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Booting Up the System: Case Management Models, Principles, and Practices

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This distance learning coursework was developed for CEUMatrix by Robert A. Shearer, Ph.D.

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About the Instructor:

Dr. Robert A. Shearer is a retired professor of Criminal Justice, Sam Houston State University. He received his Ph.D. in Counseling and Psychology from Texas A & M University, Commerce. Prior to teaching Criminal Justice, he taught Educational Psychology at Mississippi State University on campus and in the extension program across rural Mississippi during the civil rights era.

He has been teaching, training, consulting and conducting research in the fields of Criminal Justice, human behavior, and addictions for over thirty-six years. He is the author of over sixty professional and refereed articles in Criminal Justice and behavior. He is also the author of *Interviewing: Theories, techniques, and practices, 5th edition* published by Prentice Hall. Dr. Shearer has also created over a dozen measurement, research, and assessment instruments in Criminal Justice and addictions.

He has been a psychotherapist in private practice and served as a consultant to dozens of local, state, and national agencies. His interests continue to be substance abuse program assessment and evaluation. He has taught courses in interviewing, human behavior, substance abuse counseling, drugs-crime-social policy, assessment and treatment planning, and educational psychology. He has also taught several university level psychology courses in the Texas Department of Criminal Justice Institutional Division, led group therapy in prison, trained group therapists, and served as an expert witness in various courts of law.

He has been the president of the International Association of Addictions and Offender Counseling and the editor of the *Journal of Addictions and Offender Counseling* as well as a member of many Criminal Justice, criminology, and counseling professional organizations prior to retirement.

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Booting Up the System: Case Management Models, Principles, and Practices

By Robert A. Shearer, Ph.D.
Sam Houston State University

Goal of the Course

The goal of this course is for the learner to understand the models, principles, and practices of case management.

Objectives of the Course

The objectives of this course are for the learner to:

1. Understand the need for case management.
2. Understand the history of case management.
3. Be able to define case management.
4. Understand the models of case management.
5. Understand the principles of case management.
6. Identify the knowledge, skills, and attitudes of case management.
7. Describe the substance abuse treatment continuum.
8. Understand which model of case management s/he prefers

Part 1
Introduction to Substance Abuse and Case Management

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 hospitalized patient's care. This course uses the term to refer to interventions designed to help substance abusers access needed social services.

As the term "booting up the system" is used to describe full access to a computer's capability, case management is the term used to refer to providing full access to social, criminal justice, or health care systems to a substance abuser. Case management involves monitoring and supervising a substance abuser's progress according to a variety of models, principles, and practices. This course presents an overview of these elements of casework or case management.

Support for the use of case management in this setting is 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. 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. Between 23 and 56 percent of individuals with diagnosable Axis I mental disorders also have a substance abuse or dependence disorder.

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. 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. Clinicians who develop a "helping alliance" with substance abusers have been shown to produce better treatment outcomes than those who do not.

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 treat 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. The course 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 course 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 who is 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 - case manager - or by a professional who has this responsibility along with therapeutic or counseling functions. This course 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. 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, 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 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. 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. Case management for substance abusers initially gained attention in the United States through the Treatment Alternatives for Safe Communities (TASC) program (formally 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 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. 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. 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 Figure 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. The National Association of Social Workers' standards for social work case management include assessing, arranging, coordinating, monitoring, evaluating, and advocacy.

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 and one of five performance domains developed in a Role Delineation Study.

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.* The 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.

Figure 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"
- "[a] process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner"
- "helping people whose lives are unsatisfying or unproductive due to the presence of many problems which require assistance from several helpers at once:
- "monitoring, tracking and providing support to a client, throughout the course of his/her treatment and after"
- "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"
- "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."

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, other 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 part of recovery. Assertive community treatment was implemented to provide parolees a wide range of integrated services, including drug treatment, skills building, and resource acquisition.

Figure 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.

Brokerage/Generalist

Brokerage/generalist models seek to identify client's 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 proven 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.

Figure 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

Primary Case Management Activities	**Broker/Generalist**	**Strengths Perspective**	**Assertive Community Treatment**	**Clinical/ Rehabilitation**
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
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

Primary Case Management Activities	**Broker/Generalist**	**Strengths Perspective**	**Assertive Community Treatment**	**Clinical/ Rehabilitation**
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	Dually diagnosed clients; female polysubstance abusers

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. 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.

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. 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. A visual representation of the broker/generalist model can be seen in figure 3.

Assertive Community Treatment

The Program of Assertive Community Treatment (PACT) model, originally developed in Wisconsin, 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

This model was among the first to adapt a mental health model for persons with substance abuse problems, specifically chronic public inebriates. 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. 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 were expected of clients. Assertive Community Treatment has been implemented alone and in conjunction with a therapeutic community. A visual representation of the ACT model can be seen in Figure 4.

Figure 3
Broker/Generalist Model

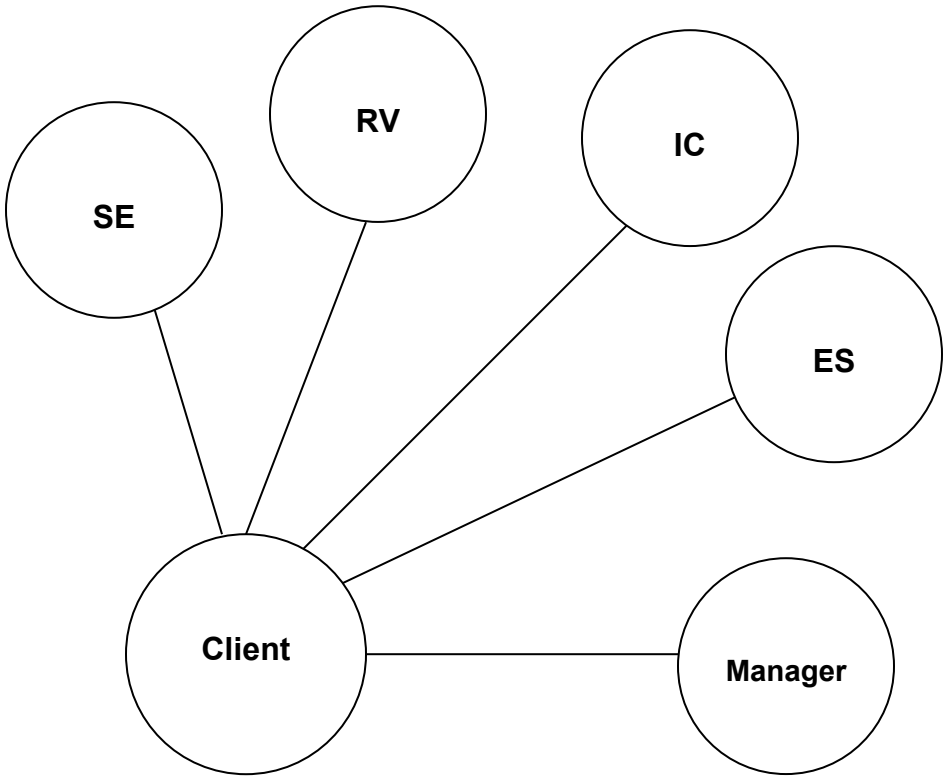


Figure 4
Assertive Community Treatment Model

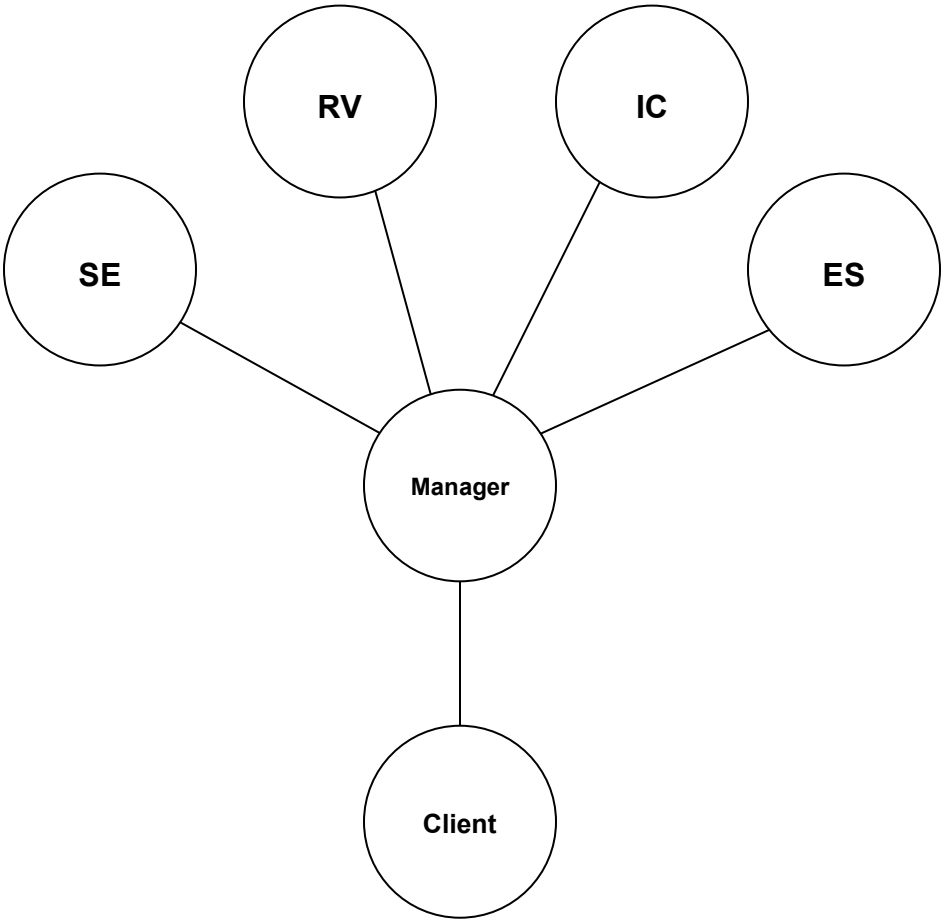


Figure 5
Strength-Based Perspective Model

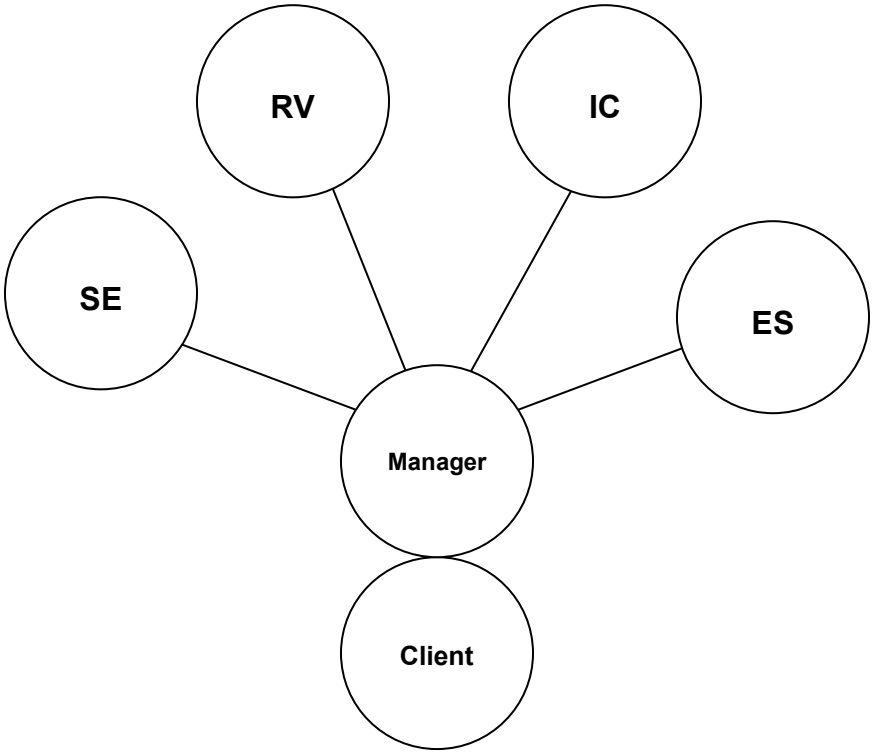
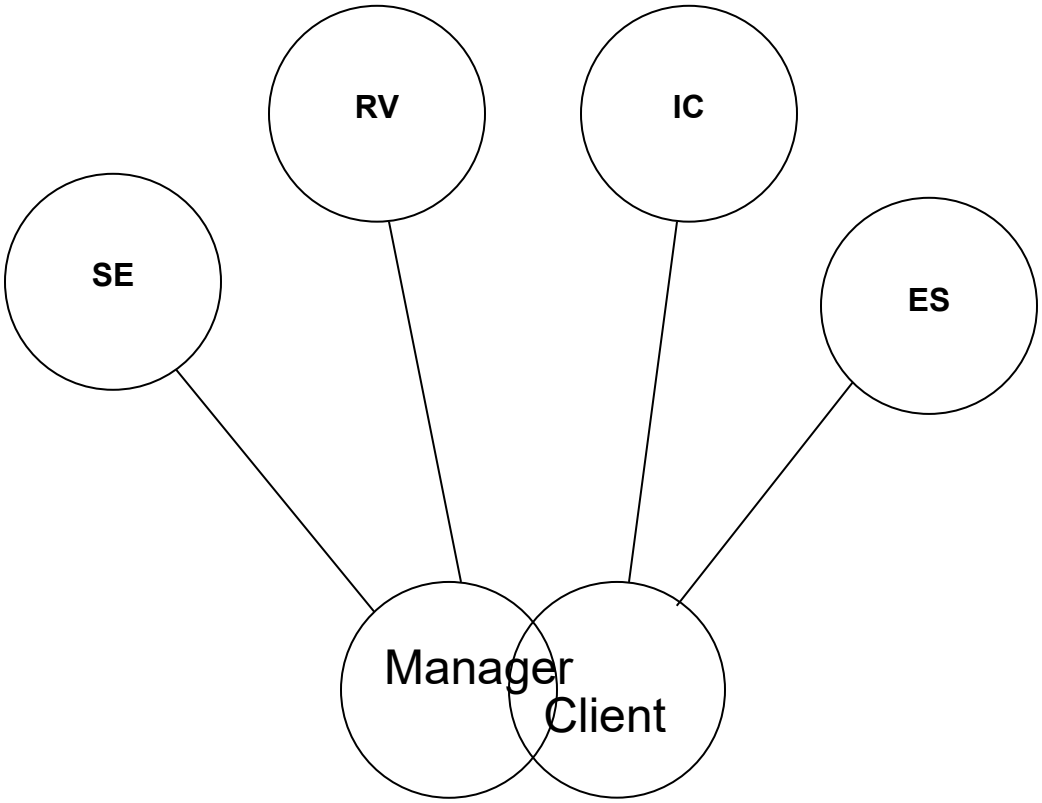


Figure 6
Clinical/Rehabilitation Model



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. 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. 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 and male substance abusers.

Because of the advocacy component and client-driven goal planning, a strength-based approach can at times cause stress between a case manager and other members of the treatment team. 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. A visual representation of the strengths-based model can be seen in Figure 5.

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. 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. A visual representation of the clinical/rehabilitation model can be seen in Figure 6.

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. 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. The *Case Management Orientation Inventory (CMOI)*, found at the end of this course, will help understand these four models.

Part 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 of 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 client's right of self-determination is emphasized. Once the client chooses from the options identified, the case manager's expertise comes into playing 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 restrictive level of care necessary so that the client's life is disrupted as little as possible.

Case management involves advocacy. The paramount goal when dealing with substance abuse clients and diverse services with frequently contradictory requirements is the need to promote the client's best interests. Case managers need to advocate with many systems, including agencies, families, legal systems, and legislative bodies. The case manager can advocate by educating non-treatment service providers about substance abuse problems in general and about the specific needs of a given client. At times the case manager must negotiate an agency's rules in order to gain access or continued involvement on behalf of a client. Advocacy can be vigorous, such as when a case manager must force an agency to serve its clients as required by law or contract. For criminal justice clients, advocacy may entail the recommendation of sanctions to encourage client compliance and motivation.

Case management is community-based. All case management approaches can be considered community-based because they help the client negotiate with community agencies and seek to integrate formalized services with informal care resources such as family, friends, self-help groups, and church. However, the degree of direct community involvement by the case manager varies with the agency. Some agencies mount aggressive community outreach efforts. In such programs, case managers accompany clients as they

take buses or wait in lines to register for entitlements. This personal involvement validates clients' experiences in a way that other approaches cannot. It suits the subculture of addiction because it enables the case manager to understand the client's world better, to learn what streets are safe and where drug dealing takes place. This familiarity helps the professional appreciate the realities that clients face and set more appropriate treatment goals – and helps the client trust and respect the case manager. Because it often transcends facility boundaries, and because the case manager is more involved in the community and the client's life, case management may be more successful in re-engaging the client in treatment and the community than agency-based efforts. For clients who are institutionalized, case management involves preparing the client for community-based treatment and living in the community. Case management can ensure that transitions are smooth and that obstacles to timely admissions into community-based programs are removed. Case management can also coordinate release dates to ensure that there are no gaps in service. The type of relationship described here is likely at times to stretch the more narrow boundaries of the traditional therapist-client relationship.

Case management is pragmatic. Case management begins "where the client is," by responding to such tangible needs as food, shelter, clothing, transportation, or child care. Entering treatment may not be a client priority; finding shelter, however, may be. Meeting these goals helps the case manager develop a relationship with and effectively engage the client. This client-centered perspective is maintained as the client moves through treatment engagement. For example, the loss of housing may provide the impetus for residential treatment. Teaching clients the day-to-day skills necessary to live successfully and substance free in the community is an important part of case management. These pragmatic skills may be taught explicitly, or simply modeled during interaction between case manager and client.

*Case management is anticipatory***.** Case management requires an ability to understand the natural course of addiction and recovery, to foresee a problem, to understand the options available to manage it, and to take appropriate action. In some instances, the case manger may intervene directly; in others, the case manager will take action to ensure that another person on the care team intervenes as needed. The case manager, working with the treatment team, lays the foundation for the next phase of treatment.

Case management with substance abusers must be adaptable to variations occasioned by a wide range of factors, including co-occurring problems such as AIDS or mental health issues, agency structure, availability or lack of particular resources, degree of autonomy and power granted to the case manager, and many others. The need for flexibility is largely responsible for the numerous models of case management and difficulties in evaluating interventions.