

# Case Management for Substance Abuse Treatment: A Guide for Treatment Providers

*Based on Treatment Improvement Protocol (TIP) 27*

*Desk Reference*



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration  
Center for Substance Abuse Treatment  
[www.samhsa.gov](http://www.samhsa.gov)

# **Case Management for Substance Abuse Treatment: A Guide for Treatment Providers**

*Treatment Improvement Protocol (TIP) Series*

**27**

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# Foreword

**C**SAT Concise Desk Reference Guides (CDRGs) are companion publications to Treatment Improvement Protocol (TIP) publications, which reflect best practice guidelines for the treatment of substance abuse. CSAT's Office of Evaluation, Scientific Analysis, and Synthesis draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. CDRGs are condensed versions of TIPs, edited and summarized to provide pertinent substance abuse treatment information targeting professionals in particular fields. Target audiences for the CDRGs include primary care physicians, substance abuse treatment providers, social service providers, administrators of substance abuse treatment programs, and others. The major goal of each CDRG is to convey "front-line" knowledge responsibly and quickly to practitioners in each of these disciplines.

This CDRG, *Case Management: A Guide for Substance Abuse Treatment Providers*, is abstracted from TIP 27, *Comprehensive Case Management for Substance Abuse*

*Treatment*. This CDRG provides the substance abuse treatment provider with an overview of common models of case management and major activities conducted along the substance abuse treatment continuum of care. It describes the unique case management needs of clients with HIV/AIDS, mental illness, and those who are incarcerated.

TIP 27, *Comprehensive Case Management for Substance Abuse Treatment*, as well as other TIPs and CDRGs, may be ordered by contacting the Substance Abuse and Mental Health Services Administration's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727).

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# Chapter 1

## Substance Abuse and Case Management: An Introduction

This CDRG, *Case Management: A Guide for Substance Abuse Treatment Providers*, presents an overview of case management practices of most relevance to direct providers of services. Though they may not refer to it by name, many providers have been using case management for years.

### What Is Case Management

Case management has been variously classified as a skill group, a core function, service coordination, or a network of “friendly neighbors.” Although it defies precise definition, case management generally can be described as a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals. This Guide uses the term to refer to interventions designed to help substance abusers access needed social services.

Due to the fragmentation of services, the accompanying inefficiency, and a growing scarcity of resources, some form of case management is used with virtually every population that routinely seeks social services. The variability in social services system configurations has led to many different implementations of case management, resulting in conceptual disagreements about case management and difficulty in assessing its value. Inevitably, many of the same issues will arise in the substance abuse setting. This CDRG 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 Guide makes the following assumptions.

1. *Case management is a set of social service functions that includes case management assessment, planning, linkage, monitoring, and advocacy.*
2. *Advocacy is one of case management’s hallmarks 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 or by a professional who has this responsibility along with therapeutic or counseling functions.*
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.*
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.*

### Why Case Management

What studies support is also proven every day in the field: **Substance abusers have better treatment outcomes if their other**

**problems are addressed concurrently.**

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

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

term sobriety while managing life in the community. Treatment must be structured to ensure smooth transitions to the next level of care, avoid gaps in service, and respond rapidly to the threat of relapse. Case management can help accomplish the above.

Case management is needed because, in most jurisdictions, services are fragmented and inadequate to meet the needs of the substance-abusing population.

**Several Views of Case Management Definitions of Case Management**

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. Nonetheless, the definitions in Figure 1-1 share a common thread.

<b>Figure 1-1 Definitions of Case Management</b>
<p><b>Case management is</b></p> <ul style="list-style-type: none"> <li>• “planning and coordinating a package of health and social services that is individualized to meet a particular client’s needs” (Moore, 1990, p. 444)</li> <li>• “[a] process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner” (Intagliata, 1981)</li> <li>• “helping people whose lives are unsatisfying or unproductive due to the presence of many problems which require assistance from several helpers at once” (Ballew and Mink, 1996, p. 3)</li> <li>• “monitoring, tracking and providing support to a client, throughout the course of his/her treatment and after” (Ogborne and Rush, 1983, p. 136)</li> <li>• “assisting the patient in re-establishing an awareness of internal resources such as intelligence, competence, and problem solving abilities; establishing and negotiating lines of operation and communication between the patient and external resources; and advocating with those external resources in order to enhance the continuity, accessibility, accountability, and efficiency of those resources” (Rapp et al., 1992, p. 83)</li> <li>• “assess[ing] the needs of the client and the client’s family, when appropriate, and arrang[ing], coordinat[ing], monitor[ing], evaluat[ing], and advocat[ing] for a package of multiple services to meet the specific client’s complex needs.” (National Association of Social Workers, 1992, p. 5)</li> </ul>

## Case Management Principles

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

- Offers the client a single point of contact with the health and social services systems.
- Is client-driven and driven by client need.
- Involves advocacy.
- Is community-based.
- Is pragmatic.
- Is anticipatory.
- Must be flexible.
- Is culturally sensitive.

## Interagency Case Management

The goal of interagency case management is to connect agencies to one another to provide additional services to clients. All organizations have boundaries; case managers or “boundary spanners” move across them to facilitate interactions among

agencies (Steadman, 1992). A 1994 network analysis of the “cracks in service delivery system” provides especially useful insights into the function and impact of various types of community linkages (Gillespie and Murty, 1994). According to Gillespie and Murty, agencies can be categorized by the connections they maintain with other community-based agencies. Figure 1-2 describes several interagency models.

## Potential Conflicts

The potential for conflict exists whenever two agencies or service providers work together. Recognizing potential triggers for interagency conflict and antagonism is a necessary first step to dealing with it. When problems do erupt, case managers and other agency personnel can use both informal and formal communication mechanisms to clarify issues, regain perspective, and refocus the interagency case management process. The list in Figure 1-3 highlights some of the common sources of conflict that may arise as a result of interagency case management.

**Figure 1-2**  
**Three Interorganizational Models**

- *Single Agency*—the case manager personally establishes a series of separate relationships on an as-needed basis with professional colleagues or counterparts in other agencies. The case manager retains full and autonomous control over the case and is accountable only to the parent agency.
- *Informal Partnership*—staff members from several agencies work collaboratively, but informally, as a temporary team constituted to provide multiple services for needy clients on a case-by-case basis.
- *The Formal Consortium*—case managers and service providers link through a formal, written contract. Agencies work together for multiple clients on an ongoing basis and are accountable to the consortium.

*Source:* Gillespie and Murty, 1994

The solution to interagency conflict is open, frank communication by personnel at all levels. Frequent meetings and other activities that bring people together foster

such communication. In the long run, the client's welfare is a shared objective, and the difficulties that are likely to arise can be successfully resolved.

**Figure 1-3  
Potential Conflicts**

- Unrealistic expectations about the services and outcomes that case management linkages can produce
- Unrealistic expectations of other agencies
- Disagreements over resources
- Conflicting loyalty between agency and consortium or partnership
- Final decisionmaking and other authority over the management of a case
- Disenchantment after the "honeymoon" period ends
- Differences in values, goals, and definitions of the problem, solutions, or roles
- Dissatisfaction with case handling or other agency's case management performance
- Clients who pit one case manager against another
- Inappropriate expectations of case managers (improper demands, "asking too much")
- Resentment over time spent on documentation, in meetings, or on forging and maintaining agency relationships rather than on providing client services
- Stratification, power, and reward differentials among various agency case managers
- Differences in case manager credentials and status among agencies
- Unclear problem resolution protocols for agency personnel

# Chapter 2

## Applying Case Management to Substance Abuse Treatment

### The Substance Abuse Treatment Continuum and Functions of Case Management

Substance abuse treatment can be characterized as a continuum arrayed along a particular measure, level of care (Institute of Medicine, 1990), or intensity of service (American Society of Addiction Medicine [ASAM], 1997). The continuum in this Guide is arranged chronologically, moving from case finding and pretreatment through primary treatment, either residential or outpatient, and finally to aftercare. See Figure 2-1.

While distinct goals and treatment activities are associated with each point on the continuum, clients' needs seldom fit neatly into anyone area at a given time. Case management is designed to span client needs and program structure.

Case management focuses 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

The previous chapter presented several definitions and ways of looking at case management. Here, we use the *functions* of case management as an overlay to explain how case management can enhance substance abuse treatment. As with

definitions, there is a high degree of consensus about a core group of functions:

1. Engagement
2. Assessment
3. Planning, goal setting, and implementation
4. Linkage, monitoring, and advocacy
5. Disengagement

### *Engagement*

#### *Case finding and pretreatment*

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. The goal of case management at this stage is to reduce barriers, both internal and external, that block admission to treatment.

A structured interview provides the client the opportunity to discuss his or 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. Figure 2-2 lists methods that may be helpful in reducing client reluctance to enter services.

A good initial relationship between client and case manager can also be invaluable when the client experiences difficulties later on in treatment (Miller and Rollnick, 1991).

**Figure 2-1**  
**Substance Abuse Treatment Continuum**

***Case finding and pretreatment***

Treatment programs may undertake case-finding activities through formal liaisons with potential referral sources. Health maintenance organizations and managed care companies often require case finding when hotlines are called. Some treatment programs operate aggressive outreach street programs to identify and engage clients. A pretreatment period is frequently the result of waiting lists or client reluctance to become fully engaged in primary treatment.

***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 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 (ASAM, 1997). Whatever the setting, an extensive biopsychosocial assessment is necessary. This assessment provides both the client and the treatment team the opportunity to determine clinical severity, client preference, coexisting diagnoses, prior treatment response, and other factors relevant to matching the client with the appropriate treatment modality and level of care.

***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. 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. Aftercare is important in completing treatment both from a funding standpoint (many funders refuse to pay for aftercare services) and from the client's perspective.

**Figure 2-2**  
**Methods To Reduce Client Reluctance To Enter Into Services**

1. Motivational interviewing 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
5. Commitment to developing the case manager-client relationship

***Primary treatment***

Engagement serves to orient those clients who do enter treatment to the program. During primary treatment, the case manager can serve as a link to the outside world, helping the client 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.

***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. Case managers are well positioned to help clients make this delicate transition. Clients in aftercare have an array of needs, including housing, a safe and drug-free home environment, a source of income, marketable skills, and a support system.

**Assessment**

The primary difference between substance abuse and case management assessment lies in the latter’s focus on the client’s need for community resources. The findings from the assessment, including specific skill deficits, basic support needs, level of functioning, and risk status, define the scope and focus of the service plan. Figure 2-3 lists skills that should be assessed at initial contact.

**Case finding and pretreatment**

It is case management’s role to explore client needs, wants, skills, strengths, and deficits and relate those attributes to an efficient service plan. This process includes assessing the client’s eligibility and appropriateness for both substance abuse and other services and for a specific level of care within those services.

**Primary treatment**

This biopsychosocial assessment should, at a minimum, examine the client’s situation in the life domains of housing, finances, physical health, mental health, vocational/ educational, social supports, family relationships, recreation, transportation, and spiritual needs. A case management assessment should include a review of the functional areas needed for service procurement and vocational skills (Harvey et al., 1997; Bellack et al., 1997).

<b>Figure 2-3 Skills To Be Assessed</b>
<p><b>Service Procurement Skills</b></p> <p>While the focus of case management is to assist clients in accessing social services, the goal is for clients to learn how to obtain those services. The client should therefore be assessed for</p> <ul style="list-style-type: none"> <li>• Ability to obtain and follow through on medical services</li> <li>• Ability to apply for benefits</li> <li>• Ability to obtain and maintain safe housing</li> <li>• Skill in using social service agencies</li> <li>• Skill in accessing mental health and substance abuse treatment services</li> </ul> <p><b>Prevocational and Vocation-Related Skills</b></p> <p>To reach the ultimate goal of independence, clients must also have vocational skills and should therefore be assessed for</p> <ul style="list-style-type: none"> <li>• Basic reading and writing skills</li> <li>• Skills in following instructions</li> <li>• Transportation skills</li> <li>• Manner of dealing with supervisors</li> <li>• Timeliness, punctuality</li> <li>• Telephone skills</li> </ul>

**Aftercare**

During aftercare, assessment may reveal new, recurring, or unresolved problems that could interfere with recovery; these must be attended to. The potential for relapse is a particularly significant challenge.

**Planning, goal setting, and implementation**

Based on the biopsychosocial or case management assessment, the client and case

manager identify goals in all relevant life domains, using the strengths, needs, and wants articulated in the assessment process. Service plan development and goal setting are discussed in detail in numerous works on substance abuse and case management (Ballew and Mink, 1996; Rothman, 1994; Sullivan, 1991).

### *Case finding and pretreatment*

While planning and goal setting are important in this early stage of treatment, it may be difficult to follow traditional approaches given the immediacy of clients' needs and the likelihood that they are still using alcohol or other drugs.

### *Primary treatment*

During primary treatment, the case manager must

- Continue to motivate the client to remain engaged and to progress in treatment
- Organize the timing and application of services to facilitate client success
- Provide support during transitions
- Intervene to avoid or respond to crises
- Promote independence
- Develop external support structures to facilitate sustained community integration

Case management techniques should be designed to reduce the client's internal barriers, as well as external barriers that may impede progress.

Another fundamental role of case management during the active treatment phase is to coordinate the timing of various interventions to ensure that the client can achieve his or her goals. Transition among programs—from institutional programming to residential treatment; from residential treatment to outpatient; or to lower level services within an outpatient setting—is

always stressful, and frequently triggers relapse. To avoid crises during transitions, case managers should intensify their contact with clients. Case managers should work to ensure that service is not interrupted. When possible, release dates should be coordinated to coincide with admission to the next program.

Too frequently, a client completes a treatment program and is moved to a lower level of supervision at the same time. This pulls out support all at once. If possible, supervision and treatment activities should be coordinated to promote gradual movement to independence in order to reduce the likelihood of relapse.

### *Aftercare*

One of the anticipatory roles for case management during primary care is to plan for aftercare, discharge, and community reentry.

### *Linking, monitoring, and advocacy*

Some findings suggest that while persons with substance abuse problems are generally adept at accessing resources on their own without case management, they often have trouble using the services effectively (Ashery et al., 1995). This is where the linking, ongoing monitoring, and, in many cases, advocacy of case management can be valuable.

After the linkage is made, the case manager moves on to monitoring the fit and relationship between client and resource. Monitoring client progress and adjusting services plans as needed are an essential function of case management. For instance, if a client involved in the criminal justice system tests positive for drugs, both the treatment counselor and the probation officer may need to know.

## **Case Example: The Treatment Alternatives for Safe Communities Project Jeopardy Meeting**

The *Treatment Alternatives for Safe Communities (TASC)* Project has developed a special form of case conference, known as “jeopardy meetings.” These meetings are attended by the case manager, treatment counselor, probation officer, client, and anyone else involved in the case. The purpose of the meeting is to confront the client with the problem and to discuss its resolution as a team. The client must agree to the proposed resolution in writing. The jeopardy meeting provides a clear warning to the client (three jeopardy meetings can result in client termination); reduces the “triangulation” or manipulation that can occur if all parties are not working in a coordinated fashion; and brings together the skills and resources of multiple agencies and professionals. (For more on jeopardy meetings, including structure and format, see the TASC Implementation Guide [Bureau of Justice Assistance, 1988]).

Monitoring may reveal that the case manager needs to take additional steps on the client’s behalf, that is, to be an advocate.

Advocacy on behalf of a client should always be direct and professional. Client advocacy should always be geared toward achieving the goals established in the service plan. Advocacy does not mean that the client always gets what he or she wants. Even when advocating for clients, the case manager must respect system boundaries. While advocacy for certain client populations is essential, concern for the client should not override goals of public safety.

### *Disengagement*

Disengagement in the case management setting, as with clinical termination, is not an event but a process. It is preferable that disengagement be planned and deliberate rather than have the relationship end in a flurry of missed appointments, with no summary of what has been learned by the client and professional. Formal disengagement gives clients the opportunity to explore what they learned about interacting with service providers and about setting and accomplishing goals. The case manager has a chance to hear from clients what they considered beneficial or not beneficial about the relationship.

## **Funding Case Management in a Managed Care World**

Managed care is “an organized system of care which attempts to balance access, quality, and cost effectively by using utilization management, intensive case management, provider selection, and cost-containment methods” (CSAT, 1995). Despite the antipathy that many public sector health care providers feel toward managed care, those providers are actually striving toward the same ends using similar means as managed care organizations (MCOs). Many substance abuse treatment providers have been working within a managed care framework for decades, that is, looking at utilization data and developing a continuum of care. Substance abuse treatment providers, particularly those who use case management, have historically recognized the importance of connecting disparate services to meet the needs of clients.

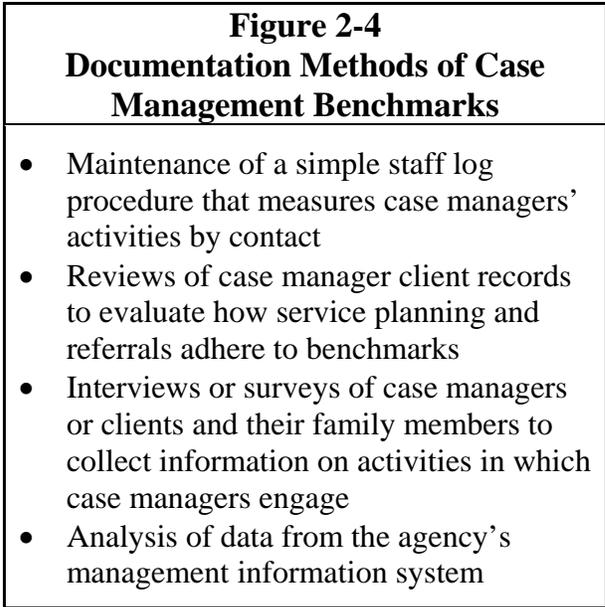
Controlling costs while providing care offers case managers an opportunity to demonstrate case management’s utility to a newly engaged managed care company. For example, clients with long-term or chronic conditions may be required to move from residential facilities to the community before some treatment providers believe they are

ready. In this scenario, case management can prove its value by providing the clients with wraparound or support services to aid in a successful transition. As another example, outreach case management can help in the area of relapse prevention and aftercare and thus avert the need for high-cost services like inpatient treatment.

Managed care tools, clinical pathways, standardized assessments, and treatment protocols can work well in a case management context. The challenge then lies in tailoring services to the unique needs of each consumer and avoiding “cookie cutter” services. Use of these tools can increase case management’s attractiveness to program administrators who operate in capitated or other forms of shared-risk environments.

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

In the managed care environment, clinical decision making relies on outcome data that traditionally describe the impact of case management and substance abuse treatment interventions in the context of services used and money spent. To gauge the effectiveness of case management, indicators of “success” must be defined by the substance abuse program and its stakeholders (including funding and regulatory agencies). In documenting a case management effort, it is necessary to establish benchmarks to measure the case management process, for example, recording how often a client shows up at treatment. Once the benchmarks are defined in measurable terms, the next step is to develop and implement a method for measuring practice; that is, to answer the questions, “What are case managers doing, and how does their practice conform to the benchmarks?” Figure 2-4 lists methods for documenting this information.



### **Measuring Client Outcomes**

Although “evaluation” is generally considered worthwhile, there is little agreement about the measurement and documentation of specific outcomes for individual clients. Some view a single measure such as sobriety to be the only meaningful indicator of success; others believe success should be gauged against a range of factors, including reduced substance use, improved family functioning, and fewer encounters with the criminal justice system. Until the debate is resolved, programs should identify treatment objectives and extrapolate from them the outcome variables they want to measure. Structured feedback loops should be established to ensure that the gathered data are returned to various stakeholders in some meaningful way so that they have an impact on shaping future program development (and future data needs). One of the benefits of the case management approach is that it can be adapted to meet the sometimes contradictory needs of the various stakeholders.

---

# Chapter 3

## Case Management Practice

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.

Case managers must also possess special abilities relating to such areas as interagency functioning, negotiating, and advocacy. The basic prerequisites of effective case management practice are

- Ability to establish rapport quickly
- Awareness of how to maintain appropriate boundaries
- Willingness to be nonjudgmental toward clients
- “Transdisciplinary foundations” as created by the Addiction Technology Transfer Centers (ATTCs)

### Practice Dimensions

CSAT established the ATTCs to funnel current information to treatment providers. ATTCs divided needed “competencies” into eight core dimensions. Two of those—referral and service coordination—provide critical knowledge, skills, and attitudes pertinent to case management. Figures 3-1 and 3-2 list activities covered under those two dimensions.

### Knowledge, Skills, and Attitudes

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

Referral and service coordination are the two practice dimensions of addiction counseling that involve case management,

according to the ATTCs. The following list of attributes that help a case manager perform these functions is excerpted from Technical Assistance Publication (TAP) 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (CSAT, 1998, reprinted 2006). TAP 21 can be ordered from the Substance Abuse and Mental Health Services Administration’s Health Information Network (SHIN) by phone at 1-877-SAMHSA-7 or downloaded from [www.kap.samhsa.gov](http://www.kap.samhsa.gov).

### Referral

Referral is the process of facilitating the client’s utilization of available support systems and community resources to meet needs identified in clinical evaluation and/or treatment planning. Guidelines for referral are listed in Figure 3-2.

*1. 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, and help to address unmet needs*

### Knowledge

a. The mission, function, resources, and quality of services offered by such entities as the following:

- civic groups, community groups, neighborhood organizations; and religious organizations
- governmental entities

**Figure 3-1  
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
- Estimate duration of care
- Know 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 (CSAT, 1998)

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• health and allied health care systems (managed care)</li> <li>• criminal justice systems</li> <li>• housing administrations</li> <li>• employment and vocational rehabilitation services</li> <li>• child care facilities</li> <li>• crisis intervention programs</li> <li>• abused persons programs</li> <li>• mutual and self-help groups</li> <li>• cultural enhancement organizations</li> <li>• advocacy groups</li> <li>• other agencies</li> </ul> | <ul style="list-style-type: none"> <li>c. The community’s political and cultural systems</li> <li>d. Criteria for receiving community services, including fee and funding structures</li> <li>e. How to access community agencies and service providers</li> <li>f. State and Federal legislative mandates and regulations</li> <li>g. Confidentiality regulations</li> <li>h. Service gaps and appropriate ways of advocating for new resources</li> <li>i. Effective communication styles</li> </ul> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
- b. Community demographics

**Figure 3-2  
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, 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
- 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

**Skills**

- a. Networking and communication
- b. Using existing community resource directories including computer databases
- c. Advocating for clients
- d. Working with others as part of a team

**Attitudes**

- a. Respect for interdisciplinary service delivery
- b. Respect for both client needs and agency services
- c. Respect for collaboration and cooperation
- d. Patience and perseverance

*2. Continuously assess and evaluate referral resources to determine their appropriateness*

**Knowledge**

- a. The needs of the client population served
- b. How to access current information on the function, mission, and resources of community service providers

- c. How to access current information on referral criteria and accreditation status of community service providers
- d. How to access client satisfaction data regarding community service providers

**Skills**

- a. Establishing and nurturing collaborative relationships with key contacts in community service organizations
- b. Interpreting and using evaluation and client feedback data
- c. Giving feedback to community resources regarding their service delivery

**Attitudes**

- a. Respect for confidentiality regulations
- b. Willingness to advocate on behalf of the client

*3. Differentiate between situations in which it is most appropriate for the client to self-refer to a resource and instances requiring counselor referral*

**Knowledge**

- a. Client motivation and ability to initiate and follow through with referrals
- b. Factors in determining the optimal time to engage client in referral process
- c. Clinical assessment methods
- d. Empowerment techniques
- e. Crisis intervention methods

**Skills**

- a. Interpreting assessment and treatment planning materials to determine appropriateness of client or counselor referral
- b. Assessing the client's readiness to participate in the referral process
- c. Educating the client regarding appropriate referral processes
- d. Motivating clients to take responsibility for referral and followup
- e. Applying crisis intervention techniques

**Attitudes**

- a. Respect for the client's ability to initiate and follow up with referral
- b. Willingness to share decision making power with the client
- c. Respect for the goal of positive self-determination
- d. Recognition of the counselor's responsibility to carry out client advocacy when needed

*4. Arrange referrals to other professionals, agencies, community programs, or other appropriate resources to meet client needs*

**Knowledge**

- a. Comprehensive treatment planning
- b. Methods of assessing client's progress toward treatment goals

- c. How to tailor resources to client treatment needs
- d. How to access key resource persons in community service provider network
- e. Mission, function, and resources of appropriate community service providers
- f. Referral protocols of selected service providers
- g. Logistics necessary for client access and follow-through with the referral
- h. Applicable confidentiality regulations and protocols
- i. Factors to consider when determining the appropriate time to engage client in referral process

**Skills**

- a. Using written and oral communication for successful referrals
- b. Using appropriate technology to access, collect, and forward necessary documentation
- c. Conforming to all applicable confidentiality regulations and protocols
- d. Documenting the referral process accurately
- e. Maintaining and nurturing relationships with key contacts in community
- f. Maintaining followup activity with client

**Attitudes**

- a. Respect for the client and the client's needs
- b. Respect for collaboration and cooperation
- c. Respect for interdisciplinary, comprehensive approaches to meet client needs

*5. Explain in clear and specific language the necessity for and process of referral to*

*increase the likelihood of client understanding and follow-through*

### **Knowledge**

- a. How treatment planning and referral relate to the goals of recovery
- b. How client defenses, abilities, personal preferences, cultural influences, presentation, and appearance affect referral and follow-through
- c. Comprehensive referral information and protocols
- d. Terminology and structure used in referral settings

### **Skills**

- a. Using language and terms the client will easily understand
- b. Interpreting the treatment plan and how referral relates to progress
- c. Engaging in effective communication related to the referral process
  - negotiating
  - educating
  - personalizing risks and benefits
  - contracting

### **Attitudes**

- a. Awareness of personal biases toward referral resources

*6. Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality regulations and generally accepted professional standards of care*

### **Knowledge**

- a. Mission, function, and resources of the referral agency or professional
- b. Protocols and documentation necessary to make referral

- c. Pertinent local, State, and Federal confidentiality regulations, applicable client rights and responsibilities, client consent procedures, and other guiding principles for exchange of relevant information
- d. Ethical standards of practice related to this exchange of information

### **Skills**

- a. Using written and oral communication for successful referrals
- b. Using appropriate technology to access, collect, and forward relevant information needed by the agency or professional
- c. Obtaining informed client consent and documentation needed for the exchange of relevant information
- d. Reporting relevant information accurately and objectively

### **Attitudes**

- a. Commitment to professionalism
- b. Respect for the importance of confidentiality regulations and professional standards
- c. Appreciation for the need to exchange relevant information with other professionals

*7. Evaluate the outcome of the referral*

### **Knowledge**

- a. Methods of assessing client's progress toward treatment goals
- b. Appropriate sources and techniques for evaluating referral outcomes

### **Skills**

- a. Using appropriate measurement processes and instruments
- b. Collecting objective and subjective data on the referral process

### **Attitudes**

- a. Appreciation of the value of the evaluation process
- b. Appreciation of the value of interagency collaboration
- c. Appreciation of the value of interdisciplinary referral

### **Service Coordination**

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.

### **Implementing the Treatment Plan**

#### *1. Initiate collaboration with referral source*

#### **Knowledge**

- a. How to access and transmit information necessary for referral
- b. Missions, functions, and resources of community service network
- c. Managed care and other systems affecting the client
- d. Eligibility criteria for referral to community service providers
- e. Appropriate confidentiality regulations
- f. Terminology appropriate to the referral source

### **Skills**

- a. Using appropriate technology to access, collect, summarize, and transmit referral data on client
- b. Communicating respect and empathy for cultural and lifestyle differences
- c. Demonstrating appropriate written and oral communication
- d. Establishing trust and rapport with colleagues in the community
- e. Assessing level and intensity of client care needed

### **Attitudes**

- a. Respect for contributions and needs of multiple disciplines to treatment process
- b. Confidence in using diverse systems and treatment approaches
- c. Open-mindedness to a variety of treatment approaches
- d. Willingness to modify or adapt plans

#### *2. Obtain, review, and interpret all relevant screening, assessment, and initial treatment-planning information*

#### **Knowledge**

- a. Methods for obtaining relevant screening, assessment, and initial treatment-planning information
- b. How to interpret information for the purpose of service coordination
- c. Theory, concepts, and philosophies of screening and assessment tools
- d. How to define long- and short-term goals of treatment
- e. Biopsychosocial assessment methods

**Skills**

- a. Using accurate, clear, and concise written and oral communication
- b. Interpreting, prioritizing, and using client information
- c. Soliciting comprehensive and accurate information from numerous sources including the client
- d. Using appropriate technology to document appropriate information

**Attitudes**

- a. Appreciation for all sources and types of data and their possible treatment implications
- b. Awareness of personal biases that may impact work with client
- c. Respect for client self-assessment and reporting

*3. Confirm the client's eligibility for admission and continued readiness for treatment and change*

**Knowledge**

- a. Philosophies, policies, procedures, and admission protocols for community agencies
- b. Eligibility criteria for referral to community service providers
- c. Principles for tailoring treatment to client needs
- d. Methods of assessing and documenting client change over time
- e. Federal and State confidentiality regulations

**Skills**

- a. Working with client to select the most appropriate treatment
- b. Accessing available funding resources
- c. Using effective communication styles

- d. Recognizing, documenting, and communicating client change
- e. Involving family and significant others in treatment planning

**Attitudes**

- a. Recognition of the importance of continued support, encouragement, and optimism
- b. Willingness to accept the limitations of treatment for some clients
- c. Appreciation for the goal of self-determination
- d. Recognition of the importance of family and significant others to treatment planning
- e. Appreciation of the need for continuing assessment and modifications to the treatment plan

*4. Complete necessary administrative procedures for admission to treatment*

**Knowledge**

- a. Admission criteria and protocols
- b. Documentation requirements and confidentiality regulations
- c. Appropriate Federal, State, and local regulations related to admission
- d. Funding mechanisms, reimbursement protocols, and required documentation
- e. Protocols required by managed care organizations

**Skills**

- a. Demonstrating accurate, clear, and concise written and oral communication
- b. Using language the client will easily understand
- c. Negotiating with diverse treatment systems
- d. Advocating for client services

### **Attitudes**

- a. Acceptance of the necessity to deal with bureaucratic systems
- b. Recognition of the importance of cooperation
- c. Patience and perseverance

*5. Establish accurate 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*

### **Knowledge**

- a. Functions and resources provided by treatment services and managed care systems
- b. Available community services
- c. Effective communication styles
- d. Client rights and responsibilities
- e. Treatment schedule, timeframes, discharge criteria, and costs
- f. Rules and regulations of the treatment program
- g. Role and limitations of significant others in treatment
- h. How to apply confidentiality regulations

### **Skills**

- a. Demonstrating clear and concise written and oral communication
- b. Establishing appropriate boundaries with client and significant others

### **Attitudes**

- a. Respect for the contribution of clients and significant others

*6. Coordinate all treatment activities with services provided to the client by other resources*

### **Knowledge**

- a. Methods for determining the client's treatment status
- b. Documenting and reporting methods used by community agencies
- c. Service reimbursement issues and their impact on the treatment plan
- d. Case presentation techniques and protocols
- e. Applicable confidentiality regulations
- f. Terminology and methods used by community agencies

### **Skills**

- a. Delivering case presentations
- b. Using appropriate technology to collect and interpret client treatment information from diverse sources
- c. Demonstrating accurate, clear, and concise oral and written communication
- d. Participating in interdisciplinary team building
- e. Participating in negotiation, advocacy, conflict resolution, problem solving, and mediation

### **Attitudes**

- a. Willingness to collaborate

### **Consulting**

*1. Summarize 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*

**Knowledge**

- a. Methods for assessing client's past and present biopsychosocial status
- b. Methods for assessing social systems that may affect the client's progress
- c. Methods for continuous assessment and modification of the treatment plan

**Skills**

- a. Demonstrating clear and concise written and oral communication
- b. Synthesizing information and developing modified treatment goals and objectives
- c. Soliciting and interpreting feedback related to the treatment plan
- d. Prioritizing and documenting relevant client data
- e. Observing and identifying problems that might impede progress
- f. Soliciting client satisfaction feedback

**Attitudes**

- a. Respect for the personal nature of the information shared by the client and significant others
- b. Respect for interdisciplinary work
- c. Appreciation for incremental changes
- d. Recognition of relapse as an opportunity for positive change

*2. Understand terminology, procedures, and roles of other disciplines related to the treatment of substance use disorders*

**Knowledge**

- a. Functions and unique terminology of related disciplines

**Skills**

- a. Demonstrating accurate, clear, and concise oral and written communication
- b. Participating in interdisciplinary collaboration
- c. Interpreting written and oral data from various sources

**Attitudes**

- a. Comfort in asking questions and providing information across disciplines

*3. Contribute as part of a multidisciplinary treatment team*

**Knowledge**

- a. Roles, responsibilities, and areas of expertise of other team members and disciplines
- b. Confidentiality regulations
- c. Team dynamics and group process

**Skills**

- a. Demonstrating clear and concise oral and written communication
- b. Participating in problem solving, decision making, mediation, and advocacy
- c. Communicating about confidentiality issues
- d. Coordinating the client's treatment with representatives of multiple disciplines
- e. Participating in team building and group process

**Attitudes**

- a. Interest in cooperation and collaboration with diverse service providers
- b. Respect and appreciation for other team members and their disciplines

*4. Apply confidentiality regulations appropriately*

**Knowledge**

- a. Federal, State, and local confidentiality regulations
- b. How to apply confidentiality regulations to documentation and sharing of client information
- c. Ethical standards related to confidentiality
- d. Client rights and responsibilities

**Skills**

- a. Explaining and applying confidentiality regulations
- b. Obtaining informed consent
- c. Communicating with the client, family and significant others, and other service providers within the boundaries of existing confidentiality regulations

**Attitudes**

- a. Recognition of the importance of confidentiality regulations
- b. Respect for a client's right to privacy

*5. Demonstrate respect and nonjudgmental attitudes toward clients in all contacts with community professionals and agencies*

**Knowledge**

- a. Behaviors appropriate to professional collaboration
- b. Client rights and responsibilities

**Skills**

- a. Establishing and maintaining nonjudgmental, respectful relationships with clients and other service providers
- b. Demonstrating clear, concise, accurate communication with other professionals or agencies

- c. Applying the confidentiality regulations when communicating with agencies
- d. Transferring client information to other service providers in a professional manner

**Attitudes**

- a. Willingness to advocate on behalf of the client
- b. Professional concern for the client
- c. Commitment to professionalism

**Continuing Assessment and Treatment Planning**

*1. Maintain ongoing contact with client and involved significant others to ensure adherence to the treatment plan*

**Knowledge**

- a. Social, cultural, and family systems
- b. Techniques to engage the client in treatment process
- c. Outreach, followup, and aftercare techniques
- d. Methods for determining the client's goals, treatment plan, and motivational level
- e. Assessment mechanisms to measure client's progress toward treatment objectives

**Skills**

- a. Engaging client, family, and significant others in the ongoing treatment process
- b. Assessing client progress toward treatment goals
- c. Helping the client maintain motivation to change
- d. Assessing the comprehension level of the client, family, and significant others

- e. Documenting the client's adherence to the treatment plan
- f. Recognizing and addressing ambivalence and resistance
- g. Implementing followup and aftercare protocols

#### **Attitudes**

- a. Professional concern for the client, the family, and significant others
- b. Therapeutic optimism
- c. Recognition of relapse as an opportunity for positive change
- d. Patience and perseverance

*2. Understand and recognize stages of change and other signs of treatment progress*

#### **Knowledge**

- a. How to recognize incremental progress toward treatment goals
- b. Client's cultural norms, biases, unique characteristics, and preferences for treatment
- c. Generally accepted treatment outcome measures
- d. Methods for evaluating treatment progress
- e. Methods for assessing client's motivation and adherence to treatment plans
- f. Theories and principles of the stages of change and recovery

#### **Skills**

- a. Identifying and documenting change
- b. Assessing adherence to treatment plans
- c. Applying treatment outcome measures
- d. Communicating with people of other cultures

- e. Reinforcing positive change

#### **Attitudes**

- a. Appreciation for cultural issues that impact treatment progress
- b. Respect for individual differences
- c. Therapeutic optimism

*3. Assess treatment and recovery progress and, in consultation with the client and significant others, make appropriate changes to the treatment plan to ensure progress toward treatment goals*

#### **Knowledge**

- a. Continuum of care
- b. Interviewing techniques
- c. Stages in the treatment and recovery process
- d. Individual differences in the recovery process
- e. Methods for evaluating treatment progress
- f. Methods for re-involving the client in the treatment planning process

#### **Skills**

- a. Participating in conflict resolution, problem solving, and mediation
- b. Observing, recognizing, assessing, and documenting client progress
- c. Eliciting client perspectives on progress
- d. Demonstrating clear and concise written and oral communication
- e. Interviewing individuals, groups, and families
- f. Acquiring and prioritizing relevant treatment information
- g. Assisting the client in maintaining motivation

- h. Maintaining contact with client, referral sources, and significant others

**Attitudes**

- a. Willingness to be flexible
- b. Respect for the client's right to self-determination
- c. Appreciation of the role significant others play in the recovery process
- d. Appreciation of individual differences in the recovery process

*4. Describe and document treatment process, progress, and outcome*

**Knowledge**

- a. Treatment modalities
- b. Documentation of process, progress, and outcome
- c. Factors affecting client's success in treatment
- d. Treatment planning

**Skills**

- a. Demonstrating clear and concise oral and written communication
- b. Observing and assessing client progress
- c. Engaging client in the treatment process
- d. Applying progress and outcome measures

**Attitudes**

- a. Appreciation of the importance of accurate documentation
- b. Recognition of the importance of multidisciplinary treatment planning

*5. Use accepted treatment outcome measures*

**Knowledge**

- a. Treatment outcome measures

- b. Understand concepts of validity and reliability of outcome measures

**Skills**

- a. Using outcome measures in the treatment planning process

**Attitudes**

- a. Appreciation of the need to measure outcomes

*6. Conduct continuing care, relapse prevention, and discharge planning with the client and involved significant others*

**Knowledge**

- a. Treatment planning process
- b. Continuum of care
- c. Available social and family systems for continuing care
- d. Available community resources for continuing care
- e. Signs and symptoms of relapse
- f. Relapse prevention strategies
- g. Family and social systems theories
- h. Discharge planning process

**Skills**

- a. Accessing information from referral sources
- b. Demonstrating clear and concise oral and written communication
- c. Assessing and documenting treatment progress
- d. Participating in confrontation, conflict resolution, and problem solving
- e. Collaborating with referral sources
- f. Engaging client and significant others in treatment process and continuing care
- g. Assisting client in developing a relapse prevention plan

**Attitudes**

- a. Therapeutic optimism
- b. Patience and perseverance

*7. Document service coordination activities throughout the continuum of care*

**Knowledge**

- a. Documentation requirements including, but not limited to
  - addiction counseling
  - other disciplines
  - funding sources
  - agencies and service providers
- b. Service coordination role in the treatment process

**Skills**

- a. Demonstrating clear and concise written communication
- b. Using appropriate technology to report information in an accurate and timely manner within the bounds of confidentiality regulations

**Attitudes**

- a. Acceptance of documentation as an integral part of the treatment process
- b. Willingness to use appropriate technology

*8. Apply placement, continued stay, and discharge criteria for each modality on the continuum of care*

**Knowledge**

- a. Treatment planning along the continuum of care
- b. Initial and ongoing placement criteria
- c. Methods to assess current and ongoing client status
- d. Stages of progress associated with treatment modalities
- e. Appropriate discharge indicators

**Skills**

- a. Observing and assessing client progress
- b. Demonstrating clear and concise written and oral communication
- c. Participating in conflict resolution, problem solving, mediation, and negotiation
- d. Tailoring treatment to meet client needs
- e. Applying placement, continued stay, and discharge criteria

**Attitudes**

- a. Confidence in client's ability to progress within a continuum of care
- b. Appreciation for the fair and objective use of placement, continued stay, and discharge criteria

# Chapter 4

## Case Management for Clients With Special Needs

No one case manager can possibly be an expert in all the types of special need clients have. In the absence of such comprehensive knowledge, several general attitudes and skills provide a basic foundation for the professional delivering case management services to “special needs clients,” as listed in Figure 4-1.

Cultural competence is one of the core functions of case management. 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.

The five elements of cultural competence are:

- Valuing diversity
- Making a cultural self-assessment
- Understanding the dynamics of cultural interaction
- Incorporating cultural knowledge
- Adapting practices to the diversity present in a given setting (Cross et al., 1989)

While it is impossible to discuss all the special needs that case managers confront, several occur repeatedly. Among these special treatment needs are HIV infection or AIDS, mental illness, chronic and acute health problems, poverty, homelessness, responsibility for parenting young children, social and developmental problems associated with adolescence and advanced age, involvement with illegal activities, physical disabilities, and sexual orientation. The information included in this Guide is not intended to be a comprehensive treatment of any of these areas, but rather an introduction to the issues that most directly relate to the implementation of case management for these special populations.

**Figure 4-1**  
**Case Management Services for Special Needs Clients**

- Make every effort to be competent in addressing the special circumstances that affect clients typically referred to a particular substance abuse treatment program
- Understand the range of clients’ reactions to the challenges associated with particular special circumstances
- Remain aware of the limits of one’s own knowledge and expertise
- Evaluate personal beliefs and biases about clients who have special problems
- Maintain an open attitude toward seeking and accepting assistance on behalf of a client
- Know where additional information on special problems can be accessed

## Minority Clients

Case managers must “respond proactively and reactively to racism, ethnocentrism, anti-Semitism, classism, and sexism...ageism and ‘ableism’” (Rogers, 1995, p. 61). According to Rogers, culturally competent case managers have six competencies:

- Ability to be self-aware
- Ability to identify differences as an issue
- Ability to accept others
- Ability to see clients as individuals and not just as members of a group
- Willingness to advocate
- Ability to understand culturally specific responses to problems

The case manager must always be sensitive to such cultural differences and identify recovery resources that are relevant to the individual’s values. Some minority group members may be inclined to seek help for a substance abuse problem from sources outside the treatment continuum, such as clergy, group elders, or members of their own social support networks. Others may prefer to be treated in a program that uses principles and treatment approaches specific to their own cultures. Case managers must advocate for culturally appropriate services for their clients.

## Clients with HIV Infection and AIDS

The usual functions and activities associated with case management in substance abuse treatment—engagement, helping orient the client to treatment, goal planning, and especially resource acquisition—are made more difficult in dealing with clients who have HIV or AIDS.

Barriers to treatment for HIV/AIDS clients include

- Providers’ and other clients’ fear of contracting HIV
- The dual stigma of being a person with both a drug abuse problem and HIV
- The progressive and debilitating nature of the disease
- The complex array of medical, especially pharmacological, interventions used to treat HIV
- The onerous financial consequences of the disease and of treatment
- The hopelessness and lack of motivation for treatment among the terminally ill

Addicted people with AIDS or HIV need help with physical functioning, interpersonal relationships, adjustment to the treatment program, housing, and practical and psychological adjustment to the two conditions.

While one person should assume primary case management responsibility for clients with HIV or AIDS, a team approach is particularly useful in combating the feelings of frustration, abandonment, grief, overidentification with the client, and anger that frequently confront professionals in this setting (Shernoff and Springer, 1992). To avoid staff burnout, providers should avoid designating the same individual as case manager for all clients with AIDS and HIV infection.

Part of the case manager’s linking function in working with an HIV-positive client is to educate the network of service providers, including substance abuse treatment staff, to recognize the competing demands of staying sober and dealing with the social and physical sequelae of HIV disease.

## Clients With Mental Illness

Substance abuse treatment staff must be prepared to address the problems of dual-diagnosis clients. Examples of the possible issues the case manager may have to address

on behalf of a client in mental health treatment programs include the following:

- Bias against substance abusers affects the provision of mental health services.
- Many inpatient facilities establish an arbitrary minimum number of days of sobriety for their clients.
- Some service providers will not accept clients who are on medication, including methadone.

Conversely, issues in substance abuse treatment programs that might be counterproductive to mental health treatment include

- Treatment approaches may rely on insight and introspection that some mental health clients are intrinsically incapable of achieving.
- The approach used in substance abuse treatment may be too confrontational.
- The treatment program and other clients may reject clients taking psychotropic medication.

While case managers may not be experts in the treatment of any one of the mental illness disorders, it is vital that they know enough to work with the client in identifying his or her needs and be able to translate and

coordinate those needs with the two types of treatment.

Three models for treating clients who are dually diagnosed are in Figure 4-2.

## Homeless Clients

A case manager always begins by working on issues the client feels are most pressing, and the need for stable shelter may not be at the top of any client's list. Many homeless people feel safer and more comfortable on the streets than in a shelter because the streets are familiar to them and because they have established routines and a network of people to watch out for them.

The case manager's rapport-building skills are critical to break through the many defensive behaviors and protective attitudes that clients develop to survive in shelters and on the streets. These behaviors—looking tough, acting with bravado, wariness of social services, maintaining a hard exterior, and letting go of social graces—make homeless clients difficult to engage and interfere with their ability to succeed in treatment or maintain stable housing. Peer case managers—homeless individuals who are in recovery themselves and are based in shelter care facilities managers—can help engage such clients.

<b>Figure 4-2</b> <b>Three Models for Treatment Services for Clients With a Dual Diagnosis</b>
<p><i>Integrated Model</i>—both disorders are dealt with at the same time and in the same program. Case management's primary role includes facilitating clients' transition from residential programs to the community, helping them identify and access needed resources, and providing long-term support for their functioning in the community.</p> <p><i>Sequential Treatment</i>—the case manager helps the client move from either substance abuse to mental health treatment or from mental health to substance abuse treatment.</p> <p><i>Parallel Treatment</i>—the case manager must facilitate communication and service coordination between two agencies whose treatment approaches may be based on different assumptions. (CSAT, 1994)</p>

To meet their linking and advocacy responsibilities, case managers must recognize that some services generally available to substance abusers are not available to homeless people and that new services may need to be created to fill those gaps.

The delivery of social services is complicated by the fact that homeless clients usually are turned out of shelters from 9:00 a.m. until 4:00 p.m. The client's social network during these hours consists of other people, often not sober, who are also out of the shelter. Providers may find it useful to provide a day room with snacks and a television where clients can stay during the day or some sort of day work where clients can earn a few dollars.

## **Women With Substance Abuse Problems**

Case-finding is an especially important case management activity with female substance abusers, who seem to follow a different path to treatment than males. Once identified, women with substance abuse problems may be difficult to engage and retain in treatment.

Case managers should help female clients in danger of domestic violence develop a safety plan setting out well-defined steps to escape. It is imperative to determine whether women are living in a safe environment. Women who have children are even more extensively involved, or need to be, with community resources, including the school system, pediatric physicians, and children's protective services if their substance use has resulted in neglect or abuse. Case managers are responsible for facilitating the acquisition of these resources as their clients move through the treatment continuum.

A woman's involvement with community resources frequently places the case manager in a position to advocate for her needs. Advocacy means securing resources

not only outside the treatment program, but also within the program, especially if the program primarily treats male clients (Brindis and Theidon, 1997). Advocacy not only improves the woman's acquisition of needed resources, but also empowers her to become more assertive on her own behalf and builds a closer relationship with the case manager. Advocacy cannot, however, stop the case manager from fulfilling the legal obligation to report child abuse or neglect.

Two excellent sources of information on the role that case management plays in the treatment of women substance abusers are *Pregnant, Substance-Using Women* (CSAT, 1993) and *Case Management in Alcohol and Drug Treatment: Conceptual Issues and Practical Applications* (Sullivan, 1991).

## **Adolescent Substance Abusers**

Adolescents whose substance use has progressed to the point of substance abuse or dependence are frequently involved with multiple systems, including child welfare, juvenile justice, mental health, and special education (CSAT, 1993). A case manager is in a unique position to help adolescents and their families interact with those systems. The case manager of a teenager must have a thorough understanding of the developmental issues pertinent to adolescence, an ability to establish rapport with young people, a knowledge of family dynamics, and the ability to provide support and skills training.

The case manager working with adolescents will almost inevitably provide extensive case management services to the entire family as well. Acquiring an entire family as clients has numerous implications for caseload size, available resources, confidentiality, and whether the client is the adolescent, the family, or both. When State or Federal laws do not provide explicit guidance, the case manager must carefully

consider who is actually the client and what are the best interests of the adolescent.

Family engagement in transition and aftercare activities is paramount for the adolescent juvenile justice client. The transition work with the family needs to begin before the end of the primary treatment episode, and preferably occurs throughout the treatment episode.

## **Clients in Criminal Justice Settings**

Case management for substance abuse clients in the criminal justice system evolved in the bringing together two complex systems with different goals and philosophies. While the criminal justice system is interested in the rehabilitation of offenders, its main focus is on public safety. Likewise, while the substance abuse treatment system supports public safety goals, its primary mission is to change individual behaviors. The need to establish and maintain a therapeutic relationship with clients while integrating the sanction and control obligations of the criminal justice system poses particular challenges. Ambiguities about the case manager's role in client supervision and confidentiality considerations surface frequently.

Case management with offender populations may be implemented at any point in the criminal justice continuum. Case management can assist offenders in securing resources that are not only vital to their recovery and overall well-being, but also required by their deferred sentencing or probation.

The case manager should address the needs of clients released from institutions in order of importance:

- Ensure immediate stability.
- Refer to sources of skills training.

- Train in setting and accomplishing short- and long-term goals.
- Advocate for the offender in both the treatment environment and the criminal justice system.

To maximize effectiveness, several configurations of case management functions have been attempted, including:

- Case management provided by the justice system
- Case management provided by a treatment agency
- Case management provided by an agency separate from the treatment and justice systems
- Case management provided by a coordinator from the criminal justice system
- Case management provided by multidisciplinary groups in the criminal justice system for offender management

See TIP 23, *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* (CSAT, 1996), for more on drug courts.

## **Clients With Physical Disabilities**

The case manager delivering services to this population must know and understand conditions and disabilities such as traumatic brain injury, spinal cord injury, mental illness, and learning disabilities as well as blindness, deafness, and chronic disease. Other suggested areas of knowledge are

- The etiology and course of various physical disabilities
- Effective treatment options, both group and individual
- The difference between appropriate disability accommodations and enabling "handicapped" behavior

- How disability acceptance and anger affect substance abuse treatment

Because many social service professionals still assume that people with disabilities are too helpless or too removed from the world to gain access to drugs, the case manager's role may lie chiefly in education, both about physical disabilities and about substance abuse treatment. Assessment includes many issues unique to physically disabled persons. The case manager should explore the relationship between the client's disability, substance abuse, and recovery potential. Treatment programs may need to be expanded to accommodate clients' disabilities. The case manager may also need to educate other service providers about the needs of people with disabilities. The case manager should become familiar with special equipment to help organizations purchase or borrow appropriate resources as required under the Americans with Disabilities Act (ADA).

## **Gay, Lesbian, Transgender, and Bisexual Clients**

Given the emotionally charged atmosphere that often surrounds sexuality, case managers must be especially aware of their own feelings and beliefs when working with this population. The case manager must know the context of the client's life and, ideally, the specialized language used to describe sexual practices in the client's community. The interviewer should gather precise information regarding the nature of the individual's sexual practices and number of sexual partners, unless a client is particularly vulnerable, in crisis, or might otherwise see the inquiry as intrusive or inappropriate.

To help gay or lesbian clients gain access to services, the case manager must know

more than just an agency's formal stance toward them. Some agencies that are officially accepting are in fact hostile to homosexual clients, or simply are not familiar enough with their special needs to serve them effectively. A case manager should know which 12-Step meetings, clinics, and other resources are available, knowledgeable, and accommodating to the gay and lesbian communities.

## **Case Management in Rural Areas**

The delivery of case management services in rural areas presents unique challenges. Social services may be lacking or so geographically dispersed that effective access and coordination are difficult. In addition, case managers working in rural areas must frequently deal with a culture in which "everyone knows everyone else," from both the client's and the service provider's standpoint. Several forms of rural case management are

- Telecommunication and videoconferencing practice models
- Services provided in a more intensive manner
- Use of informal helping networks such as Alcoholics Anonymous

Given the scarcity of resources, agencies, and specialty services, the professional in this setting is more likely to be a generalist. Case management is more likely to provide both service and service coordination. The substance abuse case manager must be a tireless source of information and education about substance abuse problems, not just for the client, but for the community as well.

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# Appendix A

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# Appendix B

## TIP 27 Consensus Panel

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*Concise Desk Reference Guides have been prepared for several published TIPs. These TIPs and their related guides are listed below:*

**TIP 24** *A Guide to Substance Abuse Services for Primary Care Clinicians (SMA) 08-4075*

*Concise Desk Reference (SMA) 09-3740*

*Guia de Servicios para el Abuso de Sustancias Para Proveedores de Atencion Primaria de la Salud MS631S*

**TIP 25** *Substance Abuse Treatment and Domestic Violence (SMA) 08-4076*

*Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Treatment Providers (SMA) 00-3390*

*Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Administrators MS667*

**TIP 26** *Substance Abuse Among Older Adults (SMA) 08-3918*

*Substance Abuse Among Older Adults: A Guide for Treatment Providers MS669*

*Substance Abuse Among Older Adults: A Guide for Social Service Providers MS670*

*Substance Abuse Among Older Adults: Physician's Guide MS671*

**TIP 27** *Comprehensive Case Management for Substance Abuse Treatment (SMA) 08-4215*

*Case Management for Substance Abuse Treatment: A Guide for Administrators (SMA) 00-3396*

*Case Management for Substance Abuse Treatment: A Guide for Treatment Providers (SMA) 04-3953*

*Other TIPs may be downloaded or ordered at [www.samhsa.gov/shin](http://www.samhsa.gov/shin). Or, please call SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).*