Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

Comprehensive Case Management for Substance Abuse Treatment

Treatment Improvement Protocol (TIP) Series

27

Substance Abuse and Mental Health Services Administration
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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?

Treatment 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.

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

The 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 Summary

Case 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 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, 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

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

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.

Interagency 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

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

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

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 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
- Research questions from broader sociological or multidisciplinary perspectives

Case Management for Clients With Special Needs

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

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.

1 Substance Abuse and Case Management: An Introduction

The 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.

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

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

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

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 Figure1-1.

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).

Figure 1-1
Definitions of Case Management

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)

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 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).

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

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.

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 acquisition needs	Strengths-based, applicable to any of client life areas	Broad-based, part of a comprehensive (biopsychosocial) assessment	Broad-based, part of a comprehensive (biopsychosocial) assessment
Assists in goal planning	Generally brief, related to acquiring resources, possibly informal	Client-driven, teaches specific process on how to set goals and objectives, goals may include any of client life areas	Comprehensive, goals may include any of client life areas	Comprehensive, goals may include any of client life areas
Makes referral to needed resources	Case manager may initiate contact or have client make contact on own	As negotiated with client, may contact resource, accompany client, or client may contact on own	As needed, many resources integrated into broad package of case management services	As negotiated with client, may contact resource, accompany client, or client may 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 about how to identify strengths and about self-help resources	Provides many services within unified package of treatment/case management services	Provision of therapeutic activities central to the model
Helps develop informal support systems	No	Development of informal resources — neighbors, church, family— a key principle of the model	Through implementation of drop-in centers and shelters	Emphasis on family and self-help support through therapeutic activities

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

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

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).

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

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).

2 Applying Case Management to Substance Abuse Treatment

Case management is almost infinitely adaptable, but several broad principles are true of almost every application. This chapter will discuss those principles, the competencies necessary to implement case management functions, and the relationship between those functions and the substance abuse treatment continuum. For the purposes of discussion, case management and substance abuse treatment are presented as separate and distinct aspects of the treatment continuum, although in reality they are complementary and at times thoroughly blended.

Case Management Principles

Case management offers the client a single point of contact with the health and social services systems. The strongest rationale for case management may be that it consolidates to a single point responsibility for clients who receive services from multiple agencies. Case management replaces a haphazard process of referrals with a single, well-structured service. In doing so, it offers the client continuity. As the single point of contact, case managers have obligations not only to their clients but also to the members of the systems with whom they interact. Case managers must familiarize themselves with protocols and operating procedures observed by these other professionals. The case manager must mobilize needed resources, which requires the ability to negotiate formal systems, to barter informally among service providers, and to consistently pursue informal networks. These include self-help groups and their members, halfway and three-quarter-way houses, neighbors, and numerous other resources that are sometimes not identified in formal service directories.

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

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