

Literature Review: Substance Abuse Specific Intensive Case Management

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Definition: Case management is 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 (SAMHSA, 2012).

Target Population: Individuals who have a primary or co-occurring substance abuse or dependence disorder, who have difficulty accessing treatment and maintaining sobriety...

Description: This literature review outlines various treatment models for individuals with primary and co-occurring substance abuse disorders, specifically the intensive case management approach and to an extent, the assertive community treatment approach. The review describes best practices related to each respective approach. It also briefly describes how these aspects vary based upon specific target population needs, including individuals experiencing homelessness, primary versus co-occurring diagnosis, etc. Finally, it compares

Research Summary:

Individuals with substance abuse disorders commonly have concurrent mental and physical health diagnosis and face multiple barriers to treatment. Such individuals oftentimes need assistance with multiple facets of their lives, including housing, employment, and relationships. Many times such individuals are also suffer from homelessness, have criminal justice involvement, and are high utilizers of public services, yet have not responded well to usual treatment services. Research has shown case management to be a promising approach for substance abuse treatment as its principle goal is to maintain engagement, retention, and provide a variety of services through a continuum of care approach. Findings suggest individuals are more likely to succeed in treatment when their other problems are addressed concurrently with substance abuse (SAMHSA, 2012). Intensive case management and assertive community treatment are two models that have shown specific promise for populations such as these.

Case management for substance abusers initially gained attention in the United States through the Treatment Alternatives for Safe Communities (TASC) program (formerly known as Treatment Alternatives to Street Crime), which began linking the criminal justice system with the drug abuse treatment system in 1972 (SAMHSA, 2012). Around 1990 the National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA) launched numerous initiatives designed to increase retention in the treatment continuum and improve treatment outcomes through case management.

Best Practices:

According to SAMHSA (2012), case management is based upon several principles, including:

1. Single point of contact—Consolidates and mobilizes multiple agencies and services in order to offer the client accessibility and continuity.
2. Client-driven—Uses expertise to identify options for the client to decide upon, while providing the least restrictive level of care so as to avoid client dependency and disruption.
3. Involves advocacy—Advocates with many systems, agencies, families, and legal systems to promote the client's best interests.
4. Community-based—Helps client negotiate with community agencies and seeks to integrate formalized services with informal care resources in the community (i.e. family, friends self-help groups, and church).
5. Pragmatic—Begins “where the client is,” by prioritizing tangible needs such as food, shelter, clothing, transportation, or child care; initially, treatment might not be the priority, but it could be after taking care of basic needs.
6. Anticipatory—Foresees problems, understands the options available to manage them, and takes action when appropriate.

7. Culturally sensitive—Demonstrates cultural competence, which includes valuing diversity, making a cultural self-assessment, understanding the dynamics of cultural interaction, incorporating cultural knowledge, and adapting practices to the diversity present in a given setting.
8. Flexible—Adaptable to client characteristics and needs.

Case management models typically focus on several core functions when working with individuals with substance use disorders, including:

1. Assessment—determining an individual’s current and potential strengths, weaknesses, and needs.
 2. Planning—developing a specific service plan for each individual, with provisions for day, evening, and night linkages to needed functions.
 3. Linking—referring or transferring individuals to all required or needed services in the formal and informal caregiving systems.
 4. Monitoring—continuous evaluation of individual progress and regress.
 5. Advocacy—interceding on behalf of an individual to ensure equity, both in the specific case and for any larger group or class to which the individual might belong.
- (Ashety, NIDA, 1992)

Specific case management competencies have been identified and utilized over the years, and focus on understanding addiction, treatment knowledge, application to practice, and professional readiness, amounting to 23 total competencies (i.e. referral and services coordination) and 82 specific points of knowledge and attitude (SAMHSA, 2012).

Models:

Case management models and implementation widely vary, and there is very little standardization across programs. While many in the field would agree that there are several core functions of case management, which are outlined above, they are all in varying degrees with diverse concentrations. Below are a few notable models utilized for substance abuse disorder treatment, including:

1. Brokerage/Generalist Model—a brief approach, usually 1-2 contacts, to case management where caseworkers attempt to assist clients with needs identification and broker ancillary or supportive services. This approach is recommended for injectable drug users, HIV positive and at-risk substance abusers.
 2. Clinical/Rehabilitation Model—a hybrid approach that combines clinical or rehabilitative activities and resource acquisition (case management). This approach is recommended for dually diagnosed clients, and female polysubstance abusers.
 3. Strengths-based Case Management Model—an approach that emphasizes the importance of the clients’ strengths, self-direction, active case manager outreach and their relationships with their clients, and utilization of informal help networks (as opposed to agency resources). This approach is recommended for male crack cocaine users and female polysubstance abusers.
 4. Assertive Community Treatment (ACT) — a comprehensive approach that consists of a team of case managers that provide outreach, crisis intervention, direct counseling services, skills-building, and family consultations on a frequent basis with client. The team approach allows for shared caseloads and thus smaller, more manageable, and appropriately served. This approach is recommended for chronic public inebriates, parolees with substance abuse problems, and dually diagnosed clients. Programs have implemented such teams in several different ways.
 5. Intensive Case Management (ICM)—a comprehensive approach that consists of one single case manager that provide outreach, crisis intervention, direct counseling services, skills-building, and family consultations.
- (Vanderplasschen, 2011).

Interagency/Inter-organizational Models:

1. The Single Agency—Small grassroots agency or major provider of services for a single problem or to a single population; Interagency case management services built on informal agreements; Case manager hired by and accountable solely to the single agency.
2. The Informal Partnership—Establishes and maintains informal partnerships or networks to respond to the needs of multiple populations with multiple problems.
3. The Formal Consortium—Two or more providers linked by a formal contractual arrangement; Represents multiple values and philosophies; Agencies cooperate and work together for a common purpose, which is formalized in the contractual relationship.

Comparing Assertive Community Treatment (ACT) & Intensive Case Management (ICM):

Both ACT and ICM approaches emphasize the importance of providing individualized and person-centered services, while supporting self-direction and independence (SAMHSA, 2017).

The structure of the ACT approach differs from the ICM approach in that it emphasizes the importance of case manager teamwork and caseload sharing. For this reason, the caseload ratio for ACT may seem larger than that of the ICM. Most literature on ACT supports having a ratio of 12:1, while ICM supports a caseload of 10:1. Though the ICM caseload is smaller, it's important to note that each caseload is only manned by one case manager, while the ACT model caseload typically has a team of 4-5 staff. Teams commonly include a clinical team leader, one or more nurses, a psychiatrist, and a substance use specialist.

One particular study compared experts' perspectives on the ACT and ICM models; where they saw similarities, differences, and why those mattered. Differences in importance ratings were greatest for organizational and structural elements and treatment goals. ACT rated the importance much higher than ICM for increasing client functioning, providing assistance in obtaining benefits, not having time-limited services, having specific admission criteria, and focusing on clients with severe and persistent mental illness (Schaedle et. al. 2002).

ACT has been adapted for various populations, for example, Forensic ACT (ForACT) which tailors the intervention to individuals are or have been involved in the criminal justice system. Other adaptations include ACT for homeless individuals, resource group ACT, which includes consumers and their significant others as part of the ACT team, and family-aided ACT.

Outcomes & Tools:

Identifying specific and definitive outcome effects for both ACT and ICM has been difficult, partly due to the varying means of implementation and lack of standardizations. Many instruments have been designed to assess fidelity to the model and the effectiveness of the implementations. Some of these include the Critical Components Assertive Community Treatment interview (CCACTI) (McGrew & Bond, 1994; McGrew et al., 1995; SAMHSA, 2017), the Dartmouth ACT (DACT) Fidelity Scale (Teague, Drake, & Anderson, 1995; Teague et al., 1998), and the Tool for Measurement of Assertive Community Treatment (TMACT) (Teague, & Moser, 2011; Moser, Monroe-De Vita, & Teague, 2013).

Common outcomes for case management treatment for substance abuse disorders include change in alcohol and drug use, adherence to treatment, health care use (for example, days of hospitalizations emergency room visits, and detoxification visits) global functioning, employment and education rates, reduction in family, social, and legal problems, and client satisfaction; for individuals involved in the criminal justice systems, outcomes also include recidivism rates such as the number of re-arrests or technical violation arrests, new arrests, and/or length of stay in jail.

While research findings are mixed, more recent discoveries suggest that case management in general, regardless of the specific model, produce some positive outcomes for substance abuse treatment. The most commonly improved outcome is engagement in treatment (Vanderplasschen, 2004, 2011). Out of all the models, however, assertive community treatment and

intensive case management have shown the most promise (Vanderplasschen, 2004). Compared with two other interventions, ICM was associated with an increase in treatment participation and a decline in drug use and criminal involvement among 1,400 arrestees. Moreover, other vulnerable populations, such as homeless individuals and individuals with co-occurring disorders, have shown improved outcomes (Vanderplasschen, 2004).

Conclusion:

Case management practices and implementation widely vary, and there is very little standardization across programs. It has been suggested that some of the negative outcomes can be explained by poor program fidelity and non-robust implementation of case management (SAMHSA, 2012). Additionally, case management does not happen in a vacuum; successful case management depends upon the ability to create linkages to other agencies in a services network, and case management may have more to do with the environment in which it functions than with the functions of the program itself (SAMHSA, 2012).

ACT and ICM were of particular focus in this literature review; they have numerous similarities and a few differences. The biggest difference between the two models is the teamwork and shared caseload component. The consensus across literature is that although intensive case management resembles assertive community treatment in most respects, assertive community treatment might be a more clearly articulated model overall.

It may best be understood by SAMHSA,

“Even in light of the implementation and methodological concerns about case management research, all the studies together with the findings of other addiction research suggest that case management can be an effective enhancement to intervention in and treatment of substance abuse. This is especially true for clients with other disorders, who may not benefit from traditional substance abuse treatments, who require multiple services over extended periods of time, and who face difficulty gaining access to those services,” (SAMHSA, 2012)

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