indicator of success; others believe

success should be gauged against a range of factors, including reduced substance use, improved family functioning, and fewer encounters with the criminal justice system. Until the debate is resolved, programs should identify treatment objectives and extrapolate from them the outcome variables they want to measure.

Anticipating Quality Assurance Data Needs

The types of data required for an evaluation of case management, how the data are collected, and the manner in which data are put to use vary among different stakeholders. It is important to understand the types of data that various stakeholders need to evaluate the program. Structured feedback loops should be established to ensure that the gathered data are returned to various stakeholders in some meaningful way so that they have an impact on shaping future program development (and future data needs). One of the benefits of the case management approach is that it can be adapted to meet the sometimes contradictory needs of the various stakeholders.

Management Information Systems

A management information system contains all of the case management services information and allows stakeholders to access it. In evaluating a MIS, local programs should

* Determine how to use data already routinely collected by a statewide MIS or a managed care company-based MIS, saving the program from duplicating primary data collection
* Develop or enhance a program-level MIS

that tracks data the program needs locally

* Integrate with other computer-based or paper-based systems
* Supply data required by third party payer

and governmental bodies

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*Executive Summary*

All staff members of a specific program should be stakeholders in the MIS, which increases both system accuracy and the likelihood that a broad array of staff members will use it. If an agency does not have the resources to develop a sophisticated system, it

* Research questions from broader sociological or multidisciplinary perspectives

##### Case Management for Clients With Special

**Needs**

should be able to automate at least a minimum

amount of client information through commercially available software. When designing today's MIS, the data requirements of managed care organizations must be addressed.

Future Research

Research centered on case management and the substance abuse field is limited, thus offering local substance abuse programs the opportunity to make significant contributions to the field.

Suggested directions for future research include the following:

* Key ingredients of successful programs, especially for hard-to-reach populations
* Relative cost-effectiveness of particular case

management models, including cost outcome results within systems incorporating full parity of substance abuse with other health care; outcome results when a full continuum of care is available to patients; and outcome results associated with use of standardized guidelines for placement, continued stay, and discharge for substance abuse patients

* Improved methodology to investigate

research questions in "real world" settings

* Development of brief versions of valid and reliable research outcome instrumentation
* The effect of particular forms of case management on societal costs of substance abuse and its treatment
* Cost shifting among health, behavioral

health, criminal justice, and other systems that can be accessed by the target population

* Creative ways to use secondary data sets

(such as Medicaid and Medicare) to determine trends and patterns of care

Case management is especially appropriate for substance abusers with special treatment needs, related to such issues as HIV infection or AIDS, mental illness, chronic and acute health problems, poverty, homelessness, responsibility for parenting young children, social and developmental problems associated with adolescence and advanced age, involvement with illegal activities, physical disabilities, and sexual orientation. Ideally, a case manager will possess all the expertise and skills needed to treat the many special needs she confronts, but this is unlikely-understanding the ramifications of even one special need can be a staggering task. In the absence of such comprehensive knowledge, a case manager should have a basic foundation of attitudes and skills for delivering services to "special needs clients." The case manager should

* Make every effort to be competent in the special circumstances that affect clients typically referred to a particular substance abuse treatment program
* Understand the range of clients' reactions to

the challenges associated with particular special circumstances

* Remain aware of the limits of his own

knowledge and expertise

* Evaluate personal beliefs and biases about clients who have special problems or needs
* Maintain an open attitude toward seeking

and accepting assistance on behalf of a client

* Know where additional information on special problems can be accessed

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*Executive Summary*

##### Funding Under Managed Care

Whatever treatment providers' attitudes toward managed care, they will have to accept that it is the new paradigm for health care. Well over

one-half of the States are currently in the process of adopting some form of managed care for providing public-sector behavioral health care services. Many have already received Federal waivers to implement Medicaid managed behavioral health programs, and other waivers are planned or pending. Managed care has changed the context in which substance abuse treatment services are delivered, and substance abuse programs must prepare to function within this new environment if case management is to survive.

Treatment providers using case management may not only survive but actually thrive under managed care. Many managed care organizations (MCOs) reimburse for case management, so it behooves providers to prove that their brand of case management should be covered. The program should develop a comprehensive case management system with the flexibility and resources necessary to eventually show tangible savings.

To adapt to this new way of doing business, treatment programs must assess how they use case management and appraise their readiness to operate in a managed care environment. One way providers can thrive under managed care is to position themselves and their case management services in a competitive market by identifying market niches, such as clients with HIV/ AIDS, criminal justice clients, or older clients.

As MCOs increasingly reimburse for case management, licensing requirements are becoming stricter. The trend is toward case managers who have advanced degrees.

Accreditation standards will also tighten under managed care.

In short, there are many reasons for substance abuse treatment providers to adopt case management or to formalize their existing case management activities. This will not necessarily mean an upheaval, as many programs are already helping clients navigate their other, non-substance abuse problems. This TIP equips providers with the knowledge they need to fully serve their clients at the same time they conform to the changing health care system.

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# Substance Abuse and Case Managen1ent: An Introduction

he term *case management* has appeared in social services literature more than 600 times in the last 30 years, referring to

everything from the routing of court dockets through the judicial system to the medical management of a hospitalized patient's care. This TIP uses the term to refer to interventions designed to help substance abusers access needed social services.

Support for the use of case management in this setting developed from both clinical practice and empirical observation suggesting that substance abusers who seek treatment have significant problems in addition to using psychoactive substances. Alcohol or other drug use often damages many aspects of an individual's life, including housing, employment, and relationships (Oppenheimer et al., 1988; Westermeyer, 1989). Clients in substance abuse treatment programs, particularly publicly funded treatment programs, present a variety of associated problems. Many use multiple substances and may be poly-addicted. Many suffer from related health disorders, either caused by their substance abuse-such as liver disease and organic brain disorders-or exacerbated by neglect of health and lack of preventive health care. In addition, some diseases-including HIV/ AIDS, tuberculosis, and some strains of

hepatitis-are transmitted by substance abuse, either directly or indirectly.

Substance abusers also have a higher incidence of mental health disorders than the general population. Up to 70 percent of individuals treated for substance abuse have a lifetime history of depression (Mirin et al., 1988). Between 23 and 56 percent of individuals with diagnosable Axis I mental disorders also have a substance abuse or dependence disorder (Regier et al., 1990).

Substance abuse clients often arrive in treatment programs with numerous social problems as well. Many are unemployed or under-employed, lacking job skills or work experience. Many in publicly funded treatment programs do not have a high school diploma. Some are homeless, and those who have been incarcerated may face significant barriers in accessing safe and affordable housing. Many substance abuse clients have alienated their families and friends or have peer affiliations only with other substance abusers. Women in treatment have often been victims of domestic violence, including sexual abuse; some women in treatment may be living with an abuser.

Achieving and maintaining abstinence and recovery nearly always requires forming new, healthy peer associations.

*1*

*Chapter 1*

A significant number of clients in treatment are also under some form of control by the criminal justice system. Criminal justice substance abuse clients represent more than half of all clients in treatment in many state and local jurisdictions. Although those afflicted by chemical addiction are found among all socioeconomic groups, persons already plagued by poverty, disease, and unemployment are over-represented (CSAT, 1994). Particularly in publicly funded treatment programs, substance abuse clients have limited resources and may lack health insurance. Many are eligible for publicly supported health and social benefits, including Medicare, food stamps, or welfare.

Data suggest that substance abusers who receive professional attention for these additional problems will see improvements in occupational and family functioning and a lessening of psychiatric symptoms (McLellan et al., 1993; McLellan et al., 1982; Moos et al., 1990; Siegal et al., 1995). Clinicians who develop a "helping alliance" with substance abusers have been shown to produce better treatment outcomes than those who do not (Luborsky et al., 1985).

**Why Case Management**

Because addiction affects so many facets of the addicted person's life, a comprehensive continuum of services promotes recovery and enables the substance abuse client to fully integrate into society as a healthy, substance-free individual. The continuum must be designed to provide engagement and motivation, primary treatment services at the appropriate intensity and level, and support services that will enable the individual to maintain long-term sobriety while managing life in the community.

Treatment must be structured to ensure smooth

transitions to the next level of care, avoid gaps in service, and respond rapidly to the threat of

relapse. Case management can help accomplish all of the above.

Case management is needed because, in most jurisdictions, services are fragmented and inadequate to meet the needs of the substance­ abusing population. This lack of coordinated services results from a variety of factors, including

* Different funding streams. Substance abuse treatment is funded from a variety of sources-block grants, competitive grants, state and local funding, criminal justice funding, and others. The different requirements or goals of these sources can result in a piecemeal approach to programming
* A focus on program funding rather than

system funding

* Funding focused on single modalities rather than a continuum of care
* Inadequate funding created by missing pieces in the continuum
* Waiting lists caused by inadequate funding
* Barriers between systems (e.g., mental health vs. substance abuse, criminal justice vs. mental health and substance abuse)
* Lack of incentives geared to client outcome;

programs rewarded for process measures, not outcome measures

* Eligibility/ admission criteria that exclude

certain clients

* Lack of agreement on priority for admission/ treatment
* Lack of incentives for programs to work together

Due to the fragmentation of services, the accompanying inefficiency, and a growing scarcity of resources, some form of case management is used with virtually every population that routinely seeks social services. The variability in social services system configurations has led to many different implementations of case management, resulting

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*Introduction*

in conceptual disagreements about case management and difficulty in assessing its value. Inevitably, many of the same issues will arise in the substance abuse setting. This TIP is designed to establish a common starting point for case management work with substance abusers. To address at least some of those conceptual disagreements, the TIP makes several assumptions, including

1. Case management is a set of social service *functions* that helps clients access the resources they need to recover from a substance abuse problem. The functions that comprise case management-assessment, planning, linkage, monitoring, and advocacy-must always be adapted to fit the particular needs of a treatment or agency setting. The resources an individual seeks may be external in nature (e.g., housing and education) or internal (e.g., identifying and developing skills).
2. Advocacy is one of case management's hallmarks. While a professional conducting therapy may speak out on behalf of a client, case management is dedicated to making services fit clients, rather than making clients fit services.
3. Case management may be implemented by an individual dedicated solely to helping the client access needed resources--a case manager---or by a professional who has this responsibility along with therapeutic or counseling functions. This TIP stresses the *intervention* rather than the intervener's *profession.*
4. The primary difference between case management and therapy is that the former stresses resource acquisition, while the latter focuses on facilitating intra- and interpersonal change. However, case management and therapy are not incompatible. Indeed, both are generally called for in addressing the needs of a majority of substance abuse clients.
5. When implemented to its fullest, case management challenges the addiction treatment continuum of pretreatment, primary treatment, and aftercare (discussed further in Chapter 2). This occurs because of the advocacy function of case management; the need for case managers to be flexible, community-based, and community-oriented; and the need for case managers to be the primary figures in planning work with the client.

These assumptions are all affected by the setting in which case management is practiced. Practitioners who work with substance abusers do so in methadone maintenance clinics, hospital- and community-based addiction programs, local social service departments, family preservation programs, and storefront community outreach programs. These physical settings are in turn influenced by numerous other factors, including the source(s) of an agency's funding; the agency's mission; staff orientation, education, and training; the agency's treatment philosophy; and the makeup of other social services in a particular geographical area.

Complicating the implementation of case

management with substance abusers are three trends that will alter the current manner in which substance abuse treatment and case management are implemented: Managed care, treatment provided in the criminal justice system, and diminishing social services and resources. Managed care uses case management to *restrict* access to services as well as to *facilitate* access to services. In addition to the issue of cost containment, the movement of a great deal of substance abuse treatment (and thereby case management) into criminal justice venues is significant. The potential conflicts between coerced involvement in treatment and case management will test the limits of advocacy and client-driven aspects of the intervention.

Finally, unlike the early period of case

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management, clients and professionals practicing case management now negotiate a drastically *constricted* menu of services. Each of these contemporary conditions makes implementation and evaluation an increasingly difficult task.

**Case Management** - **A**

##### Brief History

More than 70 years ago when Mary Richmond envisioned a cadre of "friendly neighbors" helping others in their struggles with real world needs (Richmond, 1922), she created not only the field of social work, but case management as well. While she applied the term *social casework* to the activities that affected the adjustment between an individual and the social environment, she could well have been describing the key functions that now comprise case management.

One of the first legislative embodiments of case management occurred in the 1963 Federal Community Mental Health Center Act (Intagliata, 1982) in anticipation of deinstitutionalization, in which persons in long­ term psychiatric care were moved into community settings. The expectation that these individuals would need services previously provided in the institution led to the rapid expansion of community-based social services. Unfortunately, these services were often created independently of one another and, coupled with the categorical nature of the eligibility for services, led to difficulties for persons used to having these services provided in institutions.

The Community Support System developed by the National Institutes of Mental Health in 1977 envisioned case management as a mechanism for helping clients navigate this fragmented social service system. Accessing these resources would thus enable them to live and function adequately in their communities (Intagliata,

1982; Stein and Test, 1980; Test, 1981; Turner and

TenHoor, 1978).

Substance abusers historically were never institutionalized as often as were persons with chronic mental illness and so were not directly impacted by deinstitutionalization legislation. Substance abusers were not generally targeted for the development of categorical systems of service delivery and were not generally recipients of case management services.

However, case management-like services were provided to substance abusers under other titles, such as "mission work," and frequently delivered by the clergy or others in skid row missions, detoxification centers, and ad hoc halfway houses. Jails and county work farms were generally the institutions of choice in dealing with this population. Only after substance abuse began to be decriminalized and defined as a disease were substance abusers referred to various social services.

Policymakers in Canada were among the first to translate many generic case management functions into the field of substance abuse treatment, outlining the essential elements of a union of case management and substance abuse treatment (Graham and Birchmore-Timney, 1990; Ogborne and Rush, 1983; Rush and Ekdahl, 1990). Case management for substance abusers initially gained attention in the United States through the Treatment Alternatives for Safe Communities (TASC) program (formerly known as Treatment Alternatives to Street Crime), which began linking the criminal justice system with the drug abuse treatment system in 1972 and has grown to over 185 programs (Cook, 1992) today.

A 1987 National Institute of Mental Health

initiative funded 13 demonstration projects targeted at young adults with coexisting mental health and substance use problems. Of these 13 projects, 10 identified some form of case management as a primary service and provided a general description of the case management

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intervention (Teague et al., 1990). Initiatives undertaken by both the National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA) resulted in numerous projects that used case management to enhance treatment (Bonham et al., 1990; Conrad et al., 1993; Cox et al., 1993; Inciardi et al., 1993; Fletcher et al., 1994; Mejta et al., 1994). Case management in these projects was designed to increase retention in the treatment continuum and to improve treatment outcomes.

##### Definitions and Functions

Any definition of case management today is inevitably contextual, based on the needs of a particular organizational structure, environmental reality, and prior training of the individuals who are implementing it, whether

they are social workers, nurses, or case management specialists. Nonetheless, there is relatively widespread agreement on the basic definition, as illustrated in Figurel-1.

While definitions are useful in guiding general discussions, *functions* are a more helpful way to approach case management as it is actually practiced. As with definitions, there is a high degree of consensus about a core group of functions. One widely accepted set of functions comprises (1) assessment, (2) planning, (3) linkage, (4) monitoring, and (5) advocacy (Joint Commission on Accreditation of Healthcare Organizations, 1979). The National Association of Social Workers' standards for social work case management include assessing, arranging, coordinating, monitoring, evaluating, and advocacy (National Association of Social Workers, 1992).

**Case management is**

* "planning and coordinating a package of health and social services that is individualized to meet a particular client's needs" (Moore, 1990, p. 444)
* "[a] process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner" (Intagliata, 1981)
* "helping people whose lives are unsatisfying or unproductive due to the presence of many problems which require assistance from several helpers at once" (Ballew and Mink, 1996, p. 3)
* "monitoring, tracking and providing support to a client, throughout the course of his/her treatment and after" (Ogborne and Rush, 1983, p. 136)
* "assisting the patient in re-establishing an awareness of internal resources such as intelligence, competence, and problem solving abilities; establishing and negotiating lines of operation and communication between the patient and external resources; and advocating with those external resources in order to enhance the continuity, accessibility, accountability, and efficiency of those resources" (Rapp et al., 1992, p. 83)
* "assess[ing] the needs of the client and the client's family, when appropriate, and arranges,

coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs." (National Association of Social Workers, 1992, p. 5)

Figure 1-1 Definitions of Case Management

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There is also general agreement about case management functions in the specific context of substance abuse treatment. Case management is one of eight counseling skills identified by the National Association of Alcoholism and Drug Abuse Counselors (National Association of Alcoholism and Drug Abuse Counselors, 1986) and one of five performance domains developed in the Role Delineation Study (International

*Addiction Counseling Competencies* describes the knowledge, skills, and attitudes required for all eight practice dimensions. Those supporting referral and service coordination are reproduced in full in Appendix B.

##### Models of Case

**Management With Substance Abusers**

Certification and Reciprocity Consortium, 1993).

Another framework is supplied by the Addiction Technology Transfer Centers (ATTCs), established by CSAT to transmit current information on treatment to providers in the field. The essential elements of case management are laid out in their publication *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (CSAT, 1998). That document has been endorsed by many leading addiction organizations.

Referral and service coordination are two of eight practice dimensions the ATTCs deem essential to the effective practice of addiction counseling. Activities considered part of those two dimensions include engagement; assessment; planning, goal-setting, and implementation; linking, monitoring, and advocacy; and disengagement. The document defines service coordination as:

"The administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan. Service coordination, which includes case management and client advocacy, establishes a framework of action for the client to achieve specified goals. It involves collaboration with the client and significant others, coordination of treatment and referral services, liaison activities with community resources and managed care systems, client advocacy, and ongoing evaluation of treatment progress and client needs" (CSAT, 1998, p. 53).

Case management models, like the definitions of case management, vary with the context. Some models focus on delivering social services, others on coordinating the delivery of services by other providers. Some provide both. The models result as much from the needs of specific client populations and service settings as they do from distinct theoretical differences about what case management should be. Four models from the mental illness field have been adapted for the field of substance abuse treatment. Each of these models-broker/generalist, strengths­ based, assertive community treatment, and clinical/rehabilitation-has proved valuable in treating substance abusers in a particular setting.

For example, the strengths-based approach

was adapted to work with crack cocaine users. This approach was chosen not only for its focus on resource acquisition but also because it helps clients see their own assets as a valuable part of recovery (Siegal and Rapp, 1996). Assertive community treatment was implemented to provide parolees a wide range of integrated services, including drug treatment, skills building, and resource acquisition.

Figure 1-2 compares the four models across 11 activities of case management and specifies which models are appropriate for particular substance abuse populations. Implementation of these models may vary with other populations and from setting to setting.

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|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Figure 1-2  Models of Case Management | | | | |  |
| *Primary Case*  ***Management***  *Activities* | | **Broker/Generalist** | **Strengths**  **Perspective** | **Assertive**  **Community Treatment** | **Clinical/**  **Rehabilitation** | |
| *Conducts outreach*  *and case finding* | | Not usually | Depends on  agency mission &  structure | Depends on  agency mission &  structure | Depends on  agency mission &  structure | |
| *Provides assessment*  *and ongoing reassessment* | | Specific to  immediate  resource | Strengths-based,  applicable to any of client life areas | Broad-based, part  of a comprehensive | Broad-based, part  of a comprehensive | |
|  | | acquisition needs |  | (biopsychosocial) | (biopsychosocial) | |
|  | |  |  | assessment | assessment | |
| *Assists in goal*  *planning* | | Generally brief,  related to | Client-driven,  teaches specific | Comprehensive,  goals may include | Comprehensive,  goals may include | |
|  | | acquiring | process on how to | any of client life | any of client life | |
|  | | resources, possibly | set goals and | areas | areas | |
|  | | informal | objectives, goals |  |  | |
|  | |  | may include any |  |  | |
|  | |  | of client life areas |  |  | |
| *Makes referral to*  *needed resources* | | Case manager may  initiate contact or | As negotiated with  client, may contact | As needed, many  resources | As negotiated with  client, may contact | |
|  | | have client make | resource, | integrated into | resource, | |
|  | | contact on own | accompany client, | broad package of | accompany client, | |
|  | |  | or client may | case management | or client may | |
|  | |  | contact on own | services | contact on own | |
| *Monitors referrals* | | Follow-up checks made | Close involvement in ongoing relationship between client and resource | Close involvement in ongoing relationship between client and resource | Close involvement in ongoing relationship between client and resource | |
| *Provides therapeutic services beyond resource acquisition, e.g., therapy, skills-*  *teaching* | | Referral to other sources for these services if requested | Usually limited to responding to client questions about treatment  issues, education | Provides many services within unified package of treatment/ case  management | Provision of therapeutic activities central to the model | |
|  | |  | about how to | services |  | |
|  | |  | identify strengths |  |  | |
|  | |  | and about self- |  |  | |
|  | |  | help resources |  |  | |
| *Helps develop informal support*  *systems* | | No | Development of informal resources  - neighbors, | Through  implementation of drop-in centers | Emphasis on family and self-  help support | |
|  | |  | church, family- a | and shelters | through | |
|  | |  | key principle of |  | therapeutic | |
|  | |  | the model |  | activities | |

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Figure 1-2 Continued

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Primary Case*  *Management Activities* | **Broker/Generalist** | **Strengths**  **Perspective** | **Assertive**  **Community Treatment** | **Clinical/**  **Rehabilitation** |
| *Responds to crisis* | Responds to crises related to resource needs such as housing | Responds to crises related to both resource needs and mental health concerns; active in stabilization and then referral | Responds to crises related to both resource needs and mental health concerns; active in stabilization and then referral | Responds to crises related to both resource needs and mental health concerns; will stabilize crisis situation and provide further therapeutic intervention |
| *Engages in advocacy on behalf of individual client* | Usually only at level of line staff | Assertive advocacy, will pursue multiple administrative levels within agency | Assertive advocacy, will pursue multiple administrative levels within agency | Assertive advocacy, will pursue multiple administrative levels within agency |
| *Engages advocacy in support of resource development* | Not usually | Usually in context of specific client needs | Either advocates for needed resources or may create resources as part of case management services | Usually in context of specific client needs |
| *Provides direct services related to resource acquisition as part of case management, e.g., drop-in center, employment counseling* | Referral to resources that provide direct services | Provides services crucial to preparing client for resource acquisition activities, e.g., role playing, accompanying client to interviews | Provides many direct services within unified package of treatment/ case management | Provides services that are part of rehabilitation services plan; skill-teaching |

*Appropriate for the following substance abuse populations*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Injectable drug | Male crack | Chronic public | Dually diagnosed |
| users; HIV positive | cocaine users; | inebriates; | clients; female |
| and at-risk | female | parolees with | polysubstance |
| substance abusers | polysubstance | substance abuse | abusers |
|  | abusers | problems; dually |  |
|  |  | diagnosed clients |  |

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Brokerage/Generalist

Brokerage/ generalist models seek to identify clients' needs and help clients access identified resources. Planning may be limited to the client's early contacts with the case manager rather than an intensive long-term relationship. Ongoing monitoring, if provided at all, is relatively brief and does not include active advocacy.

Brokerage/ generalist models are sometimes disparaged in discussions of case management because of the limited nature of the client-case manager relationship and the absence of advocacy. Nonetheless, this approach shares the basic foundations of case management and has proved useful in selected situations. The relatively limited nature of the relationship in this model allows the case manager to provide services to more clients. This approach is also appropriate in instances where treatment and social services in a particular area are relatively integrated and the need for monitoring and advocacy is minimal. The model works best with clients who are not economically deprived, who have significant intent and sufficient resources, or who are not in late-stage addiction. Small agencies or agencies that offer narrowly defined services may be in an ideal position to offer brokerage-only services.

Two creative uses of a brokerage model

involved clients who were infected with the human immunodeficiency virus (HIV) or who were at significant risk of acquiring HIV. In one program, case managers also served as educators, delivering cognitive, behaviorally oriented, educational sessions focusing on substance abuse and high-risk behaviors (Falck et al., 1992). The mixing of the educator and case manager roles was intended to increase clients' receptivity to HIV prevention messages by reducing barriers to services that would address problems that might divert attention from those messages. In another variation of the brokerage model, case managers in a large

metropolitan area conducted extensive assessments with HIV-infected clients, generally making at least two referrals during the initial session. This "quick response" approach was intended to provide immediate results to clients and to link them with agencies or services that would provide ongoing services (Lidz et al., 1992).

Generalist approaches to working with substance-abusing clients have taken several forms. Case managers in the central intake facility of a large metropolitan area performed the core functions of case management, linking clients with area substance abuse treatment and other human service providers. These case managers had access to funds for purchasing treatment services, thereby drastically reducing waiting periods for these services (Bokos et al., 1993). Another example of a generalist model is Providence, Rhode Island's Project Connect, a family-centered, community-based intervention program designed to address the problems of substance abuse among high-risk families in the child welfare system. Staff members provide intensive home-based counseling services and work with families to obtain other services they may need, including safe and affordable housing and adequate health care.

Assertive Community Treatment

The Program of Assertive Community Treatment (PACT) model, originally developed in Wisconsin (Stein and Test, 1980), emphasizes the following components

* Making contact with clients in their homes and natural settings
* Focusing on the practical problems of daily living
* Assertive advocacy
* Manageable caseload sizes
* Frequent contact between a case manager and client
* Team approach with shared caseloads
* Long-term commitment to clients

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Willenbring and his colleagues were among the first to adapt a mental health model for persons with substance abuse problems, specifically chronic public inebriates (Willenbring et al., 1990). Following the tenets of PACT, an individual case manager was closely supported by a core services team that together carried the responsibility for providing services. The model deviated from the usual approach to dealing with substance abuse clients in two ways. First, instead of expecting clients to come to services when they "hit bottom," case managers sought out clients through a process known as "enforced contact." Second, case managers and the services team acknowledged the chronic nature of the client's condition and sought to modify the course of the condition and to alleviate suffering. The clients were not required to pledge a goal of abstinence.

A derivation of PACT, the Assertive

Community Treatment (ACT) model, was used with parolees who had histories of injecting drugs (Martin and Scarpitti, 1993). In this implementation, case managers provided direct counseling services and worked with clients to develop the skills necessary to function successfully in the community. Case management staff also provided family consultations and crisis intervention services and functioned as group facilitators to provide skills training in areas such as work skills, relapse prevention, and education about

HIV/ AIDS. Departing from the mental health tenets of the PACT model, ACT had time limits and success goals rather than the continuous care envisioned for the mentally ill.

Achievement of protracted periods of abstinence and graduation from treatment continuum components were expected of clients (Martin and Scarpitti, 1993). Assertive Community Treatment has been implemented alone and in conjunction with a therapeutic community (Martin et al., 1993).

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Strengths-Based Perspective

The strengths-based perspective of case management was originally developed at the University of Kansas School of Social Welfare to help a population of persons with persistent mental illness make the transition from institutionalized care to independent living (Rapp and Chamberlain, 1985). The foremost two principles on which the model rests are (1) providing clients support for asserting direct control over their search for resources, such as housing and employment, and (2) examining clients' own strengths and assets as the vehicle for resource acquisition. To help clients take control and find their strengths, this model of case management encourages use of informal helping networks (as opposed to institutional networks); promotes the primacy of the

client-case manager relationship; and provides

an active, aggressive form of outreach to clients.

A strengths perspective of case management has been selected for work with substance abusers for three reasons. First is case management's usefulness in helping them access the resources they need to support recovery. Second, the strong advocacy component that characterizes the strengths approach counters the widespread belief that substance abusers are in denial or morally deficient-perhaps unworthy of needed services (Bander et al., 1987; Ross and Darke, 1992). Last, the emphasis on helping clients identify their strengths, assets, and abilities supplements treatment models that focus on pathology and disease. Strengths-based case management has been implemented with both female (Brindis and Theidon, 1997) and male substance abusers (Rapp, 1997; Siegal et al., 1995).

Because of the advocacy component and

client-driven goal planning, a strengths-based approach can at times cause stress between a case manager and other members of the treatment team (Rapp et al., 1994). Despite this, there is evidence that the approach can be

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integrated with the disease model of treatment and that its presence leads to improved outcomes for clients. The improved outcomes include employability, retention in treatment, and (through retention in treatment) reduced drug use (Rapp et al., in press; Siegal et al., 1996; Siegal et al., 1997).

###### Clinical/Rehabilitation

Clinical/rehabilitation approaches to case management are those in which clinical (therapy) and resource acquisition (case management) activities are joined together and addressed by the case manager. It has been suggested that the separation of these two activities is not feasible over an extended period of time and that the case manager must be trained to respond to client-focused, as opposed to solely environmental issues (Kanter, 1996).

Client-focused services could include providing psychotherapy to clients, teaching specific skills, and family therapy. Beyond the usual repertoire of case management functions (e.g., monitoring), the case manager should be aware of numerous issues including transference, countertransference, how clients internalize what they observe, and theories of ego functioning (Harris and Bergman, 1987; Kanter, 1996).

Many substance abuse treatment programs use a clinical model in which the same treatment professional provides, or at least coordinates, both therapy and case management activities.

Such an approach is frequently driven by staffing considerations: It is more economical to have one treatment professional provide all services than to have separate clinical and case managers deliver them.

One example of combining clinical and case management activities is found in a program for women who have substance abuse problems (Markoff and Cawley, 1996). In Project Second Beginning, an emphasis on relationships and empowerment is used both to secure needed resources and to guide implementation of therapy activities. This approach is based on the belief that women have special needs in the treatment setting-needs that can most appropriately be addressed through a therapeutic relationship with a single caregiver. The clinical/rehabilitation approach has been widely used in the treatment of persons with diagnoses of both substance abuse and psychiatric problems (Anthony and Farkas, 1982; Drake et al., 1993; Drake and Noordsey, 1994; Lehman et al., 1993; Shilony et al., 1993).

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# Applying Case Managen1ent to Substance Abuse Treatn1ent

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

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

##### Case Management Principles

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

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

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

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# Appendix A

**Bibliography**

Alemi, F.; Stephens, R.C.; and Butts, J. Case management: A telecommunications practice model. In: Ashery, R.S., ed.

*Progress and Issues in Case Management.*

Rockville, MD: National Institute on Drug Abuse, 1992. pp. 261-273.

Alter, C., and Hage, J. *Organizing Working Together.* Newbury Park, CA: Sage, 1993.

Alterman, A.I.; Bedrick, J.; Howden, D.; and Maany, I. Reducing waiting time for substance abuse treatment does not reduce attrition. *Journal of Substance Abuse* 6(3):325-332, 1994.

American Hospital Association. Case management: An aid to quality and continuity of care. In: Rose, S.R., ed. *Case Management and Social Work.* New York: Longman, 1992. pp. 149-159.

American Society of Addiction Medicine.

*Patient Placement Criteria for the Treatment of Substance-Related Disorders.* 2nd *edition.* Chevy Chase, MD: American Society of Addiction Medicine, 1997

Anthony, W.A., and Farkas, M. A client outcome planning model for assessing psychiatric rehabilitation interventions. *Schizophrenic Bulletin* 8(1):13-38, 1982.

Ashery, R.S. Case management for substance abusers: More issues than answers. *Journal of Case Management* 3(4):179-183, 1994.

Ashery, R.S., ed. *Progress and Issues in Case Management.* NIDA Research Monograph, Number 127. HHS Pub. No. (ADM) 92-

1946. Rockville, MD: National Institute on Drug Abuse, 1992.

Ashery, R.S.; Carlson, R.G.; Falck, R.S.; and Siegal, H.A. Injection drug users, crack­ cocaine users, and human service utilization: An exploratory study. *Social Work*

40(1):75-82, 1995.

Ballew, J.R., and Mink, G. *Case Management in Social Work: Developing the Professional Skills Needed for Work With Multiproblem Clients.* Springfield, IL: Charles C. Thomas, 1996.

Bander, K.W.; Goldman, D.S.; Schwartz, M.A.; Rabinowitz, E.; and English, J.T. Survey of attitudes among three specialties in a teaching hospital toward alcoholics. *Journal of Medical Education* 62(1):17-24, 1987.

Beckman, L., and Amaro, H. Personal and social difficulties faced by women and men entering alcoholism treatment. *Journal of Studies on Alcohol* 47:135-145, 1986.

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Bellack, A.S.; Mueser, K.T.; Gingerich, S.; and Agresta, **J.** *Social Skills Training for Schizophrenia: A Step-by-Step Guide.* New York: Guilford Press, 1997.

Bokos, P.; Mejta, C.; Monks, R.; and Mickenberg,

**J.** Case management program: A case management model for intravenous drug users. In: Inciardi, J.A., ed. *Innovative Approaches to the Treatment of Drug Abuse: Program Models and Strategies.* Westport, CT: Greenwood, 1993. pp. 87-96.

Bond, *C.R.;* McGrew, J.H.; and Fekete, D.M. Assertive outreach for frequent users of psychiatric hospitals: A meta-analysis. *Journal of Mental Health Administration* 22: 4- 16, 1995.

Bonham, G.S.; Hague, D.E.; Abel, M.H.; Cummings, P.; and Deutsch, R.S. Louisville's Project Connect for the homeless alcohol and drug abuser. In: Stahler, G.J., and Stimmel, B., eds. *Alcoholism and Drug Abuse Among Homeless Men and Women.* New York: Haworth Press, 1990. pp. 57-78.

Braucht, N.G.; Reichardt, C.S.; Geissler, **L.J.;** Bormann, C.A.; Kwiatkowski, C.F.; and Kirby, M.W. Effective services for homeless substance abusers. In: Stahler, G.J., and Stimmel, B., eds. *The Effectiveness of Social Interventions for Homeless Substance Abusers.* New York: Haworth Medical Press, 1995. pp. 87-109.

Brekke, **J.** The model-guided method of monitoring program implementation. *Evaluation Review* 11(3):281-299, 1987.

Brindis, C.; Pfeffer, R.; and Wolf, A. A case management program for chemically dependent clients with multiple needs. *Journal of Case Management* 4(1):22-28, 1995.

Brindis, C.D., and Theidon, K.S. The role of case management in substance abuse treatment services for women and children. *Journal of Psychoactive Drugs* 29(1): 79-88, 1997.

Broskowski, A., and Eaddy, M. Community mental health in a managed care environment. *Administration and Policy in Mental Health* 27:335-352, 1994.

Brown, **J.D.** Preprofessional socialization and identity transformation: The case of the professional ex-. *Journal of Contemporary Ethnography* 20(2):157-178, 1991.

Brown, S.A.; Vik, P.W.; and Creamer, V.A. Characteristics of relapse following adolescent substance abuse treatment. *Addictive Behaviors* 14:291-300, 1989.

Bureau of Justice. *Treatment Alternatives to Street Crime.* 2nd ed. Administration Program Brief. Washington, DC: U.S. Department of Justice, April 1992.

Bureau of Justice Assistance. *Guidelines for Implementing and Operating T ASC Programs.* Washington, DC: U.S. Department of Justice, 1988.

Case Management Standards Work Group.

*NASW Standards for Social Work Case Management.* Washington, DC: National Association of Social Workers Press, 1992.

Center for Substance Abuse Treatment.

*Pregnant, Substance-Using Women.* Treatment Improvement Protocol (TIP) Series, Number 2. HHS Pub. No. (SMA) 93-1998.

Washington, DC: U.S. Government Printing Office, 1993a.

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*Bibliography*

Center for Substance Abuse Treatment.

*Guidelines for the Treatment of Alcohol and Other Drug Abusing Adolescents.* Treatment Improvement Protocol (TIP) Series, Number 4. HHS Pub. No. (SMA) 93-2010.

Washington, DC: U.S. Government Printing Office, 1993b.

Center for Substance Abuse Treatment.

*Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series, Number 7. HHS Pub. No. (SMA) 94-2076. Washington, DC: U.S.

Government Printing Office, 1994a.

Center for Substance Abuse Treatment.

*Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse.* Treatment Improvement Protocol (TIP) Series, Number 9. HHS Pub. No. (SMA) 94-2078. Washington, DC: U.S.

Government Printing Office, 1994b.

Center for Substance Abuse Treatment.

*Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series, Number

12. HHS Pub. No. (SMA) 94-3004. Washington, DC: U.S. Government Printing Office, 1994c.

Center for Substance Abuse Treatment. *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders.*

Treatment Improvement Protocol (TIP) Series, Number 13. HHS Pub. No. (SMA)

95-3021. Washington, DC: U.S. Government Printing Office, 1995a.

Center for Substance Abuse Treatment.

*Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System.* Treatment Improvement Protocol (TIP) Series, Number 17. HHS Pub. No. (SMA) 95-3039. Washington, DC: U.S.

Government Printing Office, 1995b.

Center for Substance Abuse Treatment.

*Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System.* Treatment Improvement Protocol (TIP) Series, Number 21. HHS Pub. No. (SMA) 95-3051. Washington, DC:

U.S. Government Printing Office, 1995c.

Center for Substance Abuse Treatment.

*Purchasing Managed Care Services for Alcohol and Other Drug Treatment: Essential Elements and Policy Issues.* Technical Assistance Publication (TAP) Series, Number 16. HHS Pub. No. (SMA) 95-3040. Washington, DC:

U.S. Government Printing Office, 1995d.

Center for Substance Abuse Treatment.

*Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* . Treatment Improvement Protocol (TIP) Series, Number 23. OHS Pub. No. (SMA)

96-3113. Washington, DC: U.S. Government Printing Office, 1996a.

Center for Substance Abuse Treatment. *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice.* Technical Assistance Protocol (TAP) Series, Number 21. HHS Pub. No. (SMA)

98-3171. Washington, DC: U.S. Government Printing Office, 1998.

Chamberlain, R. and Rapp, C.A. A decade of case management: A methodological review of outcome research. *Community Mental Health Journal* 27:171-188, 1991.

75

*Appendix A*

Conrad, K.J.; Hultman, C.I.; and Lyons, J.S. Treatment of the chemically dependent homeless: A synthesis. *Alcoholism Treatment Quarterly* 10(3-4):235-246, 1993.

Cook, F. TASC: Case management models linking criminal justice and treatment. In: Ashery, R.S., ed. *Progress and Issues in Case Management.* NIDA Research Monograph Series, Number 127. HHS Pub. No. (ADM) 92-1946. Rockville, MD: National Institute on Drug Abuse, 1992. pp. 368-382.

Cook, F. "Client Management: Fundamental Issues." Presentation to Criminal Justice Treatment Network Grantee Meeting, Center for Substance Abuse Treatment, Washington, DC: April 28, 1997.

Cook, K. Exchange and power in networks of interorganizational relations. *The Sociological Quarterly* 18(1):62-82, 1977.

Cox, G.B.; Meijer, L.; Carr, D.I.; and Freng, S.A. Systems Alliance and Support (SAS): A program of intensive case management for chronic public inebriates: Seattle. In: Conrad, K.J.; Hultman, C.I.; and Lyons, J.S., eds. *Treatment of the Chemically Dependent Homeless: Theory and Implementation in Fourteen American Projects.* New York: Haworth Press, 1993. pp. 125-138.

Cross, T.; Bazron, B.; Dennis, K.; and Isaacs, M. *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed.* Washington, DC: Georgetown University Child Development Center, 1989.

Crystal, S. *Chronic and Situational Dependency: Long Term Residents in a Shelter for Men.* New York: Human Resources Administration, 1982.

Deleon, G. Legal pressure in therapeutic communities. *Journal of Drug Issues* 18:625- 640, 1988.

DiMaggio, P. Structural analysis of organizational fields: A block model approach. *Research in Organizational Behavior* 8:335-370, 1986.

Drake, R.E.; Bebout, R.R.; and Roach, J.P. A research evaluation of social network case management for homeless persons with dual disorders. In: Harris, M., and Bergman, H.C., eds. *Case Management for Mentally Ill Patients: Theory and Practice.* Vol. 1., *Chronic Mental Illness.* Langhorne, PA: Harwood Academic Publishers, 1993. pp. 83-98.

Drake, R. and Noordsey, D. Case management for people with coexisting severe mental disorder and substance abuse disorder.

*Psychiatric Annals* 24(8): 427-431, 1994.

Falck, R.; Carlson, R.G.; Price, S.K.; and Turner,

J.A. Case management to enhance HIV risk reduction among users of injection drugs and crack cocaine. *Journal of Case Management* 3(4):162-166, 1994.

Falck, R.; Siegal, H.A.; and Carlson, R.G. Case management to enhance AIDS risk reduction for injection drug users and crack users: Theoretical and practical considerations. In: Ashery, R.S., ed. *Progress and Issues in Case Management.* NIDA Research Monograph Series, Number 127. HHS Pub. No. (ADM) 92-1946. Rockville, MD: National Institute on Drug Abuse, 1992. pp. 167-180.

Fletcher, B.W.; Inciardi, J.A.; and Horton, A.M., eds. *Drug Abuse Treatment: The Implementation of Innovative Approaches to Drug Abuse Treatment.* Westport, CT: Greenwood Press, 1994.

*76*

*Bibliography*

Freeman, Michael A., MD. General Editor. *How to Respond to Managed Behavioral Health*

*Care-A Workbook Guide to Your Organization's Success.* Tiburon, CA: CentraLink Publications, 1995.

Gilbert, F.S. The effect of type of aftercare follow-up on treatment outcome among alcoholics. *Journal of Studies on Alcohol* 49(2):149-159, 1988.

Gillespie, D.F., and Murty, S.A. Cracks in a postdisaster service delivery network.

*American Journal of Community Psychology*

22(5):639-660, 1994.

Gilson, S.F.; Chilcoat, H.D.; and Stapleton, J.M. Illicit drug use by persons with disabilities: Insights from the National Household Survey on Drug Abuse. *American Journal of Public Health* 86(11):1613-1615, 1996.

Godley, S.H.; Godley, M.D.; Pratt, A.; and Wallace, J.L. Case management services for adolescent substance abusers: A program description. *Journal of Substance Abuse Treatment* 11:309-317, 1994.

Graham, K., and Birchmore-Timney, C. Case management in addictions treatment. *Journal of Substance Abuse Treatment* 7:181-188, 1990.

Harris, M., and Bergman, H. Case management with the chronically mentally ill: a clinical perspective. *American Journal of Orthopsychiatry* 57(2): 296-302, April 1987.

Harvey, P.O.; Davidson, M.; Mueser, K.T.; Farella, M.; White, L.; and Powchik, P. The social-adaptive functioning evaluation (safe): A rating scale for geriatric psychiatric patients. *Schizophrenia Bulletin* 23:131-145, 1997.

Hasson, A.L.; Grella, C.E.; Rawson, R.; and Anglin, M.D. Case management within a methadone maintenance program. A research demonstration project for HIV risk reduction. *Journal of Case Management* 3(4):167-172, 1994.

Hepburn, M. Social problems. *Baillieres Clinical Obstet. Gynaecol.* 4(1): 149-168, 1990.

Hoffman, N.G.; Halikas, J.A.; Mee-Lee, D.; and Weedman, R.D. *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders.* Chevy Chase, MD: American Society of Addiction Medicine, 1991.

Hubbard, R.L.; Collins, J.J.; Rachel, J.V.; and Cavanaugh, E.R. The criminal justice client in drug abuse treatment. In: Leukenfeld, C.J., and Tims, F.M., eds. *Compulsory Treatment of Drug Abuse: Research and Clinical Practice.* Rockville, MD: National Institute on Drug Abuse, 1988. pp. 57-80.

Inciardi, J.A.; Martin, S.S.; and Scarpitti, F.R. Appropriateness of assertive case management for drug-involved prison releases. *Journal of Case Management* 3(4):145-149, 1994.

Inciardi, J.A., and McBride, D. *Treatment Alternatives to Street Crime: History, Experience, and Issues.* U.S. Department of Health and Human Services, Public Health Services. HHS Pub. No. (ADM) 91-1749.

Washington, DC: U.S. Government Printing Office, 1991.

Inciardi, J.A.; Tims, F.M.; and Fletcher, B.W., eds. *Innovative Approaches in the Treatment of Drug Abuse: Program Models and Strategies.* Westport, CN: Greenwood Press, 1993.

Institute of Medicine. *Broadening the Base of Treatment for Alcohol Problems.* Washington, DC: National Academy Press, 1990.

77

*Appendix A*

Institute of Medicine. *Treating Drug Problems.*

Vol. l. Washington, DC: National Academy Press, 1990.

Intagliata, J. Improving the quality of community care for the chronically mentally disabled: The role of case management.

*Schizophrenia Bulletin* 8(4):655-674, 1982.

Intagliata, J. Operationalizing a case management system: A multilevel approach. *National Conference on Social Welfare: Case Management: State of the Art.* Washington, DC: U.S. Department of Health and Human Services, 1981.

Joint Commission on Accreditation of Healthcare Organizations. *Principles of Accreditation of Community Mental Health Service Programs.* Oakbrook Terrace, IL: Joint Commission on Accreditation of Hospitals, 1979.

Joint Commission on Accreditation of Healthcare Organizations. *Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services. Vol. 1, Standards.* Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 1995.

Kanter, J.S. Case management of the young adult chronic patient: A clinical perspective. In: Kanter, J.S., ed. *Clinical Issues in Treating the Chronic Mentally Ill: New Directions for Mental Health Services.* No. 27. San Francisco: Jossey-Bass, 1985. pp. 77-92.

Kanter, J. Case management with long-term patients: A comprehensive approach. In: Sore££, S., ed. *Handbook for the Treatment of the Seriously Mentally Ill.* Seattle: Hogrefe and Huber, 1996. pp. 171-189.

Kanter, J. Clinical issues in the case management relationship. In: Harris, M., and Bachrach, L., eds. *Clinical Case Management New Directions for Mental Health Services.* No 40. San Francisco: Jossey-Bass, Winter 1988.

Kennedy, B.P., and Minami, M. The Beech Hill Hospital/Outward Bound adolescent chemical dependency treatment program. *Journal of Substance Abuse Treatment* 10:395- 406, 1993.

Khantzian, E., and Treece, C. Psychiatric diagnosis of narcotic addicts: Recent findings. *Archives of General Psychiatry* 42:1067-1071, 1985.

Kosten, T.R., and Kleber, H.D. Differential diagnosis of psychiatric comorbidity in substance abusers. *Journal of Substance Abuse Treatment* 5:201-206, 1988.

Lehman, A.F.; Herron, J.D.; Schwartz, R.P.; and Myers, C.P. Rehabilitation for adults with severe mental illness and substance use disorders: A clinical trial. *Journal of Nervous and Mental Disease* 181(2): 86-90, February,

1993.

Levy, J.A.; Gallmeier, C.P.; Weddington, W.W.; and Wiebel, W.W. Delivering case management using a community-based service model of drug intervention. In: Ashery, R.S., ed. *Progress and Issues in Case Management.* NIDA Research Monograph Series, Number 127. HHS Pub. No. (ADM) 92-1946. Rockville, MD: National Institute on Drug Abuse, 1992. pp. 145-166.

*78*

*Bibliography*

Levy, J.A.; Strenski, T.; and Amick, D.J. Community-based case management for active injecting drug users. In: Albrecht, G.L., ed. *Advances in Medical Sociology.* Vol. 6, *Case and Care Management.* Greenwich, CT: JAi Press, 1995. pp. 183-206.

Lidz, V.; Bux, D.A.; Platt, J.J.; and Iguchi, M.Y. Transitional case management: A service model for AIDS outreach projects. In: Ashery, R.S., ed. *Progress and Issues in Case Management.* NIDA Research Monograph Series, Number 127. HHS Pub. No. (ADM) 92-1946. Rockville, MD: National Institute on Drug Abuse, 1992. pp. 112-144.

Lightfoot, L.; Rosenbaum, P.; Ogurzsoff, S.; Laverty, G.; Kusiar, S.; Barry, K.; and Reynolds, W. *Final Report of the Kingston Treatment Programme Development Research Project.* Ottawa: Department of Health, Health Promotion Directorate, 1982.

Luborsky, L; Mclellan, A.T.; Woody, G.E.; O'Brien, C.P.; and Auerbauch, A. Therapist success and its determinants. *Archives of General Psychiatry* 42: 602-611, 1985.

Manoleas, P., ed. The Cross Cultural Practice of Clinical Case Management in Mental Health. New York: Haworth Press, 1997.

Markoff, L.S., and Cawley, P.A. Retaining your clients and your sanity: Using a relational model of multi-systems case management. *Journal of Chemical Dependency Treatment* 6(1- 2): 45-65, 1996.

Martin, S.S.; Isenberg, H.; and Inciardi, J.A. Assertive community treatment: Integrating intensive drug treatment with aggressive case management for hard-to-reach populations. In: Inciardi, J.A.; Tims, F.M.; and Fletcher, B.W., eds. *Innovative Approaches in the Treatment of Drug Abuse: Program Models and Strategies.* Westport, CN: Greenwood Press, 1993. pp. 97-108.

Martin, S., and Scarpitti, F. An intensive case management approach for paroled IV drug users. *Journal of Drug Issues* 23(1):81-96, 1993.

McCarthy, E.P.; Feldman, Z.T.; and Lewis, B.F. Development and implementation of an interorganizational case management model for substance users. In: Ashery, R.S., ed.

*Progress and Issues in Case Management.*

NIDA Research Monograph Series, Number

127. HHS Pub. No. (ADM) 92-1946. Rockville, MD: National Institute on Drug Abuse, 1992. pp. 331-349.

McGrew, J.H., and Bond, G.R. Critical ingredients of assertive community treatment: Judgments of the experts. *Journal of Mental Health Administration* 22:113-125, 1995.

McKirnan, D.J., and Peterson, P.L. Alcohol and drug use among homosexual men and women: Epidemiology and population characteristics. *Addictive Behaviors*

14(5):545-553, 1989.

Mclellan, A.T.; Arndt, I.; Metzger, D.S.; Woody, G.E.; and O'Brien, C.P. The effects of psychosocial services in substance abuse treatment. *Journal of the American Medical Association* 269:1953-1959; 1993.

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*Appendix A*

Mclellan, A.T.; Luborsky, L.; O'Brien, C.P.; Woody, G.E.; and Druley, K.A. Is treatment for substance abuse effective? *Journal of the American Medical Association* 247:1423-1428, 1982.

Mechanic, D.; Schlesinger, M.; and McAlpine,

D.D. Management of mental health and substance abuse services: State of the art early results. *Milbank Quarterly* 73:19-55, 1995.

Mejta, C.L.; Bokos, P.J.; Mickenberg, J.H.;

Maslar, E.M.; Hasson, A.L.; Gil, V.; O'Keefe,

Z.; Martin, S.S.; Isenberg, H.; Inciardi, J.A.;

Lockwood, D.; Rapp, R.C.; Siegal, H.A.; Fisher, J.H.; and Wagner, J.H. Approaches to case management with substance abusing populations. In Lewis, J., ed. *Addictions: Concepts and Strategies for Treatment.*

Gaithersburg, MD: Aspen, 1994.

Miles, M., and Huberman, A. *Qualitative Data Analysis.* Newbury Park, CA: Sage, 1997.

Miller, W.R. and Rollnick, S. *Motivational Interviewing: Preparing People to Change Addictive Behavior.* New York: Guilford Press, 1991.

Mirin, S.M.; Weiss, R.D.; and Michael, J. Psychopathology in substance abusers: Diagnosis and treatment. *American Journal of Drug and Alcohol Abuse* 14(2):139-157, 1988.

Modrcin, M.; Rapp, C.; and Chamberlain, R. *Case Management With Physically Disabled Individuals: Curriculum and Training Program.* Lawrence, KS: University of Kansas School of Social Welfare, 1985.

*80*

Mondanaro, J.E.; Wedenoja, M.; Densen-Gerber, J.; Elahi, J.; Mason, M.; and Redmond, A.C. Sexuality and fear of intimacy as barriers to recovery for drug dependent women. In: Beschner, G.M.; Reed, B.D.; and Mondanaro, J., eds. *Treatment Services for Drug Dependent Women,* Vol. 2. NIDA Treatment Monograph Series. Washington, DC: National Institute on Drug Abuse, 1982.

Monti, P.M.; Abrams, D.B.; Kadden, R.M.; and Cooney, N.L. *Treating Alcohol Dependence.* New York: Guilford Press, 1989.

Moore, D., and Polsgrove, L. Disabilities, developmental handicaps, and substance misuse: A review. *International Journal of the Addictions* 26(1): 65-90, 1991.

Moore, S.T. A social work practice model of case management: The case management grid. *Social Work* 35(5):444-448, 1990.

Moos, R.H.; Finney, J.W.; and Cronkite, R.C. *Alcoholism Treatment: Context, Process, and Outcome.* New York: Oxford University Press, 1990. pp. 220-248.

Morlock, L.; Taube, C.; and Ross, A. *Alternatives for Case Management of the CMI in Baltimore City: Implications for Cost and Impact.*

Unpublished report. Baltimore, MD: The Johns Hopkins University, Center on Organization and Financing of Care for the Severely Mentally Ill, 1988.

Morrissey, J.P.; Ridgely, M.S.; Goldman, H.H.; and Bartko, W.T. Assessments of community mental health support systems: A key informant approach. *Community Mental Health Journal* 30(6): 565-579, 1994.

Mumm, A.M.; Olsen, L.; and Allen, D. "Families Affected by Substance Abuse: Implications for Generalist Practice." Submitted for publication, 1997.

*Bibliography*

National Association of Alcoholism and Drug Abuse Counselors. *Certification Commission Oral Exam Guidelines.* Arlington, VA: National Association of Alcoholism and Drug Abuse Counselors, 1986.

National Association of Social Workers. Case management's cost, benefits eyed. *National Association of Social Workers News.*

Washington, DC: NASW Press, 1992. p. 12.

National Certification Reciprocity

Consortium/ Alcohol and Other Drug Abuse. *Standards for Certification.* Atkinson, NH: National Certification Reciprocity Consortium/ Alcohol and Other Drug Abuse, 1993.

National Institute on Alcohol Abuse and Alcoholism. *Homelessness, Alcohol and Other Drugs.* HHS Pub. No. (ADM) 89-1614.

Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1989.

Ogborne, A.C., and Rush, B.R. The coordination of treatment services for problem drinkers: Problems and prospects. *British Journal of Addiction* 78:131-138, 1983.

Ohio Credentialing Board for Chemical Dependency Professionals. *Standards and Procedures of the Ohio Certification Program.* Columbus, OH: Ohio Credentialing Board for Chemical Dependency Professionals, 1995.

Olfson, M. Assertive community treatment: An evaluation of experimental evidence.

*Hospital and Community Psychiatry* 41:534-641,

1990.

Oppenheimer, E.; Sheehan, M.; and Taylor, C. Letting the client speak: Drug misusers and the process of help seeking. *British Journal of Addiction* 83:635-647, 1988.

Orwin, R.G.; Sonnefeld, L.J.; Garrison-Mogren, R.; and Smith, N.G. Pitfalls in evaluating the effectiveness of case management programs for homeless persons. *Evaluation Review* 18(2):153-207, 1994.

Ouellet, L.; Kelly, M.; Coward, A.; and Wiebel,

W.W. Developing community resources for a stigmatized population. In: Albrecht, G.L., ed. *Advances in Medical Sociology.* Vol. 6, *Case and Care Management.* Greenwich, CT: JAi Press, 1995. pp. 207-230.

Perl, H.I. and Jacobs, M.L. Case management models for homeless persons with alcohol and other drug problems: An overview of the NIAAA research demonstration program. In: Ashery, R.S., ed. *Progress and Issues in Case Management,* NIDA Research Monograph Series. Number 127. HHS Pub. No. (ADM) 92-1946. Rockville, MD: National Institute on Drug Abuse, 1992. pp. 208-222.

Platt, J.J.; Buhringer, G.; Kaplan, C.D.; Brown, B.B.; and Taube, 0.0. The prospects and limitations of compulsory treatment for drug addiction. *Journal of Drug Issues* 18: 505-525, 1988.

Prochaska, J.0., and DiClemente, C.C. Self­ change and therapy change of smoking behavior: A comparison of processes of change in cessation and maintenance.

*Addictive Behaviors* 7(2):133-142, 1982.

Raif£, N.R., and Shore, B.K. *Advanced Case Management: New Strategies for the Nineties.* Newbury Park, CA: Sage, 1993.

Rapp, C.A., and Chamberlain, R. Case management services for the chronically mentally ill. *Social Work* 30(5): 417-422, 1985.

*81*

*Appendix A*

Rapp, R.C. The strengths perspective and persons with substance abuse problems. In: Saleebey, D., ed. *The Strengths Perspective in Social Work Practice,* 2nd ed. New York: Longman Press, 1997.

Rapp, R.C.; Kelliher, C.W.; Fisher, J.H.; and Hall,

F.J. Strengths-based case management: A role in addressing denial in substance abuse treatment. *Journal of Case Management* 3(4):139-144, 1994.

Rapp, R.C.; Siegal, H.A.; and Fisher, J.H. A strengths-based model of case management/ advocacy: Adapting a mental health model to practice work with persons who have substance abuse problems. In: Ashery, R.S., ed. *Progress and Issues in Case Management.* NIDA Research Monograph Series, Number 127. HHS Pub. No. (ADM) 92-1946. Rockville, MD: National Institute on Drug Abuse, 1992. pp. 79-91.

Rapp, R.C.; Siegal, H.A.; Li, L.; and Saha, P. Predicting post-primary treatment services and drug use outcome: A multivariate analysis. *American Journal of Drug and Alcohol Abuse,* in press.

Regier, D.A.; Farmer, M.E.; Rae, D.S.; Locke,

B Z.; Keith, S.J.; Judd, L.L.; and Goodwin,

F.K. Comorbidity of mental disorders with alcohol and other drug abuse: Results from the epidemiologic catchment area (ECA) study. *Journal of the American Medical Association* 264(19):2511-2518, 1990.

Rehabilitation Research and Training Center on Drugs and Disability. *Substance Abuse, Disability and Vocational Rehabilitation.*

Dayton, OH: Rehabilitation Research and Training Center on Drugs and Disability, 1996.

Richmond, M. *What Is Social Casework?* New York: Russell Sage Foundation, 1922.

Ridgely, M.S., and Willenbring, M.L. Application of case management to drug abuse treatment: Overview of models and research issues. In: Ashery, R., ed. *Progress and Issues in Case Management.* NIDA Research Monograph Series, Number 127. HHS Pub. No. (ADM) 92-1946. Rockville, MD: National Institute on Drug Abuse, 1992. pp. 12-33.

Rife, J.C.; First, R.J.; Greenlee, R.W.; Miller, L.D.; and Feichter, M.A. Case management with homeless mentally ill people. *Health and Social Work* 16(1):58-67, 1991.

Roberts-DeGennaro, M. Generalist model of case management practice. *Journal of Case Management* 2(3):106-111, 1993.

Robinson, R., and Bergman, G. *Choices in Case Management: A Review of Current Knowledge and Practice for Mental Health Programs.*

Washington, DC: Policy Resources, Inc., 1989.

Rogers, G. Educating case managers for culturally competent practice. *Journal of Case Management* 4(2):60-65, 1995.

Ross, H. *Proceedings of the Conference on the Evaluation of Case Management Programs.* Los Angeles: Volunteers for Services to Older Persons, 1980.

Ross, **H.E.;** Glasser, F.B.; Germanson, T. The prevalence of psychiatric disorders in patients with alcohol and other drug problems. *Archives of General Psychiatry* 45:1023-1031, 1988.

*82*

*Bibliography*

Ross, M.W., and Darke, S. Mad, bad, and dangerous to know: Dimensions and measurements of attitudes toward injecting drug users. *Drug and Alcohol Dependence* 30(1):71-74, 1992.

Rothman, J. *Guidelines for Case Management.*

Itasca, IL: F.E. Peacock Publishers, 1992.

Rothman, J. *Practice With Highly Vulnerable Clients.* Englewood Cliffs, NJ: Prentice Hall, 1994.

Rubin, A. Is case management effective for people with serious mental illness? A research review. *Health and Social Work* 17:138-150, 1992.

Rush, B., and Ekdahl, A. Recent trends in the development of alcohol and drug treatment services in Ontario. *Journal of Studies on Alcohol* 51(6): 514-522, 1990.

Saleebey, 0., ed. *The Strengths Perspective in Social Work Practice,* 2nd ed. New York: Longman Press, 1997.

Schlenger, W.E.; Kroutil, L.A.; and Roland, E. J. Case management as a mechanism for linking drug abuse treatment and primary care: Preliminary evidence from the ADAMHA/HRSA linkage demonstration. In: Ashery, R.S., ed. *Progress and Issues in Case Management.* NIDA Research Monograph Series, Number 127. HHS Pub. No. (ADM) 92-1946. Rockville, MD: National Institute on Drug Abuse, 1992. pp. 316-330.

Schwartz, B.; Dilley, J.; and Sorensen, J.L. Case management of substance abusers with HIV disease. In: Siegal, H., and Rapp, R.C., eds. *Case Management and Substance Abuse Treatment: Practice and Experience.* New York: Springer, 1996. pp. 123-140.

Shernoff, M., and Springer, E. Substance abuse and AIDS: Report from the front lines (The impact on professionals). *Journal of Chemical Dependency Treatment* 5(1):35-48, 1992.

Shilony, E.; Lacey, D.; O'Hagan, P.; and Curto,

M. All in one neighborhood: A community­ based rehabilitation treatment program for homeless adults with mental illness and alcohol/ substance abuse disorders. *Psychosocial Rehabilitation Journal* 16(4):103- 116, April, 1993.

Shwartz, M.; Baker, G.; Mulvey, K.P. and Plough, A. Improving publicly funded substance abuse treatment: The value of case management. *American Journal of Public Health* 87(10):1659-1664, 1997.

Siegal, H.A.; Fisher, J.A.; Rapp, R.C.; Kelliher,

C.W.; Wagner, J.H.; O'Brien, W.F.; and Cole,

P.A. Enhancing substance abuse treatment with case management: Its impact on employment. *Journal of Substance Abuse Treatment* 13(2):93-98, 1996.

Siegal, H.A.; Rapp, R.C.; Kelliher, C.W.; Fisher,

**J.H.;** Wagner, J.H.; and Cole, P.A. The strengths perspective of case management: A promising inpatient substance abuse treatment enhancement. *Journal of Psychoactive Drugs* 27(1):67-72, 1995.

Siegal, H.A.; Rapp, R.C.; Li, L.; Saha, P.; and Kirk, K. The role of case management in retaining clients in substance abuse treatment: An exploratory analysis. *Journal of Drug Issues* 27(4):821-831, 1997.

Skinner, W.F. The prevalence and demographic predictors of illicit and licit drug use among lesbians and gay men. *American Journal of Public Health* 84(8):1307-1310, 1994.

*83*

*Appendix A*

Soloman, P. The efficacy of case management services for severely mentally disabled clients. *Community Mental Health Journal* 28:163-180, 1992.

Soloman, P., and Draine, J. Consumer case management and attitudes concerning family relations among persons with mental illness. *Psychiatric Quarterly* 66(3):249-261, 1995.

Sonsel, G.E.; Paradise, F.; and Stroup, S. Case management practice in an AIDS service organization. *Social Casework: The Journal of Contemporary Social Work* 69(6):388-392, 1988.

Sosin, M.R.; Bruni, M.; and Mairead, R. Paths and impacts in the progressive independence model: A homelessness and substance abuse intervention in Chicago. In: Stahler, G.J., and Stimmel, B., eds. *The Effectiveness of Social Interventions for Homeless Substance Abusers.* New York: Haworth Medical Press, 1995. pp. 1-20.

Sosin, M.R.; Yamaguchi, J.; Bruni, M.; Grossman, S.; Leonelli, B.; and Reidy, M. *Treating Homelessness and Substance Abuse in Community Context: A Case Management and Supported Housing Demonstration.* Chicago, IL: The University of Chicago, 1994.

Stahler, G.J.; Shipley, T.F.; Bartlet, D.; DuCette, J.P.; and Shandler, I.W. Evaluating alternative treatments for homeless substance abusing men: Outcomes and predictors of success. In: Stahler, G.J., and Stimmel, B., eds. *The Effectiveness of Social Interventions for Homeless Substance Abusers.* New York: Haworth Medical Press, 1995. pp. 151-167.

Stark, M.J., and Kane, B.J. General and specific psychotherapy role induction with substance abusing clients. *International Journal of the Addictions* 20(8):1135-1141, 1985.

Steadman, H.J. Boundary spanners: A key component for the effective interactions of the justice and mental health systems. *Law and Human Behavior* 16(1):75-87, 1992.

Stein, L., and Test, M. Alternatives to mental hospital treatment. I. Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry* 37:392-397, 1980.

Sullivan, W. Technical assistance consultation: A new model for social work practice [Diss.] *Dissertation Abstracts International* 50:4106, 1990.

Sullivan, W.P. *Case Management in Alcohol and Drug Treatment: Conceptual Issues and Practical Applications.* Springfield, MO: Center for Social Research, Southwest Missouri State University, 1991.

Sullivan, W.P.; Wolk, J.L.; and Hartmann, D.J. Case management in alcohol and drug treatment: Improving client outcomes.

*Families in Society: The Journal of Contemporary Human Service* 73:195-201, 1992.

Tausig, M. Detecting "cracks" in mental health service systems: Application of network analytic techniques. *American Journal of Community Psychology* 15:337-351, 1987.

Teague, G.B.; Schwab, B.; and Drake, R.E. *Evaluation of Services for Young Adults With Severe Mental Illness and Substance Use Disorders.* Alexandria, VA: National Association of State Mental Health Program Directors, 1990.

*84*

*Bibliography*

Test, M.A. Effective community treatment of the chronically mentally ill: What is necessary? *Journal of Social Issues*

37(3):71-86, 1981.

Test, M.A. Training in community living. In: Libermann, R.P., ed. *Handbook of Psychiatric Rehabilitation.* New York: MacMillan, 1992. pp. 153-170.

Toborg, M.A.; Levin, D.R.; Milkman, R.H.; and Center, L.J. *Treatment Alternatives to Street Crime: (T ASC) Projects: National Evaluation Program, Phase I Summary Report.*

Washington, DC: National Institute of Law Enforcement and Criminal Justice, 1976.

Turner, J., and TenHoor, W. The NIMH community support program: Pilot approach to a needed social reform. *Schizophrenia Bulletin* 4(3):319-348, 1978.

U.S. General Accounting Office. *Management Practices: U.S. Companies Improve Performance Through Quality Efforts.* Pub. No. GAO/NSLAD-91-190. Washington, DC:

U.S. Government Printing Office, 1991.

Van de Ven, A.H., and Ferry, D.L. *Measuring and Assessing Organizations.* New York: Wiley, 1980.

Wallace, J. The new disease model of alcoholism. *Western Journal of Medicine* 152:502-505, 1990.

Weil, M.; Karls, J.M.; and Associates. *Case Management in Human Service Practice. A Systematic Approach to Mobilizing Resources for Clients.* San Francisco: Jossey-Bass, 1989.

Westermeyer, J. Cross-cultural studies on alcoholism. In: Goedde, H.W., and Agarwal, D.P., eds. *Alcoholism: Biomedical and Genetic Aspects.* Elmsford, NY: Pergamon Press, 1989. pp. 305-311.

Wholey, J.; Hatry, H.; and Newcomer, **K.M.,** eds. *Handbook of Practical Program Evaluation.* San Francisco: Jossey-Bass, 1994.

Wildwind, L. When women resist treatment: Approaches for counselors. *Journal of Substance Abuse Treatment* 1:47-54, 1984.

Willenbring, M.; Ridgely, M.S.; Stinchfield, R.; and Rose, M. *Application of Case Management in Alcohol and Drug Dependence: Matching Techniques and Populations.* Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1991.

Willenbring, M.L.; Whelan, J.A.; Dahlquist, J.S.; and O'Neal, M.E. Community treatment of the chronic public inebriate. I: Implementation. *Alcoholism Treatment Quarterly* 7(2):79-97, 1990.

Zweben, A. The efficacy of role induction in preventing early dropout from outpatient treatment of drug dependency. *American Journal of Drug and Alcohol Abuse*

8(2):171-183, 1981.

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