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CASE MANAGEMENT BEST PRACTICES

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MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH

Table of Contents

I. INTRODUCTION

The purpose of this report is to review and identify the most recent advances in services and research on variations in case management in mental health practice. This report is filed in accordance with a legislative directive included in the Fiscal Year 2026 Appropriations Act (Chapter 9 of the Acts of 2025), line-item 5011-0100, which requires the Department of Mental Health (DMH) "…not less than 90 days prior to a change in the case management delivery model, the department of mental health shall submit a report and a catalogue of best practices for publicly-operated case management services to the house and senate committees on ways and means, the joint committee on health care financing and the joint committee on mental health, substance use and recovery."

DMH's current case management delivery model has been in existence for several decades. During this time, the field of behavioral health has advanced tremendously with greater focus on research and the development of evidence-based treatments and interventions. Case management is a valued and important DMH service, as further highlighted within this report, and DMH is adjusting its case management delivery model to align with current evidence on best practice, that address the unique challenges of individuals who often present with comorbidity and social determinants of health. This evidence supports DMH's plan to adjust its case management to a more flexible, critical needs approach to improve health outcomes for the individuals and families DMH serves. The model is designed to facilitate greater engagement with individuals and families at critical transitions in care and at times when individuals need support the most.

This report includes a summary description of case management services, including traditional case management, other best practice service delivery models, and case management models utilized at DMH.

II. CASE MANAGEMENT OVERVIEW

Case management has emerged as an intervention designed to support individuals and their families, particularly those navigating complex health and service needs, in obtaining rapid, easy access to healthcare and to other resources and supports from difficult to navigate and often fragmented systems of medical and psychosocial services.

The Case Management Society of America defines Case Management as "the collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs."[1]

Case management is intended to improve health outcomes, optimize use of available resources based on individual needs, and reduce use of high-cost services through timely access to effective support and services.

[1] Case Management Society of America . What is a case manager? https://www.cmsa.org/who-we-are/what-is-a-case-manager/. Published 2017.

Purpose of Case Management:

- **To improve client outcomes:**
  By ensuring access to appropriate services, case management can help individuals improve their mental health, develop skills, and achieve their goals.
- **To reduce hospitalizations:**
  By providing support in the community, case management can help prevent unnecessary hospitalizations and support individuals' recovery.
- **To improve quality of life:**
  By addressing the client's overall needs, case management can help individuals lead more fulfilling and independent lives.
- **To enhance recovery:**
  By providing the necessary support, resources, and tools, case management aims to assist individuals in their recovery from mental health challenges.
- **To promote social reintegration:**
  By helping individuals access resources and build skills, case management can support their reintegration into the community.

Basic components of Case Management (see Appendix A for more information)

1. Intake (engagement)
2. Assessment of needs
3. Care planning along with goal setting,
4. Plan implementation (linkage to services)
5. Monitoring and Evaluation
6. Client advocacy

May also include

1. Crisis intervention,
2. Discharge planning,
3. Direct services such as emotional support, client education, and skill building.[2]

III. PRIMARY MODELS OF CASE MANAGEMENT

As Case Management has been deployed across care settings to meet the needs of diverse populations, variations have emerged with regard to the scope of services provided (stand-alone case vs team-based clinical; short-term vs extended), the intensity (e.g. daily, weekly), and duration (e.g. one month, multiple months, multiple years)

1. **Standard Case Management (SCM)**
   Traditional psychiatric case management, also known as brokerage case management, focuses on assessing needs, making referrals to appropriate services, and coordinating and monitoring ongoing treatment. It involves linking clients to necessary resources, developing care plans, and ensuring effective support.

2. **Critical Time Intervention**
   Critical Time Intervention (CTI) is a time-limited, intensive case management approach focused on supporting individuals with serious mental illness during critical transitions. It

[2] De Vet R, Van Luijtelaar MJA, Brilleslijper-Kater SN, Vanderplasschen W, Beijersbergen M, Wolf J. Effectiveness of case management for homeless persons: A systematic review. *Am J Public Health*. 2013;103(10):e13-e26.

aims to prevent homelessness and other negative outcomes by providing targeted support and connecting individuals to needed services and resources. CTI is often used for individuals transitioning from inpatient psychiatric settings, correctional facilities, highly structured residential care to independent living, or from homelessness to housing. CTI approaches includes drop-in or open access options.

3. **Intensive Case Management (see DMH ACCS services and/or MassHealth BHCP)**
   Intensive Case Management (ICM) consists of management of the mental health problem and the rehabilitation and social support needs of the person concerned, over an indefinite period of time, by a team of people who have a small group of clients (fewer than 20). ICM aims to help people with severe mental illness acquire material resources (such as food, shelter, clothing, and medical care) and to improve their psychosocial functioning; to provide sufficient support to help the individual to be engaged in community life and to encourage growth towards greater autonomy; to develop coping skills to meet the demands of community life; and to ensure continuity of care among treatment agencies. People are seen 1-3 times per week over an indefinite period of time; and the range of services are provided through a collaborative approach with other community providers rather than through the one team. Twenty-four-hour help is offered, and clients are seen in a non-clinical setting.

4. **Assertive Community Treatment (PACT, PACT-Y)**
   Assertive Community Treatment (ACT) is an intensive, community-based service delivery model for individuals with serious mental illness who have difficulty engaging in traditional outpatient treatment. It involves a multidisciplinary team providing comprehensive, individualized, and integrated psychiatric treatment, rehabilitation, and support services in the community (see Appendix B for more information).

Evidence for Positive Impact of Case Management:
The extent of the outcomes varies across different studies and models of case management, depending on individual program design/factors.

1. **Case management** in Primary Care for frequent users of health care services was associated with improvement in:
   1. self-management skills,
   2. care plan adherence,
   3. satisfaction,
   4. self-reported health status,
   5. perceived quality of life.[3]

2. **Case management** for individuals experiencing homelessness is associated with:
   - increased housing stability,
   - increased engagement in medical and non- medical services,

[3] Hudon C, Chouinard MC, Aubrey-Bassler K, Muhajarine N, Burge F, Bush PL, Danish A, Ramsden VR, Légaré F, Guénette L, Morin P, Lambert M, Fick F, Cleary O, Sabourin V, Warren M, Pluye P. Case Management in Primary Care for Frequent Users of Health Care Services: A Realist Synthesis. Ann Fam Med. 2020 May;18(3):218-226. [PMC free article: PMC7213991] [PubMed: 32393557]

- improved mental health status,
- improved quality of life,
- reduced use of drug and alcohol,
- reduced use of high-cost health system services.[4]

3. Individuals receiving **Intensive Case Management (ICM)** experienced reductions in
    - substance use over 12 months,
    - psychiatric symptoms over 12 months,
    - number of days homeless,
    - emergency department (ED) visits,
    - length of hospitalization.[5]

4. For frequent ED users experiencing homelessness, **Critical Time Intervention (CTI)** was successful in reducing:
    - acute care admissions,
    - ED visits,
    - length of hospitalization.[6]

5. Team based **drop-in case management** was associated with
    - Reduction in ED visits for individuals with complex behavioral health and medical needs,[7]
    - Reduced levels of psychological distress and substance abuse and improved social situation for street children and youth,[8]
    - Greater ease accessing emergency shelter when needed, attainment of permanent supportive housing, and GED completion.[9]

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[4] De Vet R, Van Luijtelaar MJA, Brilleslijper-Kater SN, Vanderplasschen W, Beijersbergen M, Wolf J. Effectiveness of case management for homeless persons: A systematic review. *Am J Public Health*. 2013;103(10):e13-e26.

[5] Gordon RJ, Rosenheck RA, Zweig RA, Harpaz-Rotem I. Health and social adjustment of homeless older adults with a mental illness. *Psychiatr Serv*. 2012; 63:561-568.

Subria B. Intensive CM cuts ED visits, hospitalizations. *Hosp Case Manag*. 2012; 20(10):153-154.

Van Draanen J, Corneau S, Henderson T, Quastel A, Griller R, Stergiopoulos V. Reducing services and substance use among frequent service users: a brief report from the Toronto Community Addictions Team. *Subst Use Misuse*. 2013;48:532-538.

[6] Subria B. Intensive CM cuts ED visits, hospitalizations. *Hosp Case Manag*. 2012; 20(10):153-154.

[7] Patch, S. Reducing Utilization by Uninsured Frequent Users of the Emergency Department: Combining Case Management and Drop-in Group Medical Appointments. J Am Board Fam Med 2012;25:184 –191.

[8] Guo, X., & Slesnick, N. (2017). Reductions in Hard Drug Use Among Homeless Youth Receiving a Strength-Based Outreach Intervention: Comparing the Long-Term Effects of Shelter Linkage Versus Drop-in Center Linkage. Substance Use & Misuse, 52(7), 905–915.

[9] Foldes, S.S, Long, K.H., Piescher, K., Warburton, K., Hong, S., & Alesci, N.L. (2021). *Does a*

Key Features of CTI:

- **Time-limited:**
  CTI interventions are typically focused on a specific time period, often 3-9 months, with a clear plan for transitioning to ongoing supports.
- **Intensive:**
  CTI involves frequent contact and support, including home visits and collaboration with other professionals and support networks.
- **Focused:**
  CTI prioritizes addressing the most critical needs related to the transition, such as housing, employment, and access to mental health services.
- **Community-based:**
  CTI emphasizes connecting individuals to community resources and building their support network, including family, friends, and community organizations.
- **Phased Approach:**
  CTI often uses a phased approach to intervention, with each phase focusing on specific goals and activities.

How CTI Helps Individuals:

- **Stable Housing:**
  Supports individuals in securing and maintaining stable housing, which is a critical factor in their recovery.
- **Access to Services:**
  Helps individuals access and navigate mental health services, primary care, and other support services.
- **Increased Independence:**
  Empowers individuals to develop the skills and resources they need to live independently and manage their own lives.
- **Improved Relationships:**
  Strengthens connections with family, friends, and community organizations, which can be a source of support and encouragement.
- **Reduced Relapse:**
  Through intensive support during critical transitions, CTI can help reduce the risk of relapses and other negative outcomes.

<u>Drop-In Case Management (Open Access)</u>

Drop-in case management, also known as Open Access case management, is a variation of Critical Time Intervention which aims to make support more accessible and responsive to the needs of individuals seeking help. Drop-in case management has emerged in response to challenges hard-to-reach communities (e.g., drug users, people living with HIV, people from sexual minority communities, asylum seekers, refugees, people from ethnocultural communities, and homeless people) face when seeking needed care and support and, as a result, are often alienated from health and social services. Open Access offers vital case management services without formal intake or pre-screening, allowing individuals to access support based on their

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drop-in and case management model improve outcomes for young adults experiencing homelessness: A case study of YouthLink (White Paper). Center for Advanced Studies in Child Welfare, University of Minnesota.

immediate needs. It focuses on building connections, offering assistance, and ensuring individuals have access to necessary resources without the need for extensive paperwork or lengthy wait times.

Key Features of Drop-In Case Management:

- **Open Access**: Individuals can access services without formal intake processes.
- **Immediate Support**: Services are readily available to address immediate needs.
- **Flexibility**: Focuses on adapting to the individual's needs and circumstances.
- **Building Connections**: Emphasis on forming strong relationships with individuals and building trust.
- **Resource Navigation**: Helping individuals navigate the complex systems of support and access resources.

Benefits of Drop-In Case Management:

- **Increased Accessibility:** Reduces barriers to accessing services, making support more readily available.
- **Improved Engagement:** Allows individuals to engage with services when they are ready and able.
- **Reduced Wait Times:** Eliminates the need for extended waiting periods for services.
- **Personalized Support:** Allows case managers to tailor services to the individual's specific needs.

How Drop-In Case Management Work

- **Initial Contact:** Individuals can approach a drop-in center or service provider without a formal appointment.
- **Needs Assessment:** A case manager or other staff member assesses the individual's needs and circumstances.
- **Service Provision:** Case managers provide immediate support, connect individuals with resources, and develop a service plan if needed.
- **Ongoing Support:** Case managers offer ongoing support and guidance as needed.

Examples of Drop-In Case Management:

- **MA Young Adult Access Centers**
  https://www.speakingofhope.org/access-centers/
- **DotHouse Health, Dorchester MA**
  http://www.dorchesterhouse.org/m/case_management.html
- **The Village, Los Angeles CA**
  http://www.village-isa.org/

Case Management is both a core service for Massachusetts Department of Mental Health and is a critical component of Massachusetts behavioral health community services, some of which are directly overseen by DMH. People seeking DMH services typically experience challenges in addition to their severe mental illness because of factors like poverty, food insecurity, housing insecurity, systemic stigma and complexity of their condition. DMH service users often require dedicated or team-based case management to collaborate and coordinate with many other care providers and supports, to address needs including personal care, housekeeping, rent supplements/subsidies, assistance with food, and more. DMH Case Management services are long standing and well-established. Consistent with the DMH mission to facilitate access and reduce barriers to services, DMH

continuously engages in a continuous quality improvement process and over time DMH has implemented the full continuum of Case Management models across child, youth and family services.

The Table below identifies the DMH services that provide case management functions by model type and DMH's planned changes

Table 1. DMH Services by Case Management Model Type

Model of Case Management	**DMH Service**	**Description of Current Practice**	**Planned Model Changes**
Standard Case Management	DMH Case Management	Standard delivery model for current clients enrolled in case management	Continue with standard CM for those individuals determined to need case management for longer than 6 months.
Critical Time Intervention	DMH Case Management Young Adult Access Centers	DMH offers Critical Need Case Management (Critical Needs) for individuals seeking DMH services to address urgent needs pending DMH authorization and enrollment in services. (104 CMR 29.05). Critical Needs supports individuals through the transition to engagement with DMH services. Case management scheduling provides for at least one case manager at the Site office during business hours to respond to walk-ins and calls. Youth Adult Access Centers provide a community space that allow young adults with mental health concerns to access services and supports and are available to all young adults.	Utilize Critical Need CM to provide timely, intensive, solution-focused case management for 3-6 months with transition to other DMH services, other behavioral health services, health plan or provider-based care coordination (BH CP, One Care, etc) or standard case management Formalize and expand DMH's use of Site office and community based Open Access available to all DMH clients and serve as front-door to DMH for individuals not previous served Continue Young Adult Access Centers

Intensive Case Management	Adult Community Clinical Services (ACCS) and Mass Health Behavioral Health Community Partner (BH CP) program	ACCS provides a team-based model that provides rehabilitation, clinical intervention and supports to facilitate engagement, support functioning, maximize symptom stabilization and self-management, and promote community tenure. BH CP provides care coordination and supports to MassHealth members with significant behavioral health needs within a care team model. Individual receiving ACCS are offered BH CP.	No change
Assertive Community Treatment	Program for Assertive Community Treatment (PACT) and PACT-Y (youth)	PACT programs utilize a multidisciplinary team approach providing acute and long term support, community based psychiatric treatment, assertive outreach, and rehabilitation services consistent with the SAMHSA evidence-based model.	No change

APPENDIX A

6 Key Elements of all Case Management models:

1. **Intake (engagement)**

2. **Needs assessments** are crucial for understanding a client's unique challenges and goals, and for developing a tailored plan of care. They involve gathering information to identify the gaps between the client's current situation and their desired outcomes, often focusing on areas like mental health, housing, employment, and social support.

   Purpose:
   Needs assessments help case managers identify specific areas where clients need assistance, understand the reasons for those needs, and develop a plan to address them.

   Focus Areas:
   In psychiatric case management, needs assessments typically cover a wide range of areas, including:
   - **Mental Health:** This includes identifying the severity, type, and specific symptoms of a client's mental health condition, as well as their access to and satisfaction with mental health services.
   - **Housing:** Assessing the client's living situation, including the stability and safety of their housing, and identifying needs related to housing supports like finding affordable housing or accessing transitional housing.
   - **Employment:** Evaluating the client's employment history, skills, and training needs, and identifying resources to help them find and maintain employment.
   - **Social Support:** Assessing the client's social network, support systems, and the availability of informal support, as well as identifying the need for formal support services like therapy or peer support groups.
   - **Other Needs:** Needs assessments may also address other critical areas like financial needs, transportation, education, legal issues, and substance use.

   Methods:
   Various methods can be used to conduct needs assessments, including:
   - **Direct Interviews:** Talking to the client directly to gather information about their experiences, challenges, and goals.
   - **Client Records:** Reviewing existing client records, such as medical records, court documents, or previous case management reports.
   - **Referrals:** Gathering information from other professionals or agencies that have worked with the client.
   - **Surveys:** Administering standardized questionnaires to assess specific areas of need.
   - **Assessments:** Using standardized tools to assess the client's mental health status or other relevant areas.

Impact on Case Management:
A comprehensive needs assessment forms the foundation for developing a personalized and effective case management plan. It helps case managers:

- **Set Realistic Goals:** By understanding the client's specific needs and resources, case managers can help them set realistic and achievable goals.
- **Develop a Tailored Plan:** The needs assessment informs the development of a case management plan that addresses the client's unique needs and challenges.
- **Access Appropriate Resources:** Case managers can identify and connect clients with the appropriate resources and services to meet their needs.
- **Monitor Progress and Evaluate Outcomes:** Needs assessments can be used as a baseline to track progress and evaluate the effectiveness of the case management plan.

3. **Care planning along with goal setting:**
   Developing a personalized plan that outlines the services and supports needed to meet the client's goals.

4. **Plan implementation (linkage to services):**
   Connecting clients with appropriate resources, such as therapists, psychiatrists, support groups, and community services.

5. **Monitoring and Evaluation**
   Regularly tracking progress, adjusting the care plan as needed, and ensuring the client is receiving effective support.

6. **Client advocacy**
   Client advocacy is an integral element of a case manager's practice and is considered a critical function. Case managers, for example, assist clients in gaining access to necessary health care services, speak for themselves and own their voice, advocate for their rights, participate in making decisions about their care options, gain awareness of their health insurance benefits, and become empowered as owners of their health status and well-being.

APPENDIX B

Assertive Community Treatment Case Management

Assertive Community Treatment (ACT) is an intensive, community-based service delivery model for individuals with serious mental illness who have difficulty engaging in traditional outpatient treatment. It involves a multidisciplinary team providing comprehensive, individualized, and integrated psychiatric treatment, rehabilitation, and support services in the community.

Key Features of Assertive Community Treatment:

1. **Intensive and Assertive:**
   ACT teams are proactive in their outreach and engagement, actively working with individuals in their homes and communities.
2. **Multidisciplinary:**
   Teams typically include psychiatrists, nurses, social workers, case managers, and other professionals with expertise in mental health, substance use, and other related areas.
3. **Community-Based:**
   Services are delivered in the community rather than in a traditional hospital or clinic setting, allowing individuals to maintain their independence and integrate into their lives.
4. **Holistic and Individualized:**
   ACT services address a wide range of needs, including mental health treatment, housing, financial assistance, vocational support, and social integration.
5. **Focus on Recovery:**
   ACT emphasizes a person-centered, recovery-based approach, aiming to help individuals regain control over their lives and achieve their personal goals.

How Assertive Community Treatment Works:

1. **Assessment and Planning:**
   Individuals are assessed to determine their needs and goals, and a treatment plan is developed that is tailored to their individual circumstances.
2. **Service Delivery:**
   The ACT team provides a range of services, including medication management, counseling, crisis intervention, and support for housing, employment, and social activities.
3. **Follow-Up and Monitoring:**
   ACT teams actively monitor individuals' progress and provide ongoing support, ensuring that they remain engaged in treatment and maintain their stability.
4. **Collaboration and Communication:**
   ACT teams work closely with other professionals, such as primary care physicians, social workers, and vocational rehabilitation counselors, to provide a coordinated and comprehensive approach to care.

Benefits of Assertive Community Treatment:

1. **Reduced Hospitalization Rates:**
   ACT has been shown to reduce the need for psychiatric hospitalization by providing intensive, community-based support.

2. **Improved Quality of Life:**
   ACT can help individuals with serious mental illness improve their functioning in various areas of life, including housing, employment, and social relationships.
3. **Increased Engagement in Treatment:**
   ACT's assertive outreach and personalized approach can help individuals who struggle to engage in traditional outpatient treatment remain connected to services.
4. **Reduced Stigma and Isolation:**
   ACT's community-based approach helps individuals feel less stigmatized and isolated, promoting their sense of belonging and well-being.

Who is Assertive Community Treatment for?

ACT is typically offered to individuals with serious mental illness who have a history of frequent hospitalizations, difficulties engaging in traditional treatment, and high service needs. It can also be a beneficial option for individuals who are at risk of hospitalization, those who have recently been discharged from an inpatient setting, or those who are struggling to maintain their independence in the community.