



# **BOOTING UP THE SYSTEM: CASE MANAGEMENT MODELS, PRINCIPLES AND PRACTICES**

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Then when you know better, do better.*

— Maya Angelou

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# ABOUT THE INSTRUCTOR

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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. 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 (ASAM, 2023), 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.

# **Evolving Case Management Models for Substance Use Disorders**

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Since this course was originally developed, the landscape of case management in substance use treatment has shifted substantially. Three areas deserve particular attention: outreach models for hard-to-reach populations, the integration of peer support specialists, and the ongoing challenge of workforce development.

## **Outreach and Engagement Models**

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A 2026 systematic review and network meta-analysis examining outreach models for individuals experiencing homelessness and substance use disorders synthesized the comparative effectiveness of multiple approaches, including assertive community treatment, intensive case management, and the Community Reinforcement Approach (Ghafouri et al., 2026). The findings reinforce what many practitioners already suspect: sustained, proactive engagement produces better outcomes than waiting for clients to seek services on their own. For case managers working with criminal justice populations or individuals cycling through emergency services, these findings affirm the value of meeting clients where they are -- literally and figuratively.

## **Peer Support Integration**

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One of the most significant developments in case management practice has been the growing role of peer support specialists. Hamilton et al. (2022) examined peer support in criminal justice settings specifically for opioid use disorder and found that these specialists remain underutilized despite clear benefits. Peers help clients navigate the healthcare system, support reintegration into the community, and improve adherence to treatment goals. Their lived experience provides a bridge that traditional case managers, regardless of clinical skill, cannot always replicate. For substance abuse counselors coordinating care across systems, understanding how to collaborate with and appropriately deploy peer specialists has become an essential competency rather than an optional enhancement.

## **Workforce Development Challenges**

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The substance use treatment workforce faces persistent training gaps that directly affect case management quality. Scott et al. (2022) analyzed 258 training events involving 10,143 participants and documented a sharp increase in demand for workforce development during the early COVID-19 pandemic period. The training needs identified spanned multiple domains, including evidence-based practices, provider self-care, leadership development, health equity, stigma reduction, and consumer needs. For case managers, this signals that the field is actively evolving, and that staying current requires ongoing professional development beyond initial certification. The sheer scale of demand (over ten thousand participants across these events) also points to a workforce that recognizes its own knowledge gaps and is actively seeking to address them.

## Implications for Practice

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Taken together, these developments suggest that effective case management in 2026 requires fluency in outreach-based engagement, meaningful collaboration with peer support staff, and a commitment to continuous learning. The traditional brokerage model -- referring clients to services and following up periodically -- is no longer sufficient on its own. Counselors who can integrate assertive outreach, peer partnerships, and evidence-based engagement strategies will be better positioned to serve clients across the complex systems they navigate.

## Recovery Capital and Case Management Outcomes

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The concept of recovery capital -- the personal, social, and community resources that support sustained recovery -- has emerged as a critical framework for understanding case management effectiveness. Recent research has examined how recovery capital develops during treatment, how physical health intersects with recovery resources, and how workforce development and treatment court participation shape outcomes.

Headid et al. (2024) compared 39 SUD treatment completers with 30 non-completers and found that both groups began treatment with similarly limited recovery capital. Graduates, however, showed substantially more resources by discharge, including stronger social connections, improved coping skills, and greater community engagement (Headid et al., 2024). For case managers, this finding suggests that actively facilitating the accumulation of recovery capital -- through resource linkage, skills building, and social connection -- may be more impactful than attempting to screen for pre-existing strengths at intake. The case management role shifts from assessing what clients already have to building what they need.

Osborne and Kelly (2023) investigated the relationship between physical health and recovery capital in SUD treatment. The study found that untreated physical health problems undermined recovery by consuming resources and attention that could otherwise support sobriety. Conversely, addressing health conditions enhanced recovery capital across multiple domains including knowledge, autonomy, and social connection (Osborne & Kelly, 2023). For case managers coordinating care, this research provides evidence that health services linkage is not merely a supplementary function -- it is a core recovery support. Clients whose medical needs go unmet face a steeper path to sustained recovery, regardless of how effective their addiction treatment may be.

Mendoza et al. (2022) described an Interdisciplinary Training Academy that provided 30 weeks of interprofessional rotations totaling 7,257 hours of supervised training across policy, prevention, treatment, integrated care, harm reduction, and recovery support services. The academy addressed workforce development gaps by training practitioners to work across disciplinary boundaries (Mendoza et al., 2022). For case management practice, this model represents the type of cross-system fluency that effective coordination requires. Case managers who understand the perspectives and workflows of medical, behavioral health, and social service providers are better equipped to navigate the fragmented systems their clients must traverse.

Knapp et al. (2024) tracked recovery capital trajectories in 165 drug treatment court clients over the

course of one year and found that education level predicted gains in recovery capital, particularly for opioid intervention court (OIC) participants. Clients with a high school diploma or GED at baseline accumulated recovery resources more rapidly within OIC settings. Additionally, the relationship between drug use and recovery capital strengthened over time among OIC participants -- as treatment progressed, the negative impact of continued substance use on recovery capital became more pronounced (Knapp et al., 2024). For case managers working with treatment court populations, this finding highlights the value of educational support as a case management function and suggests that recovery capital monitoring should be integrated into ongoing case reviews rather than conducted only at intake and discharge.

## 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 (SAMHSA, 2020).

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 (NIDA, 2024) 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 (SAMHSA, 2024). 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 mental health conditions also have a substance abuse or dependence disorder (SAMHSA, 2024).

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 (SAMHSA, 2024).

### **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 treatment 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

9. 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) (SAMHSA, 2020).
10. 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 (SAMHSA, 2020).
11. 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.
12. 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.
13. 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 (SAMHSA, 2020).

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 (NIDA, 2024) 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 (SAMHSA, 2020).

### **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 (SAMHSA, 2020). 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 (SAMHSA, 2020). 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 (NIDA, 2024).

Policymakers in Canada were among the first to translate many generic case management functions into the field of substance abuse treatment (NIDA, 2024), 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, reflecting the broader evolution of case management approaches during the 1980s (SAMHSA, 2020). 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, (SAMHSA, 2020), 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 (SAMHSA, 2020).

There is also general agreement about case management functions in the specific context of substance abuse treatment (NIDA, 2024). 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 (SAMHSA, 2020), 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.

### **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” (SAMHSA, 2020)
- “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 (NIDA, 2024). 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 (McGahan et al., 2023).

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 1

# Figure 1

<b>Primary Case Management Activities</b>	<b>Broker/Generalist</b>	<b>Strengths Perspective</b>	<b>Assertive Community Treatment</b>	<b>Clinical/Rehabilitation</b>
<i>Conducts outreach and case finding</i>	Not usually	Depends on agency mission & Structure	Depends on agency mission & Structure	Depends on agency mission & Structure
<i>Provides assessment and ongoing reassessment</i>	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
<i>Assists in goal planning</i>	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.
<i>Makes referral to needed resources</i>	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
<i>Monitors referrals</i>	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

## *Models of Case Management (CDC, 2024)*

### **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 (SAMHSA, 2020).

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 (SAMHSA, 2020).

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 role (SAMHSA, 2020)s 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.

### **Assertive Community Treatment**

The Program of Assertive Community Treatment (PACT) model, originally developed in Wisconsin, emphasizes the following components (UNC Center for Excellence in Community Mental Health, 2024):

- 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.

### **Strengths-Based Perspective**

The strengths-based perspective of case management was originally developed at the University of Kansas School of Social Welfare (NASW, 2024) to help a population of persons with persistent mental illness make the transition from institutionalized care to independent living (Dissanayake et al., 2024). 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 (SAMHSA, 2020).

### **Clinical/Rehabilitation**

Many substance abuse treatment (NIDA, 2024) 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 (SAMHSA, 2020).

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 (SAMHSA, 2024), 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 (NIDA, 2024) 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 (SAMHSA, 2020) 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 (SAMHSA, 2020).

Case management is community-based (NASW, 2024). 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 (SAMHSA, 2024). 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 manager 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.

Case management is culturally sensitive. Accommodation for diversity, race, gender, ethnicity, disability, sexual orientation, and life stage (for example, adolescence or old age), should be built into the case management process. Five elements are associated with becoming culturally competent: (1) valuing diversity, (2) making a cultural self-assessment, (3) understanding the dynamics of cultural interaction, (4) incorporating cultural knowledge, and (5) adapting practices to the diversity present in a given setting.

### **Case Management Practice – Knowledge, Skills, and Attitudes**

All professionals who provide services to substance abusers, including those specializing in case management, should possess particular knowledge, skills, and attitudes that prepare them to provide more treatment-specific services. The basic prerequisites of effective practice include the ability to establish rapport quickly, an awareness of how to maintain appropriate boundaries in the fluid case management relationship, the willingness to be nonjudgmental toward clients, and certain “transdisciplinary foundations” created by the Addiction Technology Transfer Centers (ATTCs). These foundations – understanding addiction, treatment knowledge, application to practice, and professional readiness – are articulated in 23 competencies and 82 specific points of knowledge and attitude. Examples of competencies include: (SAMHSA, 2024)

- Understanding a variety of models and theories of addiction and other problems related to substance use
- 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
- Recognizing the importance of family, social networks, and community systems 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

Even though case managers have not always enjoyed the same stature accorded other specialists in the substance abuse treatment continuum, they must possess an equally extensive body of knowledge and master a complex array of skills in order to provide optimal services to their clients. Case managers must not only have many of the same abilities as other professionals who work with substance abusers (such as counselors), they must also possess special abilities relating to such areas as interagency functioning, negotiating, and advocacy. In recognition of the specific competencies applicable to conducting case management functions, two of the eight core dimensions – referral and service coordination (SAMHSA, 2020) – provide critical knowledge, skills, and attitudes pertinent to case management. Below are the activities covered under those dimensions:

### **Referral**

- Establish and maintain relations with civic groups, agencies, other professionals, governmental entities, and the community at large to ensure appropriate referrals, identify service gaps, expand community resources (SAMHSA, 2020), and help to address unmet needs
- Continuously assess and evaluate referral resources to determine their appropriateness
- Differentiate between situations in which it is more appropriate for the client to self-refer to a resource and those in which counselor referral is required
- Arrange referrals to other professionals, agencies, community programs, or other appropriate resources to meet client needs (SAMHSA, 2020)
- Explain in clear and specific language the necessity for and process of referral to increase the likelihood of client understanding and follow-through

- Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality regulations and professional standards of care
- Evaluate the outcome of the referral

## **Service Coordination**

### ***Implement the treatment plan***

- Initiate collaboration with referral source
- Obtain, review, and interpret all relevant screening, assessment, and initial treatment-planning information
- Confirm the client's eligibility for admission and continued readiness for treatment and change
- Complete necessary administrative procedures for admission to treatment
- Establish realistic treatment and recovery expectations with the client and involved significant others including, but not limited to:
  - Nature of services
  - Program goals
  - Program procedures
  - Rules regarding client conduct
  - Schedule of treatment activities
  - Costs of treatment
  - Factors affecting duration of care
  - Client rights and responsibilities
- Coordinate all treatment activities with services provided to the client by other resources

## **Consulting**

- Summarize the client's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress for purpose of ensuring quality of care, gaining feedback, and planning changes in the course of treatment

- Understand terminology, procedures, and roles of other disciplines related to the treatment of substance use disorders
- Contribute as part of a multidisciplinary treatment team
- Apply confidentiality regulations appropriately
- Demonstrate respect and nonjudgmental attitudes toward clients in all contacts with community professionals and agencies

Almost 200 specific knowledge items, skills, and attitudes are associated with these dimensions.

## **The Substance Abuse Treatment Continuum and Functions of Case Management (SAMHSA, 2020)**

### **Substance Abuse Continuum of Care**

Substance abuse treatment can be characterized as a continuum arrayed along a particular measure, such as the gravity of the substance abuse problem, level of care – inpatient, residential, intermediate, or outpatient – or intensity of service. The continuum in this is arranged chronologically, moving from case finding and pretreatment through primary treatment, either residential or outpatient, and finally to aftercare. Inclusion of case finding and pretreatment acknowledges the wide variety of case management activities that take place before a client has actually become part of the formal treatment process. While distinct goals and treatment activities are associated with each point on the continuum, clients' needs seldom fit neatly into any one area at a given time. For example, a client may need residential treatment for a serious substance abuse problem, but only be motivated to receive assistance for a housing problem. Case management is designed to span client needs (SAMHSA, 2020) and program structure.

### **Case finding and pretreatment**

The case-finding aspect of treatment is generally of paramount concern to treatment programs because it generates the flow of clients into treatment. Pretreatment has changed enormously in the past five years as programs have closed, resources have dwindled, and services available under managed care plans have been severely curtailed. Many individuals identified as viable

treatment candidates cannot get through the gate, and pretreatment may in fact constitute brief intervention therapy. Treatment programs may undertake case-finding activities through formal liaisons with potential referral sources such as employers, law enforcement authorities, public welfare agencies, acute emergency medical care facilities, and managed care companies. Health maintenance organizations and managed care companies often require case finding when hotlines are called. General media campaigns and word of mouth also lead substance abusers to contact treatment programs.

Some treatment programs operate aggressive outreach street programs to identify and engage clients. Outreach workers contact prospective clients and offer to facilitate their entry into treatment. Although treatment admission may be the foremost goal of the worker and the treatment program, prospective clients frequently have other requests before agreeing to participate. Much of the assistance offered by outreach workers resembles case management in that it is community-based, responds to an immediate client need, and is pragmatic.

A pretreatment period is frequently the result of waiting lists or client reluctance to become fully engaged in primary treatment. In a criminal justice setting, it may be a time to prepare clients who are not ready for primary treatment because they do not have support systems in place and lack homes, transportation, or necessary work and living skills. The pretreatment period may be when clients lose interest in treatment. When the appropriate services are provided, however, it may actually increase the commitment to treatment at a later time. Numerous interventions – role induction techniques, pretreatment groups, and case management – have been instituted to improve outcomes associated with the pretreatment period.

### **Primary treatment**

Primary treatment is a broad term used to define the period in which substance abusers begin to examine the impact of substance use on various areas of their lives. The American Society of Addiction Medicine (ASAM, 2023) (ASAM) delineates five categories of primary treatment, characterized by the level of treatment intensity: early intervention, outpatient services, intensive outpatient or partial hospitalization, residential or inpatient services, and medically

managed intensive inpatient services. Whatever the setting, an extensive biopsychosocial (NIDA, 2024) assessment is necessary. This assessment provides both the client and the treatment team the opportunity to determine clinical severity, client preference, coexisting diagnosed, prior treatment response, and other factors relevant to matching the client with the appropriate treatment modality and level of care. If not already established during the case finding/pretreatment phase, this assessment should also consider the client's needs for various resources that case management can help secure.

### **Aftercare**

Aftercare, or continuing care, is the stage following discharge, when the client no longer requires services at the intensity required during primary treatment. A client is able to function using a self-directed plan, which includes minimal interaction with a counselor. Counselor interaction takes on a monitoring function. Clients continue to reorient their behavior to the ongoing reality of a pro-social, sober lifestyle. Aftercare can occur in a variety of settings, such as periodic outpatient aftercare, relapse/recovery groups, 12-Step and self-help groups, and halfway houses. Whether individuals completed primary treatment in a residential or outpatient program, they have at least some of the skills to maintain sobriety and begin work on remediating various areas of their lives. Work is intrapersonal and interpersonal as well as environmental. Areas that relate to environmental issues, such as vocational rehabilitation, finding employment, and securing safe housing, fall within the purview of case management (SAMHSA, 2020) (IC&RC, 2024).

If different individuals perform case management and addictions counseling, they must communicate constantly during aftercare about the implication and progress of all service plans. Because case managers interact with the client in the community, they are in a unique position to see the results of work being done in aftercare groups and provide perspective about the client's functioning in the community. Recent findings suggest that the case management relationship may be as valuable to the client during this phase of recovery as that with the addictions counselor. Aftercare is important in completing treatment both from a

funding standpoint (many funders refuse to pay for aftercare services), as well as from the client's perspective.

## **Case Management Functions and the Treatment Continuum**

In this section, case management functions are presented against the backdrop of the substance abuse continuum of care to highlight the relationship between treatment and case management. The primary difference between the two is case management's focus on assisting the substance abuser in acquiring needed resources. Treatment focuses on activities that help substance abusers recognize the extent of their substance abuse problem, acquire the motivation and tools to stay sober, and use those tools. Case management functions mirror the stages of treatment and recovery.

If properly implemented, case management supports the client as she moves through the continuum, encouraging participation, progress, retention, and positive outcomes. The implementation of the case management functions is shaped by many factors, including the client's place to the continuum and level of motivation to change, agency mission, staff training, configuration of the treatment or case management team, needs of the target population, and availability of resources. The fact that not all clients move through each phase of the treatment continuum or through a particular phase at the same pace adds to the variability inherent in case management.

### **Engagement**

#### **Case findings and pretreatment**

Engagement during the case finding/pretreatment phase is particularly proactive. The case manager frequently needs to provide services in nontraditional ways, reaching out to the client instead of waiting for the client to seek help. Engagement is not just meeting clients and telling them that a particular resource exists. Engagement activities are intended to identify and fulfill the client's immediate needs, often with something as tangible as a pair of socks or a ride to the doctor (SAMHSA, 2024).

This initial period is often difficult. Motivation may be fleeting and access to services limited. In many jurisdictions, there is a significant wait to schedule an orientation, assessment, or intake appointment. Third parties responsible for authorizing behavioral health benefits may be involved, and client persistence may be a key factor in accessing services.

Additional factors may come into play with clients referred from the criminal justice system. They may be angry about their treatment by the criminal justice system and may resent efforts to help them. Clients who begin treatment after serving time in jail or prison have significant life issues that must be addressed simultaneously (such as safe housing, money, and other subsistence issues) as well as resentment, resistance, and anger. Others may have active addictions or be engaged in criminal activity. Requirements imposed by the criminal justice system must also be met; these can present conflicts with meeting other goals, including participation in substance abuse treatment (NIDA, 2024).

Potential clients may be unfamiliar with the treatment process. Their expectations about treatment may not be realistic, and they may know very little about substance abuse and addiction. It is not uncommon for people at this stage to minimize the impact substance use or abuse has on their lives. These factors often manifest in client behaviors such as missing appointments, continued use, excuses, apathy, and an unwillingness to commit to change.

The goal of case management at this stage is to reduce barriers, both internal and external, that impede admission to treatment. Client reluctance to enter into services can be reduced by (1) motivational interviewing (SAMHSA, 2024) approaches; (2) basic education about addiction and recovery; (3) reminding clients of past and future consequences of continued substance abuse; (4) assistance in meeting the client's basic survival needs; and (5) commitment to developing the case manager-client relationship. Prescreening for program eligibility, coordination referrals, and working to reduce any administrative barriers can facilitate access to services.

The process of motivating a client, beginning the education process, identifying essential needs, and forming a relationship can begin during a prescreening or screening interview. The motivational approaches encourage client engagement through exploratory rather than confrontational means. Recognizing that not every client enters treatment with the same

motivational levels, they build on Prochaska and DiClemente's stages of motivation for treatment. The stages move from the client's non-recognition of a problem (precontemplation) to contemplation of a need for treatment, to determination, to action, and finally, to the maintenance of attained goals. Case management can use this framework to engage the client with stage-appropriate services. This means that clients who have not decided to address their substance abuse can often be "hooked" into more intensive treatment by providing basic practical supports. Providing these supports can have the additional effect of reducing the perceived desirability of continued substance use and the lifestyles associated with it.

A structured interview provides the client the opportunity to discuss her drug use and history with the case manager and to explore the losses that may have resulted from that use. For some clients, this history may reveal a pattern of increasing loss of control (and perhaps loss of freedom). Review and discussion of losses can serve to motivate clients to proceed to treatment. Listening empathetically and showing genuine concern about a client's well-being can facilitate the beginning of a meaningful, supportive relationship between the client and the case manager and can serve to motivate the client as well. A good initial relationship between client and case manager can also be invaluable when the client experiences difficulties later on in treatment.

In addition to information regarding substance abuse and the treatment process, clients must be informed about requirements and obligations of the case manager or case management program, and about requirements they will be expected to meet once they are admitted to treatment. This type of discussion presents another opportunity to solidify the client's commitment to practice in treatment. Even at the earliest stages, clients should be reminded that permanent changes are necessary for recovery. Finally, any questions the client has should be addressed. This can be particularly important for clients referred by the criminal justice system, who may be somewhat confused about that system's requirements, the consequences of noncompliance, and the difficulties they encounter in meeting those requirements.

While case management in the pretreatment phase may be intended to route clients to a particular program, engagement is not just a "come-on" to treatment. Many prospective clients will not formally enter treatment within an agency-defined period, but, within flexible limits,

case management services should still be made available to these individuals. The transition from engagement to planning is a gradual one and does not lend itself to agency-created distinctions such as “pretreatment” and “primary treatment.”

### **Primary treatment**

For clients who elect to enter treatment, engagement serves (IC&RC, 2024) to orient the client to the program. Orientation involves explaining program rules and regulations in greater detail than was possible or necessary during pretreatment. The provider elicits the client’s expectations of the program and describes what the program expects of the client. The person responsible for delivering case management to a particular client is in a unique position to assist in the match between individual and treatment. During primary treatment, the case manager can serve as one of the client’s links with the outside world, assisting the client to resolve immediate concerns that may make it difficult to focus on dealing with the goal of primary treatment – coming to grips with a substance abuse problem.

In addition to orienting clients to treatment programs, case managers can orient treatment programs to the clients they refer. Sharing information gathered during the pretreatment phase can provide support for the treatment process that ensues upon program admission.

### **Aftercare**

While in treatment, most of a client’s time is spent dealing with substance use. Although discharge plans may have been considered, it is not until discharge that the day-to-day realities of living assume the most urgency. Because of their relationship with their clients and their community ties, case managers are well positioned to help clients make this delicate transition. Case management serves to coordinate all aspects of the client’s treatment. This coordination occurs within a given treatment program, between the program and other resources, and among these other resources. The extent of the case manager’s ability to work on the client’s behalf will be guided both by the formal authority vested in the individual by the service providers involved and by the individual’s informal relationships (SAMHSA, 2020).

The case manager’s extensive knowledge of the client’s real-world needs can help the client who is no longer using. Clients in aftercare have an array of needs, including housing, a safe and