Case Management: Substance Use Disorder

Overview

Case Management (CM) for patients with substance use disorder (SUD) typically involves interventions to treat the SUD and to access needed social services on a continuous basis throughout recovery. Patients with SUDs often present with complex medical conditions, comorbid psychiatric disorders, and legal issues. Depending on the case setting, four CM models have proven valuable in treating patients with SUD: broker/generalist, strengths-based, assertive community treatment, and clinical/rehabilitation (for more information, see Utilization Management Strategies, below). Licensed social workers (LSW) and registered nurse (RN) case managers often collaborate in SUD cases to optimize outcomes.

In 2013, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) replaced the terms “substance abuse” and “substance dependence” with the phrase “substance-related and addictive disorders.” This category clearly defined addiction to drugs or alcohol as a mental illness. This category is divided into two groups: substance-induced disorders and SUDs, which are categorized as mild, moderate, or severe, depending on the number of confirmed diagnostic criteria met by the patient. A diagnosis of SUD requires evidence of pharmacological use resulting in diminished control, social impairment, and risky use.

The DSM-5 SUDs encompass 10 separate classes of drugs: alcohol, caffeine, cannabis, hallucinogens (with separate categories for phencyclidine and similar agents), inhalants, opioids, sedatives, hypnotics (anxiolytics), stimulants (amphetamine-typesubstances, cocaine and other stimulants), tobacco, and other (or unknown) substances, including the constantly evolving group of synthetic agents (American Psychiatric Association, 2013).

Facts and Figures

› The 2018 United States National Survey on Drug Use and Health (NSDUH) from the Substance Abuse and Mental Health Services Administration (SAMHSA) lists the most common substances leading to SUDs in the United States (excluding caffeine) as alcohol, tobacco, cannabis, stimulants (e.g., most commonly amphetamines, methamphetamine, and cocaine), hallucinogens and inhalants—natural agents such as peyote, psilocybin mushrooms and chemically synthesized agents (e.g., LSD); opioids (e.g., prescription analgesics and opium, morphine, codeine); tranquilizers or sedatives; and benzodiazepines (SAMHSA, 2019).

› In 2017, the most recent year for which data is available, the impact of SUD-related substances ranges from impaired health and social functioning to annual deaths > 480,000 for tobacco-related products in the United States annually, including > 41,000 deaths from second-hand smoke; 88,000 for alcohol-related SUDs, and > 47,000 due to prescription opioid overdose (CDC, 2019 June; CDC, 2019, February).

› In 2014, the most currently available evidence, 20.2 million adults in the U.S. were diagnosed with an SUD and 7.9 million had an SUD disorder and another mental illness. The comorbidity of an SUD and a second mental illness increases the difficulty treatment (National Institutes of Mental Health, 2016)
Utilization Management Strategies

CM models are differentiated by the intensity of services provided

› Broker/generalist focuses on identifying patient needs and assisting them to access resources. This model works best in situations where the need for monitoring and advocacy is minimal due to well-integrated treatment and social services and for patients who have adequate resources and motivation. It is not appropriate for patients in the later stages of addiction

› Strengths-based is a two-pronged approach, which requires the CM to assess and support the client’s ability to secure resources and to provide patients with the necessary support to assert direct control over obtaining and utilizing resources. This client-driven model rejects the widespread belief that patients with SUDs are in denial or are morally deficient and thus unable or unwilling to act proactively on their own behalf. The strengths-based model can create stress between the patient and members of the treatment team if the patient’s goals/behavior diverge from the established treatment/program plan

› Assertive community treatment (also known as wraparound or the Program of Assertive Community Treatment [PACT]), deviates from the more typical approaches by acknowledging the patient has a chronic SUD problem and requires patient improvement only, not a commitment to permanent abstinence. The CM goals are to assist patients with a chronic SUD to develop the necessary skills to function effectively within the community

› Clinical/rehabilitation. This model combines counseling and resource acquisition and has been widely used for patients with both SUD and psychiatric issues

Case Management Interventions

CM competencies necessary to implement successful interventions with SUD patients include the following:

› Engage with high-risk, high-need patients to offer specific on-site assistance (i.e., immediately linking the patient to resources), not just a “warm hand off” (i.e., providing a list of resource telephone number or websites) by embedding the case managers and counselors in emergency departments (EDs)

› Simplify contacts by consolidating referrals from multiple sources/agencies (e.g., one-pharmacy policy; focus on primary care provider [PCP] visits versus ED)

› Support patient-driven needs (i.e., emphasize the patient’s right of self-determination and allow the patient to determine which resources are needed—case managers can identify options and assist in accessing services)

› Advocate for patient with agencies, legal systems, families, clinicians, and insurance/health maintenance options. Advocacy can range from educating families about the patient’s specific needs to negotiating for a patient’s rights

› Maintain community-based contacts to be able to optimize resources. Discuss options that integrate formal and informal resources (e.g., family, friends, self-help groups, church/social associations/community systems)

› Respond to the “patient where he/she is” by meeting pragmatic needs (e.g., food, shelter, clothing, childcare, transportation). This type of intervention also serves to model day-to-day living skills for the patient

› Monitor adherence to treatment program and coordinate care with providers

› Anticipate and respond to behavioral, social, and physical problems common to the natural course of addiction and recovery

› Maintain flexibility with changing circumstances, resources, and patient needs

› Understand diverse cultures and adapt relevant cultural values into clinical practice

Resources for CM:

› SAMHSA; https://www.integration.samhsa.gov/; 1-202-684-7457

› National Alliance on Mental Illness (NAMI); https://www.nami.org/; 1-800-950-6264

› Alcoholics Anonymous (AA); https://www.aa.org/

› Narcotics Anonymous (NA); https://www.na.org/

Psychosocial and Economic Issues

› Approximately 40–50% of patients with SUDs have been diagnosed with a psychiatric disorder or report symptoms of a psychiatric disorder

› SUD impacts all socioeconomic groups; however, patients who struggle with poverty, disease, and unemployment and overrepresented in this patient population. Many are eligible for publicly supported benefits such as Medicare/Medicaid, food stamps, and other health and social programs. In many jurisdictions, more than 50% of patients in SUD treatment are under some form of mandate by the criminal justice system

Outcomes Evaluation

Evaluating outcomes depends on the objectives of the treatment or program and the specific CM model used. Due to the frequently overlapping nature of multiple and complex needs/problems in this patient population, it can be difficult to separate
the success of substance abuse treatment activities from the impact of CM services, but generally the following objectives are measured (depending on the CM model used): diminished substance use, improved social/family functioning, improved psychological variables, and fewer contacts with the criminal justice system.

A three-level meta-analysis of the efficacy of CM with patients who have an SUD revealed that use of any of the first three CM models described above in Utilization Management Strategies were more effective than standard-of-care without CM intervention. In addition, use of the 3 models demonstrated a significant difference in improving task outcomes (e.g., linking with and staying in treatment, treatment satisfaction, and involvement in ancillary services); however, they were less effective in improving personal functioning outcomes (e.g., improving individual functioning in problem areas of substance abuse and decreased HIV-risk behaviors) (Rapp et al., 2014)

Adapting the “Cascade of Care” model used successfully in the HIV/AIDS field that uses intensive CM with patient navigators has been suggested for treating SUDs. (Williams, Nunes, & Olfson, 2017)

Food for Thought

Community-based case management (CBCM) is an evidence-based CM model that seeks care and referral resources within the patient’s community instead of from an acute care facility. Despite its apparent value for managing discrete episodes of care and monitoring relapses, the authors of the systematic review of the CBCM model recommend longitudinal studies before CBCM is adopted as a widespread care coordination strategy (Joo et al., 2015)

Red Flags

› SUD in older patients, especially involving withdrawal from alcohol use, can cause behavioral changes that can be mistaken for dementia

What Do I Need to Tell the Patient/Patient’s Family?

› Educate about the risks and potential complications of SUD and the importance of identifying motives for change; be supportive of all efforts to improve adherence to treatment and program goals, no matter how small
› Educate that relapse is common and that having a support network of friends, family, and individuals who have recovered from SUD (e.g., participants in AA/NA) can assist with recovery

References