



National Association of
Case Management

Bettering the profession and those who champion it

**CASE MANAGEMENT
PRACTICE STANDARDS**

**National Association of Case Management
590 Terry Reiley Way
Pottsville, PA 17901**

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OVERVIEW

This document outlines the broad assumptions/premises, concepts, and principles/values which serve as the foundation for the practice of Case Management (CM) in a variety of settings and with multiple names that apply to case management. Case Management is the comprehensive term used. These ideas and ideals are actualized in the practice of case management when applied in conjunction with the implementation of fundamental functions, critical elements, and integrative qualities within a structured service delivery process for persons served by case management. More specifically, this document delineates standards for the practice of Case Management by trained, professional Case Managers.

Section I: Purpose of Case Management

Section II: Definition of Case Management

Section III: Persons Served by Case Management

Section IV: Practice Principles of Case Management

Section V: Fundamental Functions of Case Management

Section VI: Critical Elements

Section VII: Service Delivery Process

Section VIII: Integrative Qualities

I. PURPOSE of CASE MANAGEMENT

The purpose of case management is to:

- 1) Provide assistance and hope to individuals, their families, other supports, and networks as defined by the individual.
- 2) Recognize the rights of individuals to professional and effective case management services.
- 3) Effectively and efficiently use services to promote wellness-based outcomes, identify strengths and abilities, needs, preferences, and goals within the process of service delivery.
- 4) Support individuals toward maximizing the quality of life and achieving the most interdependent and fulfilling lives possible within their communities.

This is achieved through the implementation of the NACM Practice Standards and the professional Case Manager's adherence to ethical practice and professional conduct pursuant to the NACM Code of Ethics.

II. DEFINITION of CASE MANAGEMENT

NACM defines Case Management as *a helping approach implemented by trained professionals for the delivery of human services in the realm of health and wellness*. The focus of this approach is to engage with individuals served and their support systems by using their collective strengths to address their unique needs. The ultimate aim is to help persons served realize their goals for personal fulfillment and social involvement. This is the inclusive and broad-spectrum definition that is used as a basis of the NACM Case Management Practice Standards for the profession of Case Management.

Historically, the term Case Management (CM) has been used in referring to various actions such as linkage and coordination activities. Other functions, with increasing responsibilities, have been added as CM models evolved. The development of helpful relationships and crisis prevention and intervention, resource management, sourcing supports, and coordinating integrated care are now widely accepted CM functions, as are symptom management and skills development in the more intensive CM approaches. More recently, the term CM has been used to refer to a specific service and, ultimately, a profession. For the purpose of these standards, a contemporary definition is presented which builds on early descriptions of CM in terms of functions, but also incorporates some of the most important and recently-evolved principles within the context of a service delivery process.

The process of case management can be implemented in a variety of ways in addition to the exclusive use of the methods, process, and purpose of case management being applied by trained professionals in offering a specific service/activity as circumscribed by their role and function on behalf of persons served. More specifically, case management methods and process can also be used in a partial (abridged) manner or in their totality as one of a variety of concurrent methods and processes by other professions and professionals (e.g., nursing, social work, counseling, medicine, etc.). For example, a nurse can incorporate the case management process as part of providing care coordination in a diabetes management program by referring the patient to a local clinic while a psychiatric nurse is providing group and individual therapy (therapeutic method/skill) for a patient. A social worker who is following a discharged patient from physical rehabilitation and working with the patient to acquire accessible housing (case management assessment, goal setting, brokering service, and monitoring and evaluating/terminating activity) can also work on depression reduction (therapeutic method) with the client. The above professionals may or may not identify themselves as case managers. They both, however, use a case management method and process for executing part of their work.

The term Case Manager continues to be an internationally accepted title to identify individuals who engage in the role or function of facilitating the case management process. In the United States, Canada, Australia, New Zealand, and elsewhere the position or job title of an individual providing the role of case management will differ between companies or agencies. NACM identifies a professional Case Manager by their role and function and not solely by their title.

III. PERSONS SERVED by CASE MANAGEMENT

Given that case management is provided by individuals employed in case management roles within academia, health, integrated care, education, research, insurance, welfare, criminal justice, social and human service settings, private practice, and regulatory, accreditation, and payer entities, there is a need for consistency and clarity in articulating a description of persons served by case management.

Persons served by case management may include any individual across their lifespan. It addresses their needs, conditions, concerns, symptoms, and desired human services in the realm of health and wellness.

IV. PRACTICE PRINCIPLES of CASE MANAGEMENT

The principles associated with CM are as important as the definition and functions. More specifically, professional CM services should be:

- 1) Accountable
- 2) Consistent with restoring, maintaining, and enhancing well-being
- 3) Committed to Diversity, Equity, and Inclusion
- 4) Effective in accomplishing outcomes
- 5) Empowering
- 6) Flexible
- 7) Responsive
- 8) Individualized as based on self-determination and choice
- 9) Informational
- 10) Trauma-informed
- 11) Network-inclusive
- 12) Provided to minimize risk of harm
- 13) Strength-based

V. FUNDAMENTAL FUNCTIONS of CASE MANAGEMENT

The fundamental functions of professional CM include, but are not limited to, the processes of:

- 1) Screening
- 2) Engagement and development of a professional, collaborative relationship
- 3) Establishing and maintaining a trusting relationship
- 4) Assessment based on determining strengths, needs, preferences, and resources
- 5) Outcome-focused service planning and implementation (care coordination)
- 6) Crisis prevention, intervention, and management
- 7) Referral and linkage with chosen services
- 8) Obtaining basic and other supports as necessary and/or helpful
- 9) Monitoring, coordinating, and adjusting service delivery
- 10) Advocacy
- 11) Evaluation

VI. CRITICAL ELEMENTS

The critical elements of CM include:

- 1) Conceptualizing a Holistic, Comprehensive, and Outcome-oriented Assessment
- 2) Providing Individual Choice, Empowerment, and Informed Consent
- 3) Promoting Continuity of Care/Transition Planning
- 4) Exploring and Resolving Ambivalence, Increasing Motivation, and Obtaining Commitment
- 5) Providing Skill Development and Training
- 6) Offering Outreach in Least Restrictive Settings
- 7) Adjusting Frequency/Intensity of Services as Based on Need
- 8) Encouraging Family and Network Support
- 9) Collaborating with Other Service Providers
- 10) Operating within the Relevant Legal Context
- 11) Planning and Implementing Discharge/Closure
- 12) Maintaining Clear, Concise, and Comprehensive Documentation

VII. SERVICE DELIVERY PROCESS

The service delivery process is informed by the fundamental functions and critical elements. These elements serve as the vehicle by which both principles and fundamental functions are operationalized. The articulation of these elements is furthered as these functions and principles are applied in a more concrete and practical manner. This often occurs in the context of conformance to the standards of regulatory, accreditation, and payer entities. Descriptions of these critical elements and fundamental functions are offered below in the context of a structured service delivery process.

This process is comprised of critical elements and fundamental functions which

- are completed across time;
- applied repeatedly within portions of; and
- across the entirety of, the course of an episode of service delivery.

All of the components are:

- necessary and important;
- depend and build upon one another; and
- concur and/or require the recurrence of another component.

The following are the fundamental functions and critical elements of the Service Delivery Process:

1) SCREENING

This fundamental function addresses the need to determine eligibility and appropriateness for services. Specific parameters for eligibility can vary greatly as determined by particular regulations, accrediting bodies, payers, providers of service. Eligibility can be established formally or informally, with or without the use of specific tools.

2) ENGAGEMENT and DEVELOPMENT of a PARTNERSHIP

This component consists of several key functions to establish:

A. Rapport:

Establishing a professional, working relationship which is safe, trusting, and collaborative

B. Mutual Expectations regarding:

1. *Purpose of services*
2. *Nature of services*
3. *Roles/Boundaries of/between all persons involved in the delivery of services*
4. *Expected Outcomes*

3) ASSESSMENT, CONCEPTUALIZATION, and SERVICE PLANNING

A. Assumptions

Service planning is most effective when completed in a holistic, comprehensive, and outcome-oriented manner. This approach incorporates the following key elements:

Individualization

- i) Is directed at assisting the individual to achieve regular progress towards self-determined wellness-based goals.
- ii) Addresses the individual's/family's history and current life situation in a manner which is future- and goal-oriented, avoids blame, and works from strengths toward improved self-sufficiency and independence.

Regular Progress Review and Service Plan Update

- i) Is completed by the individual and Case Manager, and includes significant others and other service providers as necessary and beneficial
- ii) Is updated based on experiences or changes in terms of progress, needs, and preferences and when indicated according to policy and regulation

B. Assessment

1. *Begins by collecting data from the individual and network as relative to issues identified in the referral and the domains of biopsychosocial information ~~as described below~~*
2. *Considers biopsychosocial history, data, or evaluation obtained through sources other than the individual, including standardized assessment tools when useful*
3. *Addresses issues identified in the referral and screening*
4. *Is thorough, complete, and ongoing*
5. *Is Holistic – addresses the following individual domains, as well as their interactive effects on the individual's/family's life, and could include but not be limited to:*

Basic needs, including living/housing situation, activities of daily living and mobility

Family and natural supports

Crisis/safety (risk of harm) relative to self and others

Behavioral health, including trauma

Intellectual or other neuro-developmental issues

Physical health, including medical issues and medications

Alcohol and other drug use

Social, recreational, leisure

Financial, Insurance

Legal, criminal

Educational, vocational

Cultural, spiritual

Other human services system involvement

Level of functioning

6. *Considers Strengths, Needs, and Preferences*

Strengths/Resources – Skills, abilities, and/or useful resources/supports, activities, or services the individual has already established, as identified by the individual/family and/or Case Manager

Needs – A negotiated process to identify deficits, problems, requirements, barriers, and/or resources/supports or skills which are lacking

Preferences – Desired or preferred activities, situations, services, skills, and/or other resources/supports

Maximizing strengths and following preferences is usually more effective and motivating than cataloging deficits and problems. An individualized strengths and preferences assessment that is related to the services a person needs to reach personal goals is likely to be more accurate and helpful than, or a critical supplement to, information gleaned from standardized functional assessments.

C. Synthesis and Case Conceptualization

Considers the bio-psycho-social data in a form which...

Articulates a concise and focused “snapshot” of the individual in their physical and social environment

Is thorough and complete

Addresses and prioritizes primary problems, needs, or desired changes

Addresses and prioritizes primary strengths, abilities, and skills

Addresses and prioritizes other significant requirements, barriers, influences, or issues impacting readiness for, or engagement in, change

Addresses preferences and envisions success toward self-management

Describes cautions and risks

D. Outcome-Focused Service Planning

Goals/Outcomes are:

Concrete, measurable outcome statements

Based on the results of the assessment

Based on the stated desires of the individual, family, and other support network in their own language

Developed through discussion into a concrete, measurable, outcome statement with specific targeted date of completion

Development of Objectives/Activities as:

Concrete and measurable

Specific in terms of timeframes, frequency, and duration

Manageable/achievable for the individual/family served

Effective in facilitating goal/outcome attainment

Crisis Planning – Identifies:

Indicators of an approaching crisis

Factors and activities which reduce problematic behaviors and situations while promoting coping and well-being, including persons and supports to engage in managing the crisis

Factors which exacerbate problematic behaviors/situations

Transition Planning – Identifies:

Indicators of readiness for transition

Transition outcome/goal

Actions, activities, services, and supports needed to ensure a successful transition

Progress toward the plans that support sustainable change

4) COORDINATING, MONITORING, and ADJUSTING SERVICE DELIVERY

In many settings, Case Managers, in their uniquely comprehensive view of the individual and the service system, are expected to accomplish the following:

a) Function as the principal providers of coordination

- b) Ensure that each involved service provider understands that services must produce the positive outcomes identified in the service plan
- c) Coordinates multiple services to ensure the provision of necessary services and continuity of care while avoiding duplication of services
- d) Ensures that services are effective and satisfactory for the individual
- e) Ensures that services are provided in the least restrictive setting

In order for services to be effective, two (2) conditions must be met:

- a) CM services must be appropriate for the individual/family
- b) The individual's/family's utilization of (CM) services must be appropriate

The actualization of these conditions is evidenced by the individual showing progress, or at least maintaining stabilization, in the community. If these conditions are not being met, adjustments must be made to help the individual engage more effectively or to more effectively engage significant others.

An effective service delivery system requires that the Case Manager is in partnership with the individual and central within the system of providers. The Case Manager's ability to professionally fulfill the duties of this role requires a comprehensive array of skills and knowledge, including, but not limited to, the following:

- a) Knowledge of other involved providers and services
- b) Knowledge of laws, regulations, and standards as outlined by applicable accreditation mandates and payers
- c) Ability to communicate with providers - knowing the terminology required of the involved professions and providers
- d) Ability to conceptualize and articulate the individual's situation
- e) Ability to facilitate meetings with individuals, networks, and providers
- f) Ability to implement the interventions described in the service plan

5) CONTINUITY, TRANSITION PLANNING, AND TERMINATION

Case Management links all services and supports. This element of case management applies in occasions of transition, including at the point of completion of case management services, as well as other transitions in the individual's life.

Transitions between services and service providers must:

- a) Be carefully managed, as individuals are more likely to be at risk when in transition

- b) Involve individuals in the development of all transition plans as described above
- c) Provide outreach to, and follow-up with, individuals to ensure that basic supports and the service linkage function are maintained during transitions
- d) Consider individual desires and choices when possible
- e) Ensure to the extent possible that the individual's functioning, personal resources, supports, and psycho-social stressors are as stable as possible prior to a transition, including termination of services
- f) Whenever possible, provide an overlap period where the current Case Manager or Case Management team is available to the individual during the transition period.

VIII. INTEGRATIVE QUALITIES

The integrative qualities described below infuse, facilitate, and guide the service delivery process.

CRISIS PREVENTION, INTERVENTION, and MANAGEMENT

This fundamental function is more comprehensive than the immediate interventions implemented at a time of acute crisis (e.g., high risk of harm). It is addressed in, and accomplished through, the process of assessment, conceptualization, and service/crisis/transition planning (as described above). It is facilitated by meeting basic needs, completing plan-based interventions, appropriately and effectively utilizing services and supports, and skill-building.

MANAGING RISK

Safety is of paramount importance to all persons involved in the individual's life. As with Crisis Prevention, Intervention, and Management, this fundamental function of identifying, assessing, and managing risk is accomplished through other functions, including screening, assessment, and service planning and implementation.

EXPLORING and RESOLVING AMBIVALENCE, INCREASING MOTIVATION, and OBTAINING COMMITMENT

The Case Manager helps the individual to be ready, willing, and able to implement the service plan and actualize change:

- a) Ready: the issue is considered by the individual to be a *priority*
- b) Willing: the issue is *important* to the individual, who wants/desires the change/outcome or considers it to be useful
- c) Able: the individual has *confidence* to execute the task (self-efficacy)

The Case Manager employs various strategies in doing so, including, but not limited to:

- a) Increasing Self-Efficacy
- b) Exploring Discrepancy
- c) Discussing "Hypothetical Change"
- d) Increasing "Change Talk" and Decreasing "Sustain Talk"

The result of these efforts is evident in the individual being motivated and committed to change.

SERVICE REFERRAL and LINKAGE

Referral and linkage to services is completed according to the goals and objectives identified in the service plan. Completing a linkage or referral may serve as an activity

toward an outcome - a means towards an end. Case Managers evaluate appropriateness and effectiveness of referrals and resources.

OBTAINING BASIC and OTHER SUPPORTS

In order for an individual to engage in service planning and for services to be effective, basic needs must be identified and met in terms of securing related supports. Basic needs, e.g. safety, housing, and food, must be addressed and related supports must be established before less immediate needs, such as socialization, can effectively be addressed.

CHOICE, EMPOWERMENT, and INFORMED CONSENT

Individuals have ownership of and responsibility for their lives. Empowering individuals and following the directions chosen by the individual result in a higher degree of motivation and participation in services which result in positive outcomes. Supporting the individual in making decisions and in developing skills in decision-making can be empowering and is essential as a critical element in case management practice. Moreover, assisting the individual in accessing the information which is helpful in making informed decisions/choices is an essential part of this process.

SETTING of SERVICES

Case management services are provided in settings or combination of settings which are most effective, accessible, and preferred, as well as least restrictive, for the particular individual/family being served; thereby maximizing the opportunity for outreach, engagement, assessment, intervention, and monitoring. As a result, case management services are provided via a variety of media and settings.

Settings may include, but not be limited to:

Face-to-face

Likely to be the most effective for communication that is information—or emotionally laden, complicated, and/or dense

Virtual

- i. Visual and audio/voice communication via a variety of technologies (e.g., "apps")
- ii. Has become an alternative when face-to-face communication is not possible, readily available, or physically safe
 - Mitigates this issue by enabling visual communication with audio communication
 - Has enabled "telehealth" or "teleservices"
- iii. Likely provides less (as compared to face-to-face) visual data (e.g., width and depth of field of view) and/or emotional connection (e.g. eye contact, "body language")
- iv. Requires the consideration of risk and informed consent, including the use of secure (e.g., encrypted) telephone/internet applications to ensure confidentiality/HIPPA compliance

- b. Telephone
 - i. Audio-/voice-only communication
 - ii. Loses visual data and communication
 - iii. Useful in the continuation or facilitation of face-to-face or virtual contact

c. Written (Electronic)

- i) Includes, but is not limited to, texting and e-mail communication
- ii) Loses sound/voice, including inflection, and, as a result, possibly diminishes affective/emotional communication
- iii) May be less effective and efficient relative to more complex or substantive information which requires more involved "dialogue" or "discussion"
- iv) Useful in brief, informational exchanges
- v) Can be useful in initially engaging individuals (until above media can be utilized)

Settings for face-to-face communication may include, but not be limited to:

- a) Community or Public Spaces: including the individual's residence or other safe ("neutral"), private or public locations
- b) Professional Spaces: including, but not limited to, the office of a provider of case management or other services

Given the variety of options relative to media and settings, it is important to establish expectations/agreements about the medium and setting of communication (meetings) in conversation with the person served/family at the start of services and on an ongoing basis.

It is also important to note that some of these settings, particularly those which are public ("mobile") and face-to-face, can be chaotic and uncomfortable, and, possibly, present safety/risk issues which must be managed by the Case Manager. Related challenges may include individuals:

- a) Experiencing significant bio-psycho-social stressors
- b) Being in crisis
- c) Having multiple and/or unidentified concerns
- d) Being early in the process of seeking/obtaining services
- e) Having a significant history of failed services
- f) Experiencing ambivalence regarding ...
 - i) Need for/benefit of change
 - ii) Need for/benefit of services
 - iii) Purpose/function/role of services
 - iv) "Involuntary" services

FREQUENCY and INTENSITY of SERVICES

In general, case management services are provided at the frequency and intensity (duration of contact) determined by the individual's needs and the Case Manager's judgment. More specific parameters are determined by the particular licensing, accreditation, payer, and provider entities involved.

ADVOCACY

This fundamental function serves to empower the individual by doing the following:

- a) Help the individual to understand their rights
- b) Express and meet individual needs, wants and preferences
- c) Actualize needs, wants and preferences to the individual's satisfaction

Advocacy facilitates the individual's self-determination, interdependence, and wellness-based outcomes. Although the specific techniques and strategies utilized by the Case Manager can vary, all approaches must be implemented in the least restrictive and least invasive manner possible with a view toward the individual being able to actively and independently advocate for themselves. In this way, this function is closely linked with the critical element of Skill Development.

NETWORK SUPPORT

Including, engaging, and providing support to an individual's network is essential in terms of working with the parents of children, adolescents, and with the extended family, significant others, and persons in an individual's network for all ages of individuals receiving services.

COLLABORATION with OTHER SERVICE PROVIDERS

In order to ensure positive outcomes via effective monitoring, coordinating, and adjusting of services, the above skills and knowledge must be applied in the context of strong and effective collaborative working relationships with other service providers. As is the case with monitoring, collaboration with other service providers requires an appreciation and understanding of the dynamics of systems, including both family and provider systems.

Other stakeholders can be both numerous and varied, including, but not being limited to providers of integrated healthcare:

- a) Child protective services
- b) Criminal justice system
- c) Drug and alcohol service providers
- d) Friends and other significant and essential persons
- e) Managed Care Organizations and other payer and insurance entities
- f) Occupational, physical, and speech therapists, teachers, mentors, etc.

- g) Other human services professionals/providers
- h) Psychiatric treatment and other behavioral health providers
- i) Primary and other health care providers
- j) State, county, and other governmental and regulatory entities

EVALUATION

The practice of Case Management requires comprehensive and ongoing evaluation. Elements of this evaluation may include, but are not limited to:

- a) Access to services
- b) Effectiveness of services
- c) Efficiency of services
- d) Individual satisfaction with services
- e) Adherence to NACM Case Management Practice Standards
- f) Adherence to all relevant regulatory and accreditation guidelines

LEGAL CONTEXT

The provision of quality Case Management requires skill and knowledge related to a variety of legal issues, including, but not limited to, confidentiality, HIPAA/HITECH, duty to warn, mandated reporting and any applicable agency, local, state, or federal laws and regulations.

CONCLUSION and CLOSURE

Ideally, closure from Case Management services results from the progress achieved in terms of:

- a) Community integration, independence and self-sufficiency, and well-being, in general
- b) Completion of the goals and desired outcomes identified in the service planning process, in particular
- c) The service recipient's choice as inherent in these processes

Fundamentally, conclusion of Case Management services results from the application of the fundamental functions and critical elements of Case Management practice within the service delivery process, including, but not limited to, service planning, frequency and intensity of services as based on need, and transition planning.

Documentation of the individual's status at the close of the service is vital in terms of continuity, assessment, and planning relative to any future services. The completion of a meaningful and concise closure summary is helpful for this purpose, as well as for the documentation of the individual's achievements and success, in general.

DOCUMENTATION

Accurate and timely documentation is an essential component of the service delivery process. In addition to being an essential component of professional CM practice documentation serves a variety of other purposes, including, but not limited to:

- a) Evidence of service delivery, particularly as related to justification for funding and billing for services
- b) Use in Case Management practice decision-making
- c) Assessment of effectiveness of services, referencing key efforts, case goals, outcomes and unmet needs threatening case stability
- d) Use in litigation

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