



FROM CASE MANAGEMENT TO RESPONSIBLE SELF-MANAGEMENT

Expanding the Role of the Participant in Mental and Behavioral Health

Abstract

Behavioral health systems face an increasing capacity challenge: demand for services continues to grow while the availability of professionals – caseworkers, therapists, and peer specialists – remains constrained.

Many of the activities that consume professional time are not inherently clinical. Setting goals, identifying resources, pursuing employment or education, maintaining routines, and tracking commitments can often be undertaken by individuals themselves – with appropriate support.

This paper draws on research concerning recovery-oriented care, self-management, peer support, collaborative care, and behavioral health service delivery to outline an approach for safely and effectively shifting a greater share of improvement activities from provider case management to participant-directed self-management.

EnVision by Organizational Performance Systems

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Introduction

The paper proposes a three-level, incentive-based model for mental and behavioral health (MH/BH):

1. **Self-directed management**, in which clients independently manage routine goals and activities
2. **Supported self-management**, in which professionals provide coaching, encouragement, and intervention when progress stalls
3. **Professionally managed care**, reserved for clinical assessment, treatment decisions, crises, and circumstances requiring professional judgment

Technology can provide an important enabling layer across all three levels. A participant-centric platform such as EnVision helps individuals establish goals, identify and access resources, plan activities, track commitments and accomplishments, receive reminders and recognition, and signal when additional assistance may be warranted.

For professionals, this creates the potential to move from managing every activity for every client toward concentrating scarce professional capacity on participants and situations that require their expertise.

The objective is not to replace therapists, caseworkers, or other behavioral health professionals. It is to reconsider how their time is deployed – and whether technology can empower more participants to take an active role in managing the nonclinical dimensions of their own recovery.

If even a portion of routine coordination and accountability can safely move from professional management to self-management, behavioral health organizations gain the ability to expand their effective capacity while simultaneously giving participants greater autonomy, ownership, and visibility into their own progress.

Opportunities in the Research

Based upon MH/BH research evidence, providers have a need – and an opportunity – to shift routine management from professionals to their clients. That is, we are not advocating for the replacement of caseworkers and therapists but, instead, for a means to increase their capacity by giving clients the necessary tools to successfully manage their recovery plans and life activities versus managing their clinical conditions.

Given that distinction, EnVision has the potential to off-load a considerable amount of day-to-day activity from providers to participants. The table below is illustrative.

Activity	Potential Level of Participant-Direction
Setting personal goals and priorities	High
Scheduling and completing ordinary activities	High
Finding resources/services	High
Tracking appointments, applications, training, employment, housing tasks, etc.	High
Maintaining routines / wellness activities	Moderate-High
Recognizing problems and deciding when to seek help	Shared
Treatment decisions / medication changes / diagnosis	Low (Professional)
Crisis intervention / relapse requiring clinical intervention	Very low (Professional)

Note that these classifications are illustrative rather than empirical but are presented as *design estimates* and an *underlying direction supported by the research*. The appropriate level of participant direction will vary according to individual circumstances, acuity, capacity, and clinical judgment.

For example, a systematic review of 37 randomized trials involving 5,790 people with severe mental illness found that self-management interventions produced improvements in symptoms, functioning, quality of life, hope, empowerment and self-efficacy. The authors concluded that self-management should be part of the standard package of care.¹



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Another systematic review specifically examining self-management among people with serious mental illness found "promising evidence" that people could either collaborate with professionals or be trained to self-manage their health and healthcare.²

Further, the current peer-support framework published by the Substance Abuse and Mental Health Services Administration (SAMHSA) is explicitly person-centered and recovery-oriented: the participant identifies goals and preferences, while the peer worker supports the person rather than dictating the recovery plan.³

In sum, the research appears to provide an important conceptual distinction: The professional care provider does not necessarily have to manage every patient; Instead, professional expertise may be better employed to simply help patients manage themselves.

That is the capability provided via EnVision.

The EnVision-reinforced 3-level Model

The research reinforces the opportunity for an effective 3-level model:

1. **Self-directed.** The participant can independently:

Discover → Choose → Plan → Act → Track → Accomplish → Advance

At this level, EnVision supports most of the administrative/coordination work.

2. **Supported.** The participant remains the primary actor, but EnVision flags situations where a caseworker, peer specialist, or other provider should intervene. For example: "Participant hasn't completed three consecutive commitments."

Instead of a caseworker having to discover this during monthly meetings, EnVision surfaces it in real time and alerts the caseworker who can then respond in a timely manner.

3. **Clinically managed.** Professionals take the lead in high acuity cases where patient issues involve diagnosis, medication, clinical assessment, suicide/self-harm risks, psychosis or mania, significant relapse, crisis intervention, treatment-plan changes, or other matters requiring professional judgment.

The objective isn't to replace professional support. It's to reserve professional time for the people and situations that need it most.

An Example

Imagine a full-time behavioral health caseworker with 40 clients. Today, it would not be uncommon for that worker to spend considerable time on routine inquiries such as:

- "Did you make the appointment?"
- "Did you apply for that job?"
- "Did you enroll in the training?"
- "Did you get your driver's license paperwork?"
- "Did you contact the housing agency?"
- "Did you attend the class?"
- "What are you working on this week?"
- "What do you want to accomplish next?"
- "Here's another resource you should call."

Rather than therapy, these are coordination, prompting, tracking, navigation and accountability actions, and it's these elements of care where EnVision can play a compelling role.

EnVision supports the development and management of personal plans including:

My goals → My activities → My commitments → My accomplishments → My next steps



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The platform provides the structure, reminders, resource connections, incentives and visibility.

This allows the caseworker to become more of an exception manager and coach. That is, "Something isn't working. Let's figure out why."

In sum, the evidence points toward self-management *PLUS* professional support, not self-management *instead of* professional support.

The Role of Incentives

Participant participation – particularly in the self-directed and supported levels of the care model – requires more than giving participants information and tools; it requires engagement and follow-through. EnVision incorporates incentives into the process by recognizing and rewarding participants for making progress toward their goals. EnVision's unique inclusion of incentives – which are provided through the system by the local business community – become an additional source of motivation and positive reinforcement.

This creates an important distinction from traditional case management. Rather than relying primarily on a professional to repeatedly prompt a participant to take the next step, EnVision gives the participant a personal reason to remain engaged: progress becomes visible, accomplishments can be recognized, and constructive actions can generate meaningful rewards. In this way, incentives – both intrinsic and extrinsic – reinforce self-directed behavior and help participants build the habits, confidence and momentum necessary to continue moving forward.

The rewards component of EnVision creates a whole-community approach to helping participants. It's also advantageous to businesses, giving them a means to show their community support, providing access to real-time, non-PII, data for use in developing new campaigns, and creating the potential for local recognition.

The Community Opportunity

EnVision – as a self-management and coordination layer – enables behavioral health participants to take responsibility for the parts of their recovery they can manage themselves – while giving caseworkers and clinicians better visibility into when their involvement is actually needed.

This is *not* the addition of another service and it is *not* a clinical treatment. It's a means to increase the amount of human progress that can occur without requiring professionals to manage every step every participants' journey to recovery.

The Community Cost Impact. When considering the cost of support, there are typically three options:

1. Reduce services to reduce costs
2. Maintain services with a generally flat budget line item cost
3. Increase participant capacity and concentrate professional resources to serve more people with the same resources

EnVision enables the third option. Communities gain the potential for substantially more value from the professionals and financial resources they already have. Most participants should not need professional supervision or guidance to accomplish, "I want to get a job."

Under the right care scenarios, through EnVision, the professional becomes an escalation resource rather than the operating system for every participant. That presents a major change in how communities think about service capacity.

EnVision as Community Multiplier. Every community has a relatively fixed pool of therapists, caseworkers, social workers, and nonprofit resources. When considering alternatives for MH/BH improvement, the conventional approach tends to revolve around the question, "How do we add or access more professional staff?"

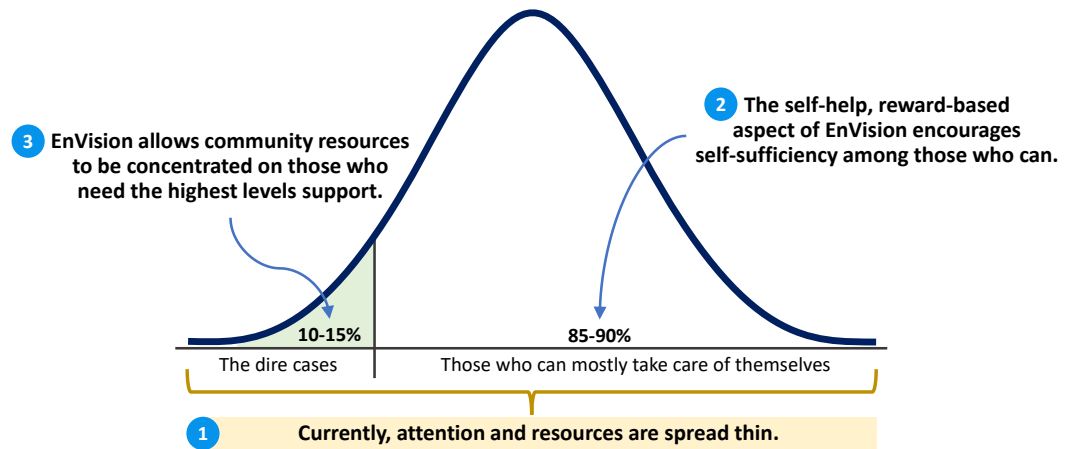
That line of questioning 's important—but the answers are difficult, slow, and expensive.



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The EnVision-reinforced self-management model approaches the challenge from a different direction by asking, “How much BH/MH staffing is enough when augmented with technology?” That is a *capacity multiplier* that concentrates community resources where they are most needed, as presented in the graphic nearby.

EnVision takes many of the routine coordination, prompting, tracking, and navigation tasks out of the professional workload, *allowing the same workforce to reserve capacity* for high-need participants.



That is, a community gains more value from its behavioral health investment when scarce professional capacity can be focused on the people and situations that require professional expertise, while participants independently manage the activities they are capable of managing themselves. That creates several layers of potential value.

The Data Opportunity → Participant-generated Intelligence.

The use of EnVision as a BH/MH intelligence system is strategically important. Through the platform, communities gain an opportunity to create a new category of information: not simply what services were provided to a participant, but what the participant actually did, accomplished, and needed help with along the way.

Optimizing the Intelligence Layer. EnVision, captures data that helps participants and improves the system; it is not a people monitor. As noted in other EnVision orientation documents, a key operating tenet is that (a) the system collects the minimum necessary information, (b) it is very explicit about who can see what, and (c) participants maintain control over their information, with legal exceptions such as court-directed oversight.

Today, most BH/MH systems primarily measure service delivery and capture adequate information on enrollment, appointments, referrals, diagnoses and assessments, treatment plans, services received, hospitalizations, crisis events, case notes, and outcomes measured...at relatively long intervals.

But there is little structured information about activities between professional encounters.

EnVision’s intelligence layer fills in the details:

From... Maria was referred to workforce training.

To... Maria identified employment as a goal → selected a training program → enrolled → attended 8 sessions → completed the course → applied for 4 jobs → completed 2 interviews → obtained employment.

The second stream of information is highly valuable. Initially, it associates events with the resources and professionals involved. Over time, it (1) produces a dataset that answers questions communities often can’t answer, and (2) it identifies effective solution patterns that can be replicated. For example, “What types and how much professional intervention is required to produce a given amount of progress?”

That is an extremely valuable planning dataset and one that can be captured without creating a “surveillance system.”



Using Intelligence to Reallocate Resources. As communities build a longitudinal participant-level activity dataset, they gain the ability to examine the relationship between:

Needs → interventions → participant activities → professional efforts → outcomes

That leads to opportunities for more sophisticated resource allocation. For example:

"People with a certain combination of circumstances tend to require approximately X type of interventions."

or..."Participants pursuing employment generally need very little professional intervention once these N barriers have been addressed."

or..."This program generates high participation but relatively little progression."

or..."Participants who receive this type of intervention are more/less likely to complete the next step."

These are questions data can answer, not conclusions that should be assumed in advance.

Measuring What Matters

The Downstream Effects. Under most current support models, communities have neither the caseworker nor the financial resources necessary to provide the necessary breadth or depth of support. Even in "normal" circumstances, caseworker time is rapidly consumed by a range of activities:

- clinical or behavioral-health concerns
- crisis prevention and intervention
- complex family situations
- coordination among multiple providers
- housing instability
- benefits problems
- routine follow-up
- reminders
- appointment coordination
- documenting progress
- helping someone identify their next step

Beyond the direct support to individuals and families, the use of EnVision to provide better participant engagement and earlier identification of problems also presents the potential to positively affect metrics related to:

- crisis services
- emergency departments
- homelessness services
- law enforcement and domestic response
- substance use treatment
- repeated intake/assessment
- duplicated services across agencies

These are impact areas we encourage communities to monitor as they plan their EnVision deployments.

Cost per Meaningful Progression. By combining participant activity with professional activity, care providers and their supported communities gain the ability to calculate the *cost per unit of progress*. For example, examining the relationship between professional hours, participant activities, accomplishments, and outcomes creates the opportunity to determine how many professional hours are associated with moving a participant from one stage to another.

That is much more sophisticated than simply calculating the aggregate cost per client served, and it leads to a better understanding of (a) cost per meaningful progression and (b) cost per successful outcome.

Discussions around these types of measure would be advantageous for outcome-oriented, cost-effective community behavioral-health planning.

Understanding "Non-completion." Where traditional systems record "services provided," EnVision tracks activities planned, attempted, completed, stalled, and abandoned – and the reasons for success and delay.



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That is a useful distinction. For example, under a scenario in which 500 participants are referred to a training program, traditional reporting might say, “500 referrals. EnVision goes deeper: 500 identified...360 enrolled...290 started...205 completed...85 stopped participating. And for those who stopped their participation, EnVision can go farther: 45 cited transportation...25 cited childcare...10 cited schedule conflicts...5 other reasons .

That’s a dataset the community can actually act on. Instead of simply funding “more training,” resource managers can discover other factors that are limiting success. That's actionable intelligence.

Implications for Community Mental and Behavioral Health

MH/BH care faces a fundamental capacity challenge: demand for support continues to grow while the professional resources available to provide that support remain constrained. Research on self-management, recovery-oriented care, peer support, and collaborative care suggests that participants can play an active role in managing many aspects of their own recovery.

The opportunity is therefore not to replace therapists, caseworkers, or other professionals, but to distinguish between activities that require professional expertise and those that participants can reasonably manage themselves – with appropriate support and clear escalation when professional intervention is needed.

EnVision provides a framework for doing this at scale. By helping participants establish goals, identify resources, plan and complete activities, track commitments and accomplishments, and recognize when additional assistance may be needed, EnVision can shift routine coordination and accountability toward the participant while giving professionals greater visibility into where their intervention is most valuable. Over time, the resulting participant-generated activity data can provide communities with a richer understanding of what drives progress, where participants encounter barriers, how much professional intervention different situations require, and where resources can be better allocated.

The larger opportunity is to rethink MH/BH capacity. Rather than measuring success primarily by services delivered or people served, communities can begin examining the relationship among participant activity, professional effort, and meaningful outcomes. The objective is not simply to reduce cost; it is to increase the amount of progress a community can achieve with its existing professional and financial resources – while giving participants greater ownership of their individual journeys.

References

¹ Lean M, et al. *Self-Management Interventions for People with Severe Mental Illness: Systematic Review and Meta-Analysis*. Br. J. Psychiatry. 214, 260–268 (2019). 10.1192/bjp.2019.54

² Kelly EL, Fenwick KM, Barr N, Cohen H, et al. *A Systematic Review of Self-management Health Care Models for Individuals with Serious Mental Illnesses*. Psychiatr Serv. 2014;65(11):1300–1310.

³ Substance Abuse and Mental Health Services Administration (SAMHSA). *Core Competencies for Peer Workers*. https://www.samhsa.gov/substance-use/recovery/peer-support-workers/core-competencies?utm_source=chatgpt.com. Last updated March 24, 2026.

