Excerpts from "TIP 27: Comprehensive Case Management for Substance Abuse Treatment"

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Executive Summary

Case management has been variously classified as a skill group, a core function, service coordination, or a network of "friendly neighbors." Although it defies precise definition, case management generally can be described as a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals. The Consensus Panel that developed this TIP believes that case management lends itself to the treatment of substance abuse, particularly for clients with other disorders and conditions who require multiple services over extended periods of time and who face difficulty in gaining access to those services. This document details the factors that programs should consider as they decide to implement case management or modify their current case management activities. This summary is excerpted from the main text, in which references to the research appear.

Research suggests two reasons why case management is effective as an adjunct to substance abuse treatment. First, retention in treatment is associated with better outcomes, and a principal goal of case management is to keep clients engaged in treatment and moving toward recovery. Second, treatment may be more likely to succeed when a client's other problems are addressed concurrently with substance abuse. Case management focuses on the whole individual and stresses comprehensive assessment, service planning, and service coordination to address multiple aspects of a client's life. Comprehensive substance abuse treatment often requires that clients move to different levels of care or systems; case management facilitates such movement.

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

Case Management and Substance Abuse Treatment

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

- Provide the client a single point of contact for multiple health and social services systems
- Advocate for the client
- Be flexible, community-based, and client-oriented
- Assist the client with needs generally thought to be outside the realm of substance abuse treatment

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

- Understanding various models and theories of addiction and other problems related to substance abuse
- Ability to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems
- Ability to recognize the importance of family, social networks, community systems, and self-help groups in the treatment and recovery process
- Understanding the variety of insurance and health maintenance options available and the importance of helping clients access those benefits
- Understanding diverse cultures and incorporating the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice
- Understanding the value of an interdisciplinary approach to addiction treatment

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

The Substance Abuse Treatment Continuum and Functions of Case Management

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

Interagency Case Management

The goal of interagency case management is to expand the network of services available to clients. All organizations have boundaries to what they can do, and case managers or "boundary spanners" transcend them to facilitate interactions among agencies.

To be successful, a case management plan must thoroughly and critically examine community resources to determine what forms of assistance are available and how case management efforts can help clients attain necessary assistance. Many communities have

published directories of social, health, welfare, housing, vocational, and other service organizations to help case management programs identify resources, possible provider linkages, and potential gaps in services for their clients. Although such directories are a good starting point, it is important to follow up on the listings to ensure they are still accurate and will be of use to the client.

The Environmental Assessment

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

Potential Conflicts

Whenever agencies or service providers work together, the potential for conflict exists. Areas of tension may be present from the very onset of the collaboration. For example, a new project may be viewed by established social service agencies as competition for scarce resources. Sometimes social pressures or the need to maximize resources can force public agencies into joint ventures even if they do not mesh well or have a history of being service competitors. Tensions can also develop in the course of delivering services; for example, interagency collaboration may result in a client having two case managers. Recognizing potential triggers for conflict is a necessary first step in developing a system to handle them. When problems do arise, case managers and other agency personnel can use both informal and formal communication to clarify issues, regain perspective, and refocus the interagency case management process.

Case Management for Clients With Special Needs

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

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

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

Chapter 1 - Substance Abuse and Case Management: An Introduction

The term *case management* has appeared in social services literature more than 600 times in the last 30 years, referring to everything from the routing of court dockets through the judicial system to the medical management of a hospitalized patient's care. This TIP uses the term to refer to interventions designed to help substance abusers access needed social services.

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

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

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

A significant number of clients in treatment are also under some form of control by the criminal justice system. Criminal justice substance abuse clients represent more than half of all clients in treatment in many state and local jurisdictions. Although those afflicted by chemical addiction are found among all socioeconomic groups, persons already

plagued by poverty, disease, and unemployment are over-represented (CSAT, 1994).

Particularly in publicly funded treatment programs, substance abuse clients have limited resources and may lack health insurance. Many are eligible for publicly supported health and social benefits, including Medicare, food stamps, or welfare.

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

Why Case Management

Because addiction affects so many facets of the addicted person's life, a comprehensive continuum of services promotes recovery and enables the substance abuse client to fully integrate into society as a healthy, substance-free individual. The continuum must be designed to provide engagement and motivation, primary treatment services at the appropriate intensity and level, and support services that will enable the individual to maintain long-term sobriety while managing life in the community. Treatment must be structured to ensure smooth transitions to the next level of care, avoid gaps in service, and respond rapidly to the threat of relapse. Case management can help accomplish all of the above.

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

- Different funding streams. Substance abuse treatment is funded from a variety of sources - block grants, competitive grants, state and local funding, criminal justice funding, and others. The different requirements or goals of these sources can result in a piecemeal approach to programming
- A focus on program funding rather than system funding
- Funding focused on single modalities rather than a continuum of care
- Inadequate funding created by missing pieces in the continuum
- Waiting lists caused by inadequate funding
- Barriers between systems (e.g., mental health vs. substance abuse, criminal justice vs. mental health and substance abuse)
- Lack of incentives geared to client outcome; programs rewarded for process measures, not outcome measures
- Eligibility/admission criteria that exclude certain clients
- Lack of agreement on priority for admission/treatment
- Lack of incentives for programs to work together

Due to the fragmentation of services, the accompanying inefficiency, and a growing

scarcity of resources, some form of case management is used with virtually every population that routinely seeks social services. The variability in social services system configurations has led to many different implementations of case management, resulting in conceptual disagreements about case management and difficulty in assessing its value. Inevitably, many of the same issues will arise in the substance abuse setting. This TIP is designed to establish a common starting point for case management work with substance abusers. To address at least some of those conceptual disagreements, the TIP makes several assumptions, including

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

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

Case Management - A Brief History

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

One of the first legislative embodiments of case management occurred in the 1963 Federal Community Mental Health Center Act (Intagliata, 1982) in anticipation of deinstitutionalization, in which persons in long-term psychiatric care were moved into community settings. The expectation that these individuals would need services previously provided in the institution led to the rapid expansion of community-based social services. Unfortunately, these services were often created independently of one another and, coupled with the categorical nature of the eligibility for services, led to difficulties for persons used to having these services provided in institutions. The Community Support System developed by the National Institutes of Mental Health in 1977 envisioned case management as a mechanism for helping clients navigate this fragmented social service system. Accessing these resources would thus enable them to live and function adequately in their communities (Intagliata, 1982; Stein and Test, 1980; Test, 1981; Turner and TenHoor, 1978).

Substance abusers historically were never institutionalized as often as were persons with chronic mental illness and so were not directly impacted by deinstitutionalization legislation. Substance abusers were not generally targeted for the development of categorical systems of service delivery and were not generally recipients of case management services. However, case management-like services were provided to substance abusers under other titles, such as "mission work," and frequently delivered by the clergy or others in skid row missions, detoxification centers, and ad hoc halfway houses. Jails and county work farms were generally the institutions of choice in dealing with this population. Only after substance abuse began to be decriminalized and defined as a disease were substance abusers referred to various social services.

Definitions and Functions

Any definition of case management today is inevitably contextual, based on the needs of a particular organizational structure, environmental reality, and prior training of the individuals who are implementing it, whether they are social workers, nurses, or case management specialists. Nonetheless, there is relatively widespread agreement on the basic definition, as illustrated in Figure 1-1.

While definitions are useful in guiding general discussions, *functions* are a more helpful way to approach case management as it is actually practiced. As with definitions, there is a high degree of consensus about a core group of functions. One widely accepted set of functions comprises (1) assessment, (2) planning, (3) linkage, (4) monitoring, and (5)

advocacy (Joint Commission on Accreditation of Healthcare Organizations, 1979). The National Association of Social Workers' standards for social work case management include assessing, arranging, coordinating, monitoring, evaluating, and advocacy (National Association of Social Workers, 1992).

There is also general agreement about case management functions in the specific context of substance abuse treatment. Case management is one of eight counseling skills identified by the National Association of Alcoholism and Drug Abuse Counselors (National Association of Alcoholism and Drug Abuse Counselors, 1986) and one of five performance domains developed in the Role Delineation Study (International Certification and Reciprocity Consortium, 1993).

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

Referral and service coordination are two of eight practice dimensions the ATTCs deem essential to the effective practice of addiction counseling. Activities considered part of those two dimensions include engagement; assessment; planning, goal-setting, and implementation; linking, monitoring, and advocacy; and disengagement. The document defines service coordination as: "The administrative, clinical, and evaluative activities that bring the client, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan. Service coordination, which includes case management and client advocacy, establishes a framework of action for the client to achieve specified goals. It involves collaboration with the client and significant others, coordination of treatment and referral services, liaison activities with community resources and managed care systems, client advocacy, and ongoing evaluation of treatment progress and client needs" (CSAT, 1998, p. 53).

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

Models of Case Management With Substance Abusers

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

setting.

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

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

Brokerage/Generalist

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

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

Two creative uses of a brokerage model involved clients who were infected with the human immunodeficiency virus (HIV) or who were at significant risk of acquiring HIV. In one program, case managers also served as educators, delivering cognitive, behaviorally oriented, educational sessions focusing on substance abuse and high-risk behaviors (Falck et al., 1992). The mixing of the educator and case manager roles was intended to increase clients' receptivity to HIV prevention messages by reducing barriers to services that would address problems that might divert attention from those messages. In another variation of the brokerage model, case managers in a large metropolitan area conducted extensive assessments with HIV-infected clients, generally making at least two referrals during the initial session. This "quick response" approach was intended to provide immediate results to clients and to link them with agencies or services that would provide ongoing services (Lidz et al., 1992).

Generalist approaches to working with substance-abusing clients have taken several

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

Assertive Community Treatment

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

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

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

A derivation of PACT, the Assertive Community Treatment (ACT) model, was used with parolees who had histories of injecting drugs (Martin and Scarpitti, 1993). In this implementation, case managers provided direct counseling services and worked with clients to develop the skills necessary to function successfully in the community. Case management staff also provided family consultations and crisis intervention services and functioned as group facilitators to provide skills training in areas such as work skills, relapse prevention, and education about HIV/AIDS. Departing from the mental health tenets of the PACT model, ACT had time limits and success goals rather than the continuous care envisioned for the mentally ill. Achievement of protracted periods of abstinence and graduation from treatment continuum components were expected of

clients (Martin and Scarpitti, 1993). Assertive Community Treatment has been implemented alone and in conjunction with a therapeutic community (Martin et al., 1993).

Strengths-Based Perspective

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

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

Because of the advocacy component and client-driven goal planning, a strengths-based approach can at times cause stress between a case manager and other members of the treatment team (Rapp et al., 1994). Despite this, there is evidence that the approach can be integrated with the disease model of treatment and that its presence leads to improved outcomes for clients. The improved outcomes include employability, retention in treatment, and (through retention in treatment) reduced drug use (Rapp et al., in press; Siegal et al., 1996; Siegal et al., 1997).

Clinical/Rehabilitation

Clinical/rehabilitation approaches to case management are those in which clinical (therapy) and resource acquisition (case management) activities are joined together and addressed by the case manager. It has been suggested that the separation of these two activities is not feasible over an extended period of time and that the case manager must be trained to respond to client-focused, as opposed to solely environmental issues (Kanter, 1996). Client-focused services could include providing psychotherapy to clients, teaching specific skills, and family therapy. Beyond the usual repertoire of case management functions (e.g., monitoring), the case manager should be aware of numerous

issues including transference, countertransference, how clients internalize what they observe, and theories of ego functioning (Harris and Bergman, 1987; Kanter, 1996).

Many substance abuse treatment programs use a clinical model in which the same treatment professional provides, or at least coordinates, both therapy and case management activities. Such an approach is frequently driven by staffing considerations: It is more economical to have one treatment professional provide all services than to have separate clinical and case managers deliver them.

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

Chapter 2 - Applying Case Management to Substance Abuse Treatment

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

Case Management Principles

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

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

Case management involves advocacy. The paramount goal when dealing with substance abuse clients and diverse services with frequently contradictory requirements is

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

Case management is community-based. All case management approaches can be considered community-based because they help the client negotiate with community agencies and seek to integrate formalized services with informal care resources such as family, friends, self-help groups, and church. However, the degree of direct community involvement by the case manager varies with the agency. Some agencies mount aggressive community outreach efforts. In such programs, case managers accompany clients as they take buses or wait in lines to register for entitlements. This personal involvement validates clients' experiences in a way that other approaches cannot. It suits the subculture of addiction because it enables the case manager to understand the client's world better, to learn what streets are safe and where drug dealing takes place. This familiarity helps the professional appreciate the realities that clients face and set more appropriate treatment goals - and helps the client trust and respect the case manager. Because it often transcends facility boundaries, and because the case manager is more involved in the community and the client's life, case management may be more successful in re-engaging the client in treatment and the community than agency-based efforts. For clients who are institutionalized, case management involves preparing the client for community-based treatment and living in the community. Case management can ensure that transitions are smooth and that obstacles to timely admissions into community-based programs are removed. Case management can also coordinate release dates to ensure that there are no gaps in service. The type of relationship described here is likely at times to stretch the more narrow boundaries of the traditional therapist-client relationship.

Case management is pragmatic. Case management begins "where the client is," by responding to such tangible needs as food, shelter, clothing, transportation, or child care. Entering treatment may not be a client priority; finding shelter, however, may be. Meeting these goals helps the case manager develop a relationship with and effectively engage the client. This client-centered perspective is maintained as the client moves through treatment. At the same time, however, the case manager must keep in mind the difficulty in achieving a balance between help that is positive and help that may impede treatment engagement. For example, the loss of housing may provide the impetus for residential treatment. Teaching clients the day-to-day skills necessary to live successfully and substance free in the community is an important part of case management. These pragmatic skills may be taught explicitly, or simply modeled during interactions 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 must be flexible. 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 (Cross et al., 1989).

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, which 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

- 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 (CSAT, 1998)

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 - 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, 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

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 (CSAT, 1998)

Almost 200 specific knowledge items, skills, and attitudes are associated with these dimensions: They can be found in Appendix B.

The Substance Abuse Treatment Continuum and Functions of Case Management

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 (Institute of Medicine, 1990) - or intensity of service (ASAM, 1997). The continuum in this TIP 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 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 (Alterman et al., 1994; Gilbert, 1988; Stark and Kane, 1985; Zweben, 1981).

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) 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. 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.

If different individuals perform case management and addictions counseling, they must communicate constantly during aftercare about the implementation 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 (Siegal et al., 1997; Godley et al., 1994). 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 in 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 finding 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.

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.

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 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, coordinating 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 suggested by Miller and Rollnick encourage client engagement through exploratory rather than confrontational means (Miller and Rollnick, 1991). 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 (Prochaska and DiClemente, 1982). 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 (Miller and Rollnick, 1991).

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 participate 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 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.

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 drug-free home environment, a source of income, marketable skills, and a support system. Many have postponed medical or dental care; in recovery, they may seek it for the first time in years. Once an individual is in recovery, physician-prescribed medication for pain management can become a major problem, an issue that may require coordination and advocacy.

Assessment

The primary difference between treatment and case management assessments lies in case management'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.

Case finding and pretreatment

Depending on the structure and mission of the program providing case management, assessment may begin when engagement begins. It is case management's role to explore client needs, wants, skills, strengths, and deficits and relate those attributes to a service plan designed to address those needs efficiently. If the client is not eligible for a

particular case manager's program, the case manager links the client with appropriate external treatment resources. 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. If the client is both eligible and appropriate for the program, the case manager's role is to engage the client in treatment.

Primary treatment

For clients who enter primary treatment, the case management assessment function, which is primarily oriented to the acquisition of needed resources, is merged with an assessment that focuses on problems amenable to therapy - substance use, psychological problems, and family dysfunction. Ideally both assessments are integrated into a biopsychosocial assessment (Wallace, 1990). 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. Detailed information should be gathered on drug use, drug use history, health history, current medical issues, mental health status, and family drug and alcohol use. This assessment, used in conjunction with the needs assessment, assists the treatment team in developing a formal treatment plan to be presented to, modified, and approved by the client. Whether one person or several conduct these two assessments is largely irrelevant. Where a team approach exists, all members of the team, including the case manager or other professional identified in that role, should bring their expertise to the assessment. Discharge planning and long-range needs identification, particularly with current funding limitations, begins at treatment admission. Because of this, intensive case management for substance abuse clients, regardless of the level of care, is imperative.

As the individual responsible for coordinating diverse services, the case manager must take a broad view of client needs, look beyond primary therapy to the impact of the client's addiction on broader domains, and assess the impact of these domains on the client's recovery. He also must assess specific areas of functional skill deficits, including personal living skills, social or interpersonal skills, service procurement skills, and vocational skills. Individuals performing this function need to have strong knowledge of and experience in the field of substance abuse. The greater the number of problems the case manager can help the client identify and manage during primary treatment, the fewer problems the client must address during aftercare and ongoing recovery - and the greater the chances for treatment success.

A case management assessment should include a review of the following functional areas (Harvey et al., 1997; Bellack et al., 1997). These items are not exhaustive, but demonstrate some of the major skill and service need areas that should be explored. The assessment of these areas of functioning gives evidence of the client's degree of impairment and barriers to the client's recovery. The case manager may have to perform many services on behalf of the client until skills can be mastered.

Service procurement skills

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

- Ability to obtain and follow through on medical services
- Ability to apply for benefits
- Ability to obtain and maintain safe housing
- Skill in using social service agencies
- Skill in accessing mental health and substance abuse treatment services

Prevocational and vocation-related skills

In order to reach the ultimate goal of independence, clients must also have vocational skills and should therefore be assessed for

- Basic reading and writing skills
- Skills in following instructions
- Transportation skills
- Manner of dealing with supervisors
- Timeliness, punctuality
- Telephone skills

The case management assessment should include a scan for indications of harm to self or others. The greater the deficits in social and interpersonal skills, the greater the likelihood of harm is to self and/or others, as well as endangerment from others. The case manager should also conduct an examination of criminal records. If the client is under the supervision of the criminal justice system, supervision officers should be contacted to determine whether or not there is a potential for violent behavior, and to elicit support should a crisis erupt.

Aftercare

The client's readiness to reintegrate into the community is a focus of case management assessment throughout the treatment continuum. Because the case manager is often out in the community with the client, she is in an excellent position to evaluate this important indicator. During aftercare, her assessment may reveal new, recurring, or unresolved problems the client must deal with before they interfere with recovery. The potential for relapse is a particularly significant challenge, and the client must be able to identify personal relapse triggers and learn how to cope with them. Because case managers are familiar with the community, clients, and substance abuse treatment issues, they can spot such triggers and intervene appropriately. If, for example, a case manager fears that a client's decision to return to a familiar neighborhood could result in contact with drug-using friends that could jeopardize sobriety, a new residence may be necessary.

Planning, goal-setting, and implementation

Flowing directly and logically from the assessment process, planning, goal-setting, and implementation comprise the core of case management. 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). These authors agree on several points: Each goal in service plans should be broken down into objectives and possibly into even smaller steps or strategies that are behaviorally specific, measurable, and tangible. Distinct, manageable objectives help keep clients from feeling overwhelmed and provide a benchmark against which to measure progress. Goals, objectives, and strategies should be developed in partnership with the client. They should be framed in a positive context - as something to be achieved rather than something to be avoided. Time frames for completing the objectives and strategies should be identified. Abbreviated, user-friendly treatment planning templates make client participation in development of a service plan more likely. The availability of staff to assist in the planning, goal-setting, and implementation of the case management aspects of the treatment plan is crucial.

Successful completion of an objective should provide the client the satisfaction of gaining a needed resource and demonstrating success. Failure to complete an objective should be emphasized as an opportunity to reevaluate one's efforts. In the latter situation, the case manager should be prepared to help the client come up with alternative approaches or to begin an advocacy process.

A deliberate, carefully considered approach to identifying client goals offers benefits that go beyond the actual acquisition of needed resources. Clients benefit by

- Learning a process for systematically setting goals
- Understanding how to achieve desired goals through the accomplishment of smaller objectives
- Gaining mastery of themselves and their environment through brainstorming ways around possible barriers to a particular goal or objective
- Experiencing the process of accessing and accepting assistance from others in goal-setting and goal attainment

These and other individually centered outcomes make the planning and goal-setting process as important as the final outcome in some cases. This is the action stage of case management, when the client participates in many new or foreign activities and may have multiple requirements imposed by multiple programs or systems. Many significant and stressful transitions may be involved - from substance use to abstinence, from institutionalization or residential placement to community reintegration, and from a drug- or alcohol-using peer group to new, abstinent friends. As clients struggle to stop using, many will relapse, sometimes after a significant period of abstinence. They may feel

overwhelmed, and it is not uncommon for clients in recovery to experience feelings of isolation and depression as they develop new peer associations and lifestyle patterns, and come to grips with their losses. In addition, the very real pressures of finances, employment, housing, and perhaps reunifying with and caring for children can be very stressful.

Case finding and pretreatment

During the pretreatment phase the planning function of case management focuses on supporting clients in achieving immediate needs and facilitating their entry into treatment. Ideally, the professional implementing case management meets with the client to plan the goals and objectives for the service plan. 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 possibility that they are still using alcohol or other drugs. The case manager may decide to complete a formal plan after an action is undertaken and present it to the client as a summary of work that was accomplished. If a client's capacity is diminished by substance abuse and the presence of multiple, serious life problems, the case manager may have to delay teaching and modeling for the client, and instead trade on his own contacts, resources, and abilities. As the client progresses through the treatment continuum, the case manager can turn more and more of the responsibility for action over to the client.

Clients who are using addictive substances while receiving case management services present a significant dilemma for the case manager. On the one hand, the client may not be willing or able to participate in treatment; on the other, treatment providers normally expect some commitment to sobriety before clients begin the treatment process. As a result, the case manager frequently needs to negotiate common ground between client and program. For example, a case manager might require the client to identify and make progress toward mutually understood goals pending entry into treatment. Structured correctly, such an approach fosters a win-win situation. Attainment of these goals either eliminates the client's need for treatment or prepares him to accept treatment more willingly. Even if the client is unwilling or unable to achieve those goals, the case manager and treatment program have additional information to use in attempting to motivate the client to seek treatment.

Primary treatment

During primary treatment, the case manager and client develop a service plan that identifies and proposes strategies to meet the client's short- and medium-term needs. The case management plan should reflect the level and intensity of the service along with the client's specific objectives. Virtually all clients have multiple needs; consequently, the service plan should be structured to enable clients to focus on addressing their problems *while* they participate in treatment. The idea that one can put lack of housing, employment issues, or a child's illness aside to concentrate exclusively on addiction treatment and recovery is unrealistic and sets up both the treatment provider and the client for failure. At the same time, it is often necessary for the client and case manager to

prioritize problems.

During primary treatment, the case manager must (1) continue to motivate the client to remain engaged and to progress in treatment; (2) organize the timing and application of services to facilitate client success; (3) provide support during transitions; (4) intervene to avoid or respond to crises; (5) promote independence; and (6) 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.

Providing ongoing motivation to clients is critical throughout the treatment continuum. Clients need encouragement to commit to entering treatment, to remain in treatment, and to continue to progress. The case manager must continually seek client-specific incentives. Clients are encouraged by different factors, and the same client may respond differently depending on the situation. For instance, many clients referred by the criminal justice system will be initially motivated to try treatment in order to avoid a jail sentence; they may be motivated to stay in treatment for very different reasons (e.g., they start to feel better, they hope to regain custody of children). The treatment process is difficult, and many clients become discouraged after their initial enthusiasm. Recovery may require them to explore uncomfortable issues. Physical discomfort, as well as depression, can ensue. Case managers can provide support during these periods by supplying information on coping techniques such as exercise, diet, and leisure activities. If depression is significant, case managers can work with substance abuse counselors to have a mental health evaluation conducted, and, if appropriate, enable the client to seek additional therapeutic support for the depression. Continued empathetic caring can also motivate clients.

Disincentives may also be used. For example, the case manager might remind clients of the outcome of terminating treatment - for some, this might mean a return to prison, for others it might mean dealing with the health or safety consequences of addictive behaviors. For clients under the control of the criminal justice system, sanctions, including possible jail stays, may be necessary to regain commitment and motivation.

In criminal justice settings, particularly drug courts, regular "status hearings" before a judge may motivate the client. In status hearings, the judge is informed of the client's progress (or lack thereof), and engages the client in a dialogue. The judge can then apply rewards (encouragement, or reduction of criminal sanctions), adjust treatment requirements, or apply sanctions. Sanctions vary, but may include warnings, community service, short jail stays, or ultimately, termination from the program and incarceration.

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 goals. The case manager has to work with the client to balance competing interests, and to develop strategies so the client can meet basic survival needs while in treatment. For example, a case manager may have to negotiate between probation and treatment to ensure that the client can attend treatment sessions and meet with his probation officer.

Some activities require staging to ensure that they are applied at the right time and in the correct order. Clients who are unemployed and lack employment skills, for instance, should begin job readiness and training activities after they are stabilized in treatment; they will need additional support for seeking and maintaining employment. It is not uncommon for clients to feel they can take on the world once they are stabilized in treatment. If this is the case, the job of the case manager is to encourage clients to go slowly and take on responsibility one step at a time. This can be particularly critical for women anxious to reconnect with their children. The financial and emotional responsibilities are great, and the case manager should work with the woman and child protective services to transition these responsibilities in manageable ways.

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. In order 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.

If the client is under the control of the criminal justice system, the case manager should work to ensure that supervision activities remain the same or increase when treatment activity decreases. 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.

In addition to activities designed to avoid a crisis or relapse, the case manager should be available to respond to relapses and crises when they do occur. In many cases, the case manager leads the response effort. Case managers should be in frequent contact with the treatment program to check on client attendance and progress. Lapses in attendance and/or poor progress can signal an impending crisis, and a case conference should be held. The case conference can resolve problems and prevent the client's termination from the program. While violence toward staff or other patients is obviously adequate grounds for immediate program termination, other infractions do not necessarily warrant expulsion. The case management team and client should work together to develop alternatives that will keep the client engaged in treatment. If removal from the program is absolutely necessary, it may be possible to have the client readmitted after he "adjusts his attitude" and re-commits to treatment and to obeying the rules.

The Treatment Alternatives for Safe Communities (TASC) Project has developed a special form of case conference, known as "jeopardy meetings" for treatment clients involved in the criminal justice system. 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 aren't 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).

Aftercare

One of the anticipatory roles for case management during primary care is to plan for aftercare, discharge, and community reentry. During primary care and into aftercare, the case manager helps the client master basic skills needed to function independently in the community, including budgeting, parenting, and housekeeping. Short-term goals increasingly become supplanted by long-term goals of integrating the individual into a recovery lifestyle. When appropriate, service plans should reflect an ever-increasing emphasis on clients' accepting greater responsibility for their actions. The case management intervention may increase or decrease in intensity, depending on client response to independence and progress toward community reintegration.

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. An additional crucial function of case management is coordinating all the various providers and plans and integrating them into a unified whole.

Linking goes beyond merely providing clients with a referral list of available resources. Case managers must work to develop a network of formal and informal resources and contacts to provide needed services for their clients.

Case finding and pretreatment

Case managers may be especially active in providing linking and advocacy during the pretreatment phase of the treatment continuum. As with each of the case management functions, the roots of linking begin much earlier, while conducting an assessment with the client and in creating goals in which the client is vested. The authors of one primer on case management identify five tasks related to linking that should be undertaken with the client before actual contact with a needed resource even occurs. Case managers must (1) enhance the client's commitment to contacting the resource; (2) plan implementation of the contact; (3) analyze potential obstacles; (4) model and rehearse implementation; and (5) summarize the first four steps for the client (Ballew and Mink, 1996).

Primary treatment

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, is an essential function of case management. Coupled with monitoring is the need to share client information with relevant parties. For instance, if a client who is involved in the criminal justice system tests positive for drugs, both the treatment counselor and the probation officer may need to know. If the case manager is aware that the client is having problems at work, this information may need to be shared with the treatment provider, within the constraints of confidentiality regulations.

Case managers who are responsible for offenders in treatment may oversee regular drug testing. This is an effective way to obtain objective information on a client's drug use, as well as to structure boundaries for the client to help prevent relapse.

Monitoring may reveal that the case manager needs to take additional steps on the client's behalf. Simply put, *advocacy* is speaking out on behalf of clients. Advocacy can be precipitated by any one of a number of events, such as

- A client being refused resources because of discrimination, whether discrimination is based on some intrinsic aspect of the client, such as gender or ethnicity, or on the nature of the client's problems, such as addiction
- A client being refused services despite meeting eligibility requirements
- A client being discharged from services for reasons outside the rules or guidelines of that service
- A client being refused services because they were previously accessed but not utilized
- The case manager's belief that a service can be broadened to include a client's needs without compromising the basic nature of the service

Advocacy on behalf of a client should always be direct and professional. Advocacy can take many forms, from a straightforward discussion with a landlord or an employer, to a letter to a judge or probation officer, to reassuring the community that the client's recovery is stable enough to permit reentry. Advocacy often involves educating service providers to dispel myths they may believe about substance abusers, or ameliorating negative interactions that may have taken place between the client and the service provider. This is particularly important for certain groups with whom some programs are reluctant to work, such as clients with AIDS/HIV or clients involved in the criminal justice system.

More complicated advocacy involves, for example, appealing a particular decision by a service staff member to progressively higher levels of authority in an organization. The highest, most involved levels of advocacy include organizing a community response to a particular situation or initiating a legal process. Modrcin and colleagues provide an advocacy strategy matrix that can help case managers systematically plan advocacy efforts (Modrcin et al., 1985). In this view of advocacy, the levels at which advocacy can be effected (individual, administrative, or policy) are weighed against varying approaches (positive, negative, or neutral). Three guidelines for advocating on behalf of a client are getting at least three "No's" before escalating the advocacy effort, understanding the point of view of the organization that is withholding service, and consulting with supervisory

personnel regularly before moving to the next level of advocacy (Sullivan, 1991).

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 she wants. Particularly for clients whose continued drug use or cessation of treatment will present considerable negative consequences such as incarceration or death, advocacy may involve doing whatever it takes to keep them in treatment, even if that means recommending jail to get them stabilized. It is not uncommon, in fact, for clients to state their preference for jail when treatment gets difficult. Even when advocating for clients, the case manger must respect system boundaries. For example, a case manager might negotiate hard to keep an offender client in community-based treatment, but agree to inform the probation office of positive drug tests or suspected criminal behavior. While advocacy for certain client populations is essential, concern for the client should not override goals of public safety. Effective, client-centered advocacy may put the case manager in a position of conflict with co-workers, program administrators, or even supervisors. Case managers who advocate for an extension of benefits for their clients may put themselves and their supervisors in jeopardy with funding sources. A coordinated infrastructure with existing policies and procedures for client centered collaboration will help.

Disengagement

Disengagement in the case management setting, as with clinical termination, is not an event but a process. In some ways, the process begins during engagement. For both client and case manager, it entails physical as well as emotional separation, set in motion once the client has developed a sense of self-efficacy and is able to function independently. To a significant degree, this decision can be based on progress defined by the service plan. If the plan has truly been developed with the client's active involvement, there will be a great deal of objective information that will help both the case manager and client decide when disengagement is appropriate. 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. Reviewing and summarizing client progress can be an important aspect of consolidating clients' gains and encouraging their future ability to access resources on their own.

Chapter 5 - Case Management for Clients With Special Needs

Case management is an appropriate intervention for substance abusers because they generally have trouble with other aspects of their lives. This is especially true for those clients whose problems or issues can be overwhelming even for non-addicted people. 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.

In an ideal world, case managers would be knowledgeable about all those problems and needs. However, understanding the ramifications of even one can be a staggering task. For example, a case manager dealing with a client who has AIDS would need to be conversant in epidemiology, transmission routes, the disease's clinical progression, advances in treatment regimens, financial and legal ramifications, available social services, as well as psychotherapeutic approaches to AIDS patients' grief and fear. Given the many other special needs the case manager confronts, it is apparent that no one individual can be an expert in every area. 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." The case manager serving special needs clients should

- 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

While it is impossible to discuss all the special needs that case managers confront, several occur repeatedly. This information 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.

Minority Clients

Demographic realities in the United States dictate that case managers will be called on to work with individuals of different gender, color, ethnicity, and sexual orientation. Some will be persons of color; some will be poor, not conversant in English, disadvantaged, and over-represented in many areas of the social services system. Case managers must

"respond proactively and reactively to racism, ethnocentrism, anti-Semitism, classism, and sexism . . . ageism and 'ableism'" (Rogers, 1995, p. 61).

There are five elements are associated with becoming culturally competent: (1) valuing diversity, (2) making a cultural self-assessment, (3) understanding the dynamics when cultures interact, (4) incorporating cultural knowledge, and (5) adapting practices to the address of diversity (Cross et al., 1989). According to Rogers, culturally competent case managers have the

- 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 (Rogers, 1995)

Case managers should either speak any foreign languages common in their locale or refer non-English speakers to someone who does. It is also crucial for the case manager to be aware of what may inhibit minorities' participation in the substance abuse treatment continuum. For example, while "accepting one's powerlessness" is a central tenet of 12-Step self-help programs, members of oppressed groups may not accept it, given their own societal powerlessness. 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 by

- 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

Case managers who provide services to this population must be prepared to work with "a base of diverse resources, enhancement or adaptation of the capabilities of existing

resources, or the development of new service programs specifically designed to address [the HIV-infected individual's] needs" (Sonsel et al., 1988, p. 390). The Linkage Program in Worcester, Massachusetts, is typical of this arrangement. It engaged 19 diverse agencies - including drug treatment programs, area churches, AIDS advocacy and support agencies, the city's department of public health and a regional medical center - in a consortium of care for substance abusers who also had HIV infection (McCarthy et al., 1992). The Worcester consortium and other linkage programs demonstrated a positive relationship between the amount of case management services provided and the receipt of drug abuse, health care, and other services (Schlenger et al., 1992).

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, over-identification 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.

The overwhelming nature of life for a person with two life-threatening conditions - AIDS and addiction - cannot be overstated. The magnitude of even daily tasks holds significant stress for both the client and the case manager. 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.

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

Almost 40 percent of people with an alcohol disorder meet criteria for a psychiatric disorder, and more than half of those with other drug disorders report symptoms of a psychiatric disorder (Regier et al., 1990). Not unexpectedly, the prevalence of coexisting disorders is significantly higher in treatment populations than in the general population, approaching 80 percent in some studies of substance abuse patients (Khantzian and Treece, 1985; Ross et al., 1988; Kosten and Kleber, 1988). Given those high comorbidity rates, substance abuse treatment staff must be prepared to address the problems of dual-diagnosis clients.

Treatment services for clients with a dual diagnosis are organized in sequential, parallel, or integrated models (CSAT, 1994b). In the integrated model, 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.

In the case of sequential treatment, the case manager helps the client move from either substance abuse to mental health treatment or from mental health to substance abuse treatment. In parallel treatment, the case manager must facilitate communication and service coordination between two agencies whose treatment approaches may be based on different assumptions. 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

Many of the special case management issues for clients with mental illness center on the client's use of prescription drugs to stabilize mood and reduce the negative effects of the mental disorder. Some substance abuse treatment providers oppose the use of any psychotropic drugs, fearing that they will interfere with the recovery process and become a new source of chemical dependency or that the prescribing physician is not adequately aware of the client's problems with addiction. Some treatment programs unwittingly precipitate a client's relapse by requiring the client to stop taking all medications as a condition of acceptance to a treatment program. Participants in 12-Step meetings may pressure clients to be free of the "crutch" of prescription drug use.

As substance abuse treatment providers become familiar with prescribed neuroleptic drugs, they are more likely to accept the medical management of the client's illness and communicate more with the professionals providing the client's medical care. To manage client symptoms and behaviors, anticipate problems, and reinforce the medical management of the client, all staff who work with dual-diagnosis clients need some knowledge of the benefits of commonly prescribed drugs, their potential side effects, actual abuse potential, and their interactions with other drugs.

Aftercare tends to be long-term for clients with mental illness because of the continuing possibility that the client will stop taking medications when he begins to feel more stable and then take illicit drugs to cope with the re-emergent symptoms of mental illness. 12-Step programs such as Double Jeopardy, Double Trouble, and Dual Recovery Anonymous designed specifically for people with mental health and substance abuse

problems can be valuable sources of support.

While case managers may not be experts in the treatment of any one of these disorders, it is vital that they know enough to work with the client in identifying her needs and be able to translate and coordinate those needs with the two types of treatment.

Homeless Clients

Alcoholism rates among the nation's homeless are estimated to be as much as two to four times the levels for individuals of the same gender in the general population. Besides alcohol, the substances most frequently used by homeless people are marijuana, cocaine, and crack cocaine (National Institute on Alcohol Abuse and Alcoholism, 1989). Crack use in particular has increased in the last 10 years, primarily among younger homeless people (Crystal, 1982). Numerous efforts at engaging homeless individuals in substance abuse treatment have been undertaken, many involving case management as a central component (Braucht et al., 1995; Conrad et al., 1993; Sosin et al., 1995; Stahler et al., 1995).

The need for case management with this population is obvious. Clients need suitable short- and long-term housing; many have mental disorders. Homeless individuals frequently suffer from significant health problems secondary to their lifestyle, including tuberculosis, HIV, and AIDS. Unemployment is high. This constellation of tangible needs can best be addressed by one individual at the interface between the streets and social service agencies.

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 the 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. While this setting is hardly ideal, it may be one in which the client can function well enough to benefit from treatment. However, some programs may claim they cannot help homeless individuals until their other life problems are solved, requiring the case manager to advocate on the client's behalf (Sosin et al., 1994).

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. One solution to this difficulty in engaging homeless clients is through the use of *peer case managers*: homeless individuals who are in recovery themselves and are based in shelter care facilities. In one such setting, peer case managers proved to be as successful as degreed professionals or an intensive residential treatment program in assisting homeless individuals in the areas of substance use, housing stability, employment, and psychological functioning (Stahler et al., 1995). In addition, clients were more satisfied with the services provided by the peer case managers than by the

degreed professional case managers. This finding may be explained by clients' beliefs that case managers who have experienced homelessness first-hand are more likely to provide needed services.

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. For example, Louisville's Project Connect used case management to help homeless alcoholic and drug abusing men move from a sobering-up shelter (the pretreatment phase of the treatment continuum) through a vocational program at the exit point of treatment (Bonham et al., 1990). Another substance abuse program at the Coatesville Veterans' Affairs (VA) Medical Center picks up homeless veterans at local shelters, takes them in vans to the VA for day treatment, feeds them, and takes them back to the shelter. This has helped to keep veterans engaged in treatment as they await placement in a VA domicile or other housing arrangement. The Department of Veterans' Affairs conducts stand-downs in its homeless program, during which veterans temporarily housed in tents receive medical services and are assessed for treatment needs. They are brought into residential care for treatment as needed.

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. Case finding can be accomplished by mobile case management teams who seek out homeless substance abusers in shelters and other areas where they sleep and congregate (Rife et al., 1991).

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. Because women are often referred by other service providers (Beckman and Amaro, 1986), case managers affiliated with substance abuse treatment programs must help their counterparts in other social service agencies identify women in need of treatment. Women with children are likely to be involved in numerous child-related services; women who have been victims of domestic violence present for services at battered women shelters; other women may appear at mental health centers and women's health centers. A significant number of women clients have suffered physical, verbal, psychological, or sexual mistreatment (Miller and Rollnick, 1991; Mondanaro et al., 1982), and many who present for treatment live in an unsafe environment.

Once identified, women with substance abuse problems may be difficult to engage in treatment. Society judges substance-abusing women more harshly than male substance abusers. A woman's substance abuse problem is likely to have progressed significantly before being identified, and treatment may be complicated by factors like psychological

functioning, situational realities, and systemic barriers (Wildwind, 1984). Other issues such as sexual abuse, victimization, and emotional dependency are frequently associated with women who have substance abuse problems (Markoff and Cawley, 1996). Transportation is a common barrier, especially in primary outpatient and aftercare treatment.

Women substance abusers who have children confront these problems and more when considering treatment. A mother's decision to enter treatment means the case manager must either identify a program that will take both the woman and her children or assist the woman in finding appropriate child care. These mothers may avoid treatment out of guilt and shame for the activities in which they have engaged to acquire drugs and the situations in which they have placed their children. Compounding a mother's shame is the fear that authorities will take her children away from her. As a result, an assessment of such a mother's needs is complicated by the fact that she is likely to lie to the case manager about her addiction and the way her family lives.

The basic functions and tenets of case management are well suited to improving retention and outcomes for women in treatment. There is evidence that women in particular do not adequately focus on their substance use and recovery until their needs for such resources as housing, food, medical care, and personal safety are adequately addressed (Hepburn, 1990). Case managers should assist female clients in developing a safety plan setting out well-defined steps to take should she fear, or be subjected to, violence. It is imperative to determine if 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 more 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 her 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 Substance Abuse Treatment: Improving Client Outcomes*(Sullivan et al., 1992).

Adolescent Substance Abusers

Substance use and dependence are significant problems among adolescents in the United States. Some substance use is due to a developmental tendency to experiment, results in

few consequences, and abates with maturity. However, a number of adolescents progress to the point of substance abuse or dependence. Because of the problems associated with abuse and dependence these adolescents 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. Problems such as poverty, child neglect, or parental substance abuse cannot be ignored. 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. Challenges can arise in numerous contexts, for instance when an adolescent tells the case manager she plans to have an abortion. 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.

One case management model describes a three-phase approach, providing services during pre-treatment/screening, residential treatment, and continuing care (Godley et al., 1994). The goal of case management services during pre-treatment/intake is to improve access to services, provide initial orientation to the treatment process, and begin skills training. Case management for clients in residential programs links the client to needed services outside the residential facility and ensures a coordinated response by multiple agencies involved in an adolescent's life. During aftercare, the professional implementing case management continues the linkage and monitoring process and provides booster relapse prevention skills training with the goal of decreasing the likelihood of relapse or interrupting a relapse episode.

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

The number of substance abusers in the criminal justice system is staggering. The Drug Use Forecasting Project, which tested arrestees in 26 major U.S. cities for illicit drug use, found positive results ranging from 48 percent to 80 percent. In one jurisdiction, 80 percent of all women arrested tested positive for at least one illicit drug. The Bureau of Justice Statistics (U.S. Department of Justice, 1991) reported that 54 percent of State prisoners reported drug use at the time of the offense, and 52 percent reported use during

the previous month.

Case management for substance abuse clients in the criminal justice system evolved in a unique fashion, 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, which is maintained with punishment and legal sanctions. Likewise, while the substance abuse treatment system supports public safety goals, its primary mission is to change individual behaviors. These goals are not mutually exclusive; in fact, experience has demonstrated that integrating the techniques of these two systems can have a powerful effect on reducing the drug use and criminal activity of drug-involved offenders. Because participation in substance abuse treatment and other social services is often mandated, case managers have the opportunity to engage clients over a longer period of time and may be more likely to effect successful change.

Integrating the two systems requires some effort, however. 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.

The criminal justice system is fragmented into numerous components through which offenders may be assigned. In most jurisdictions, supervision can be provided for certain pretrial offenders who have not yet gone to trial. In other jurisdictions, such offenders may be given the option of diversion, in which successful completion of certain activities will avoid a conviction. Convicted offenders may be sentenced to county jails, state prisons, or probation; probation can include halfway house supervision, intensive probation, or electronic monitoring. Released offenders may be on parole or some other sort of post-incarceration supervision; in some jurisdictions probation sentences may follow sentences of incarceration. Linkages between prison and probation, or between county jails and community-based supervision, may be weak; databases are often not connected; and entities often report to different management structures. For example, probation offices are part of the court system in some jurisdictions, the corrections department in others. Case management efforts are critical to ensuring continuity when offenders move from one supervision level to the next, or between one status or location and another. Managing offenders who are changing status within this system while they are participating in substance abuse treatment services (both inside institutions and in the community) is exponentially more complicated.

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. Establishing appropriate housing that will facilitate sobriety and helping the offender develop job-seeking skills are but two of the specific activities that may form the basis of the case management relationship. Offenders incarcerated in State and local correctional facilities frequently need assistance in

managing their lives as they reenter the larger community. Institutional life is highly regimented, presenting special problems when offenders are released. In working with paroled individuals, the case manager must recognize that prison life encourages behaviors that are not appropriate on the outside. Parolees who have been imprisoned longer than a year may require more time in a semi-structured setting (for example, a halfway house) in order to make the transition from institution to community.

The case manager should address the needs of clients released from institutions in order of importance. The first priority is immediate stability, which can be facilitated by safe housing, access to either primary substance abuse treatment or aftercare, and social networks that facilitate positive behavior. Second, the case manager should either provide or make referral to sources of skills training, since individuals who have served lengthy sentences will likely need either habilitation or rehabilitation training in the areas of job searches, interactions with non-offender social groups, and problem-solving strategies. Third, the case manager should train or find training in setting and accomplishing short- and long-term goals. Incarceration often leads offenders to believe that the locus for control of their lives lies totally with other persons or institutions. While goal-setting is important to any client group, it is particularly important to clients who have had most basic needs provided for them. Ideally, the case manager will begin providing these services several weeks or months before a scheduled release, then follow the offender into the community. Lastly, the case manager can advocate for the offender both in the treatment environment and the criminal justice system.

In order to maximize effectiveness, several configurations of case management functions have been attempted, including:

Case management provided by the justice system. Justice system case managers are assigned caseloads at specific stages of the system, such as probation or parole. An advantage of this model is that justice system officials are invested in the process because their staff members are implementing it and reporting back to them. Major disadvantages are the expense and the fact that there may be conflicts between the philosophies and goals of the substance abuse and criminal justice systems. Another issue in this model is whether the case manager has actual training in substance abuse treatment approaches and community referral techniques, as opposed to primarily correctional interventions.

Case management provided by a treatment agency. The advantage of a community-based treatment model is that the case manager has a thorough understanding of the substance abuse treatment process. The disadvantages include, again, the expense and the possibilities that the case manager may not be familiar with the criminal justice system or that the treatment agencies may not have the resources for effective case management.

Case management provided by an agency separate from the treatment and justice systems. To reduce costs, a case management coordinator may be employed, with or without a caseload, to conduct intake interviews and supervise paraprofessional staff. The disadvantages of this approach include the addition of another agency to the

collaboration.

Case management provided by a coordinator from the justice system who provides consulting services and technical assistance to support existing criminal justice case management. One advantage of this model is system ownership. A coordinator, with or without a caseload, oversees the work of a paraprofessional staff. The coordinator can move the criminal justice system toward a greater awareness of treatment issues by providing technical assistance that demonstrates service coordination.

Case management provided by multidisciplinary groups in the criminal justice system for offender management. This type of group may meet regularly and during crises. This model is the most inexpensive; however, it is the most difficult to successfully operate because no one is assigned overall responsibility for the offender (CSAT, 1995b).

This type of structured case management between the criminal justice and treatment systems has facilitated the traditional goals of each system. Case management benefits the criminal justice system by

- Increasing supervision through drug testing
- Reducing drug use and criminal behavior
- Broadening the range of sanctions available to the criminal justice system
- Providing systems of graduated interventions
- Offering treatment in lieu of or in combination with punishment
- Providing information to the criminal justice system
- Providing a basis for judicial decisionmaking
- Extending the power of the court to influence drug-using behavior

Case management has benefited the treatment system by

- Increasing treatment outreach
- Providing assessments and making appropriate referrals
- Utilizing resources more effectively
- Orienting clients to treatment
- Retaining clients in treatment by utilizing criminal justice leverage
- Supporting treatment compliance
- Facilitating access to additional services
- Providing a framework and structure for managing criminal justice clients (Cook, 1997)

Clients With Physical Disabilities

Chemical dependency is a coexisting problem for many people with physical disabilities (Moore and Polsgrove, 1991). Some 15 to 30 percent of all people with disabilities have a substance abuse problem, more than twice the rate in the general population. Among disabilities, rates of substance abuse are highest among people with traumatic brain

injury, spinal cord injury, mental illness, and learning disabilities (Rehabilitation Research and Training Center on Drugs and Disability, 1997). The case manager delivering services to this population must know and understand those conditions 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. Clients with disabilities may not recognize their need for substance abuse treatment or may expect to be denied treatment. Once in treatment, they may be misunderstood, or singled out for mobility or communication problems (Rehabilitation Research and Training Center on Drugs and Disability, 1996). The Americans with Disabilities Act (ADA) provides support for treatment programs oriented to this population by mandating that facilities be physically accessible to people with disabilities and that treatment professionals have an understanding of disability issues.

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. For example, clients who had a significant substance abuse problem before becoming disabled need different treatment approaches than those who started using to cope with a new disability. An individual with a disability that predates his substance abuse may be obsessively focused on his "disability" and not be aware of the functional limitations imposed by the chemical dependency. Others may have acquired a disability as a direct result of substance abuse, but without "sober" time for understanding the disability they may not be aware of their functional limitations and how their current functioning levels make it difficult to learn or perform certain tasks. Mentors who have disabilities or physical rehabilitation professionals can assist newly disabled individuals in understanding their disability.

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. To reach those with physical disabilities, 12-Step groups must be willing to use hearing enhancement equipment (e.g., hearing loops) in meetings and to hold meetings in accessible places. The case manager should become familiar with special equipment in order to help organizations purchase or borrow appropriate resources as required under the ADA.

The person in a wheelchair who must take medication for chronic pain from an injury may prompt resistance from recovery-oriented self-help groups. Similarly, some vocational programs within a treatment setting require clients to be sober for some time

before they can be placed in a training setting. As a result, vocational rehabilitation services, while appropriate, are not available to individuals receiving pharmacotherapy for opiate addiction within those programs that do not consider such people drug-free. A case manager from either the disability field or the substance abuse field should educate members of other disciplines on how to structure treatment appropriately. The Center for Substance Abuse Treatment is producing a TIP on persons with disabilities who have substance abuse problems, which will be available in late 1998.

Gay, Lesbian, Transgendered, and Bisexual Clients

Gay, lesbian, transgendered, and bisexual cultures are often associated with substance use in general and alcohol use in particular. Findings suggest that both gay men and lesbians are more likely to be involved in the use of alcohol, marijuana, and cocaine than heterosexual members of all age cohorts (McKirnan and Peterson, 1989; Skinner, 1994), with the differences particularly pronounced among younger people. Gay and lesbian clients may also find their sexual partners in areas prevalent with drugs, increasing the risk of contracting the AIDS virus. The prevalence of use, coupled with homophobia, makes the recognition and treatment of substance abuse problems more difficult.

Given the emotionally charged atmosphere that often surrounds sexuality, case managers must be especially aware of their own feelings and beliefs. The link between personal beliefs and interviewing skills is especially important in the assessment of these clients, who may be reluctant to discuss health problems or issues related to sexual practices. 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. As with any client, treatment planning includes helping the gay client identify and develop social opportunities that do not involve drugs and alcohol. Advocacy for gay clients includes helping clients seek treatment for injuries and infections sustained through sexual activity and seeing that clients' needs are taken seriously.

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 is 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.

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. Perhaps the most difficult function of the case manager in a rural setting is advocacy. In a close-knit environment, advocating for a client may mean challenging the decisions of other service providers. On the other hand, the professional's close relationships with those providers may benefit the client.

Case management in a rural setting can take one of several forms. Telecommunication and video-conferencing practice models have been used to allow clients relatively easy access to providers and to facilitate providers' communication and recordkeeping (Alemi et al., 1992). Where the client lives far away from the program, services may be provided in an intensive manner, for example, daylong sessions with a particular client. A lack of formal services can be mitigated by the use of informal helping networks such as Alcoholics Anonymous. However, in using informal networks, the case manager will have to deal with the unique challenges to confidentiality occasioned by the rural environment.

Appendix B - Practice Dimensions

Referral

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.

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
    - health and allied health care systems (managed care)
    - criminal justice systems
    - housing administrations
    - employment and vocational rehabilitation services
    - child care facilities
    - crisis intervention programs
    - abused persons programs
    - mutual and self-help groups
    - cultural enhancement organizations
    - advocacy groups
    - other agencies
b. Community demographics
c. The community's political and cultural systems
d. Criteria for receiving community services, including fee and funding structures
e. How to access community agencies and service providers
f. State and Federal legislative mandates and regulations
g. Confidentiality regulations
h. Service gaps and appropriate ways of advocating for new resources
i. Effective communication styles

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 follow-up
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 verbal 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 follow-up 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 effect 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 verbal 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 inter-agency 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. Terminologies 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 verbal 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 verbal 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 verbal 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, time frames, 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 verbal 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 verbal 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 assuring 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 verbal 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 verbal and written communication
b. Participating in interdisciplinary collaboration
c. Interpreting written and verbal 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 verbal 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 with 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 non-judgmental 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 non-judgmental, 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, follow-up, 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 follow-up 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 verbal 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 to develop 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 verbal 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

Exhibits

Figure 1-1: Definitions of Case Management

Case management is

- "planning and coordinating a package of health and social services that is individualized to meet a particular client's needs" (Moore, 1990, p. 444)
- "[a] process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner" (Intagliata, 1981)
- "helping people whose lives are unsatisfying or unproductive due to the presence of many problems which require assistance from several helpers at once" (Ballew and Mink, 1996, p. 3)
- "monitoring, tracking and providing support to a client, throughout the course of his/her treatment and after" (Ogborne and Rush, 1983, p. 136)
- "assisting the patient in re-establishing an awareness of internal resources such as intelligence, competence, and problem solving abilities; establishing and negotiating lines of operation and communication between the patient and external resources; and advocating with those external resources in order to enhance the continuity, accessibility, accountability, and efficiency of those resources" (Rapp et al., 1992, p. 83)
- "assess[ing] the needs of the client and the client's family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client's complex needs." (National Association of Social Workers, 1992, p. 5)

Figure 1-2: Models of Case Management

Figure 1-2
Models of Case Management

Primary Case Management Activities	**Broker/Generalist**	**Strengths Perspective**	**Assertive Community Treatment**	**Clinical/ Rehabilitation**
Conducts outreach and case finding	Not usually	Depends on agency mission & structure	Depends on agency mission & structure	Depends on agency mission & structure
Provides assessment and ongoing reassessment	Specific to immediate resource acquisition needs	Strengths-based, applicable to any of client life areas	Broad-based, part of a comprehensive (biopsychosocial) assessment	Broad-based, part of a comprehensive (biopsychosocial) assessment
Assists in goal planning	Generally brief, related to acquiring resources, possibly informal	Client-driven, teaches specific process on how to set goals and objectives, goals may include any of client life areas	Comprehensive, goals may include any of client life areas	Comprehensive, goals may include any of client life areas
Makes referral to needed resources	Case manager may initiate contact or have client make contact on own	As negotiated with client, may contact resource, accompany client, or client may contact on own	As needed, many resources integrated into broad package of case management services	As negotiated with client, may contact resource, accompany client, or client may contact on own

Primary Case Management Activities	**Broker/Generalist**	**Strengths Perspective**	**Assertive Community Treatment**	**Clinical/ Rehabilitation**
Monitors referrals	Follow-up checks made	Close involvement in ongoing relationship between client and resource	Close involvement in ongoing relationship between client and resource	Close involvement in ongoing relationship between client and resource
Provides therapeutic services beyond resource acquisition, e.g., therapy, skills-teaching	Referral to other sources for these services if requested	Usually limited to responding to client questions about treatment issues, education about how to identify strengths and about self-help resources	Provides many services within unified package of treatment/case management services	Provision of therapeutic activities central to the model
Helps develop informal support systems	No	Development of informal resources - neighbors, church, family - a key principle of the model	Through implementation of drop-in centers and shelters	Emphasis on family and self-help support through therapeutic activities
Responds to crisis	Responds to crises related to resource needs such as housing	Responds to crises related to both resource needs and mental health concerns; active in stabilization and then referral	Responds to crises related to both resource needs and mental health concerns; active in stabilization and then referral	Responds to crises related to both resource needs and mental health concerns; will stabilize crisis situation and provide further therapeutic intervention

Primary Case Management Activities	**Broker/Generalist**	**Strengths Perspective**	**Assertive Community Treatment**	**Clinical/ Rehabilitation**
Engages in advocacy on behalf of individual client	Usually only at level of line staff	Assertive advocacy, will pursue multiple administrative levels within agency	Assertive advocacy, will pursue multiple administrative levels within agency	Assertive advocacy, will pursue multiple administrative levels within agency
Engages advocacy in support of resource development	Not usually	Usually in context of specific client needs	Either advocates for needed resources or may create resources as part of case management services	Usually in context of specific client needs
Provides direct services related to resource acquisition as part of case management, e.g., drop-in center, employment counseling	Referral to resources that provide direct services	Provides services crucial to preparing client for resource acquisition activities, e.g., role playing, accompanying client to interviews	Provides many direct services within unified package of treatment/case management	Provides services that are part of rehabilitation services plan; skill-teaching
Appropriate for the following substance abuse populations				
	Injectable drug users; HIV positive and at-risk substance abusers	Male crack cocaine users; female polysubstance abusers	Chronic public inebriates; parolees with substance abuse problems; dually diagnosed clients	Dually diagnosed clients; female polysubstance abusers