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The Offender and Addiction – Clinical Case Management

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About the Instructor:

RAND L. KANNENBERG, M.A., LAC, CCM, CCS is a Licensed Addiction Counselor, a Certified Case Manager, and a Certified Clinical Sociologist as well as an approved education provider by both NBCC and NAADAC. Kannenberg, creator of Resocial Group TM: "A Group Treatment Curriculum for Adults with Antisocial Behavior and Substance Abuse," has been executive director of Criminal Justice Addiction Services in Lakewood, Colorado since 1995, and has provided substance abuse and corrections advanced level training and continuing education workshops in 40 states, Italy, Puerto Rico and South Africa. He also has a private clinical practice specializing in forensic drug and alcohol adult assessments. Kannenberg graduated from the state department of corrections basic training academy and completed the extended prison based training program. He has worked in two correctional facilities, a halfway house, a day reporting center and at a treatment center. He is a credentialed consultant with physicians in emergency departments and on the medical units at several local hospitals. He completed his graduate program in 1984 and has been treating amphetamine and amphetamine-like substance use disorders regularly since 1999. He has been a featured speaker or trainer at nearly 300 state, regional, national, and international workshops or conferences. Kannenberg, distinguished career award nominee and Public Health Champion of the Year recipient, is author of *Sociotherapy for Sociopaths* ™ (2003) and *Case Management Handbook for Clinicians* (2004).

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The Offender and Addiction - Clinical Case Management

Introduction

Three Federal Court Cases Impact Addictions and Offender Counseling: Case Management is Needed in Substance Abuse and Corrections

(Rand L. Kannenberg, IAAOC News, International Association of Addictions and Offender Counselors, September, 1998)

On June 15, 1998 the U.S. Supreme Court ruled against 34 states by deciding that the Americans with Disabilities Act (ADA) of 1990 covers inmates of jails and prisons. Many counties and states have made what they considered reasonable accommodations on a case-by-case basis and/or by segregating physically and mentally disabled inmates. However, this ruling may force boards, commissions, and legislatures around the country to pay millions of dollars making all correctional facility living units and educational, vocational and treatment programs (including substance abuse) reasonably accessible by any and all disabled inmates. More prisoner and special interest group litigation against criminal justice agencies and correctional programs is anticipated in individual states as a result of this Supreme Court decision.

The U.S. Supreme Court also declared on June 15, 1998 that the pooled interest on some of the money clients deposit with their lawyers belongs to the clients and may not be used by states to fund legal services for poor people. The programs in all 50 states are able to generate approximately $100 million a year under the "Interest on Lawyers Trust Accounts" which started in 1980. More litigation is anticipated on this matter as well. Legal Aid as we know it is in real jeopardy.

Finally, in U.S. District Court in Denver, and also in June 1998, there was a major victory in recognition of a prisoner's right to freedom of religion (even at the expense of the correctional facilities and despite realistic concerns such as cost, convenience, safety and staffing issues). A federal judge ruled that inmates who are in administrative segregation due to rule violations or behavior problems are still entitled to participate in the Islamic observance of Ramadan. This includes requiring prison officials to serve meals at special times to everyone who wants to fast from dawn to sunset for one month as part of their religion, even to inmates isolated as part of a punitive sanction. This same legal action also clarifies that current and former employees can be held individually liable for

violating an inmate's right to practice a religion of his choice. In this case the judge ordered a retired prison superintendent and past deputy operations director to pay the inmate $9,000 for not serving him meals at special times. This ruling was issued five years after the original 1993 complaint that later became a federal lawsuit.

With these aforementioned court cases, clinical case managers in corrections and substance abuse are needed more than ever for the functions of assessment, planning, referral, coordination, and advocacy. Effective criminal justice case management can assist the client, the agency and the system in the areas of disability resource evaluations, monitoring for psychological problems, drug/alcohol abuse, and chemical dependency; information and referrals regarding legal and financial assistance; and education, support, negotiation, and problem solving related to simple as well as complicated or controversial multicultural sensitivity issues.

Case Management is Fact versus Friction

(Rand L. Kannenberg, The Counselor, National Association of Alcoholism and Drug Abuse Counselors, 1996)

A recent contribution to The Counselor ("Alcohol and Drug Abuse Counselors as Case Managers" by social workers Blome, Raskin and Slaght, September/October 1995) is reflective of the increasing resistance to case management, which is often expressed by social workers. The authors wrote of "myths" about case management. This conflict and clashing of temperaments obviously exists widely in healthcare currently. However, in an attempt to present case management as the legitimate force it's been and will continue to be in the substance abuse and psychiatric fields, this writer will focus on the facts of case management providers, recipients, systems and savings and avoid the fables as well as the friction.

Resistance #1

Historically, case management is part and parcel with social work. Additionally, the addictions therapist or counselor is in the best position to be the case manager. BOTH ARE WRONG.

Facts

Case management was born in the 1950s when the back wards of state and private hospitals emptied in response to the development of new psychoactive medications. The result was that all services were no longer in one central

location for patients. The first case manager was hired forty years ago but was never referred to as a social worker. There were other titles used in the past, though. They included personal program coordinator, primary therapist, patient representative, and more.

In many circles, care manager is actually the currently preferred term over case manager. Warning: Don't call a social worker a care or case manager and just as wisely, avoid the opposite too. Despite the education social workers, degreed registered nurses and substance abuse counselors might receive in graduate programs, case management is not about performing clinical tasks. Case managers might give advice and guidance but are not therapists. The same person who offers extensive exploration of feelings and experiences or meanings of all symptoms is not in the best position to advocate, educate, case work, support, identify resources and facilitate community services (Certification of Insurance Rehabilitation Specialists Commission[1]). Case managers and counselors (and social workers and nurses) should work together as a team. One person cannot and should not be expected to play both professional positions[2].

Resistance #2

By definition, recipients of case management are vulnerable, have complex health care and social service problems and multiple needs. Case management needs to change, evolve and become more complicated because case management is not about personal contacts. INCORRECT.

Facts

Any individual who requests or quietly requires monitoring of changing needs, negotiation for services, assistance in problem solving, and/or linking and coordination with a system (all with the same goal of client wellness) is eligible for case management. Case management consumers may need only outpatient chemical dependency service and resources for financial assistance. This patient is no less in need of case management than the individual who requires detox then the entire continuum of inpatient to outpatient care and has numerous related needs including support, housing and employment. Case management is already very well adapted to work as part of the growing managed care systems. It is actually more likely to succeed the less complicated it becomes.

Finally, case management is definitely about personal contacts. An effective case management program understands and appreciates the system(s), is available outside of standard working hours, has direct communication with all parties and can easily gain access to all services and resources. The case manager becomes the human link for both the client and the system. Again, it's exactly about personal contacts.

Resistance #3

Case management is a long and expensive process and there is no conclusive research data to verify that case management even saves money. WRONG AGAIN.

Facts

Case management services continue for as long as needed only. A closed case after a successful three-week partial hospitalization is just as appropriate and necessary as an ongoing relationship with a chronic patient involved in several systems or levels of care. The minimal expense is in training the large number of displaced administrators and clinicians who are no longer needed in the fewer and smaller programs in this country. Training includes becoming a "partner" with the patient (Texas Department of Mental Health and Mental Retardation), instead of a supervisor and/or treater of patients by using available resources to promote quality and cost effective outcomes (Certification of Insurance Rehabilitation Specialists Commission). The research has been in for many years. Case management does save money.

Conclusion

In review, social workers, who should be knowledgeable about case management, are often guilty of being overly critical of and badly misrepresenting case management in behavioral health and medical/surgical fields alike. The friction will only prevent success for their patients and agencies. Case management is forty years old and in no way experiencing a midlife crisis over name changes alone. Substance abuse counselors are not necessarily the best case managers. No professionals can simply make the transfer from clinical practice to case management without acquiring important skills, experience and training. Case management is for any patient in need, complicated problems or not. Case management is a flexible, adaptable service that does save money by striving to achieve improved functioning and satisfaction for its most important customers: patients. Managed care industries automatically win too.

ENDNOTES:

[1] Now known as the Commission for Case Manager Certification.

[2] The author now believes that individuals trained as both counselors and case managers with relevant experience and skills, may be able to successfully wear both hats.

Overview

Case Management in the Criminal Justice System

By Kerry Murphy Healey. Originally published by the National Institute of Justice, U.S. Department of Justice, 1999. Reprinted by permission.

Jurisdictions across the country are adapting case management techniques, a service delivery approach developed by mental health and social services workers in the late 1960s and early 1970s, to suit the needs of a wide variety of criminal justice populations. These jurisdictions use case management strategies to reduce recidivism and address mental disorders, developmental disabilities, joblessness, homelessness, HIV/AIDS and other serious medical conditions, and such offenses as domestic violence and substance abuse among adult and juvenile arrestees, probationers, and parolees.

Diverse programs and agencies use a variety of case management techniques with criminal justice populations. Most employ a holistic service approach that addresses conditions within the offender's life that could contribute to recidivism, joblessness, homelessness, or substance abuse relapse. Maintaining service continuity as the client moves through the criminal justice system and returns to the community is critical. Today's criminal justice professionals who provide pretrial services, corrections programming, transitional services for incarcerated offenders, and probation and parole supervision require expertise in case management techniques.

The case management of offenders is most likely to be supervised by probation and parole officers. In a few systems across the Nation, every probationer and parolee receives some form of case management. Increasingly, these agencies employ case management strategies to link inmates returning to the community with drug treatment programs, mental health services, and social service agencies prior to their release. Pretrial service agencies frequently apply case management techniques to assure an arrestee's appearance at trial, tailoring the pretrial supervision of the arrestee to reduce risk to the community.

While strategies and practice vary from one setting to another, traditional case management consists of a social or mental health worker who secures and coordinates continued social, mental health, medical, and other services for a client. The roots of the case management approach can be found in early 20th century social work, but most researchers attribute its development as a distinct service delivery method to the social reform movement of the late 1960s and early 1970s.[1] In particular, the deinstitutionalization of the mentally ill during that period required mental health social workers to develop new ways to connect clients to community social service agencies and to monitor clients' use of services.[2] Similarly, as the numbers of offenders sentenced to community corrections supervision (in lieu of incarceration) and former

inmates returning to their communities grew, criminal justice workers began to adapt case management techniques to meet the needs of these populations. Case management reduces recidivism or relapse, encourages social reintegration, and enhances public safety.[3]

Most current literature on mental health or social work case management has distilled the fundamental functions of the case manager into five sequential activities: (1) assessing the client's needs; (2) developing a service plan; (3) linking the client to appropriate services; (4) monitoring client progress; and (5) advocating for the client as needed.[4] The original social work case management model cast the case manager exclusively as a broker of services and precluded his or her involvement with the client as a counselor or treatment provider.

Two common models are "strength-based" and "assertive" case management. Strength-based case management assesses the client's strengths and talents (with special emphasis on those strengths identified by the client) and builds on them in the treatment and service plan. This model emphasizes the case manager's unconditional positive regard for the client and assumes that clients "possess a psychological self-wisdom that can cause them to discover for themselves their inner strengths and resources" and "act on normative or socially acceptable choices."[5] In a criminal justice setting, the supportive, positive regard displayed by case managers for their clients must be balanced with disapproval of the client's antisocial attitudes or behaviors. Assertive case management involves delivering services aggressively to the client, rather than passively offering services in a centralized office setting.[6] Assertive case management may require case managers to seek out the client in his or her home, job, or community for meetings and counseling or to locate branch offices that provide services in the communities where clients reside.

Many programs combine or mix both case management models to maximize the impact on clients. Today, the "mixed model" of case management, where the case manager serves in a therapeutic capacity and brokers services, is more common than the pure "service broker" model.[7] Case managers interviewed for this report regard informal counseling to be a necessary component in their relationship with the client. A number of correctional case management programs recognize the need to blur the broker and treatment provider roles and emphasize the importance of cross-training between case managers and mental health providers, substance abuse counselors, batterer treatment program counselors, and other social service providers whose work they formally or informally augment.

The criminal justice case manager may function as a member of a team that creates and implements a service plan for an offender or as one of several case managers independently creating service plans for an offender. For example, a juvenile offender who is in the legal custody of a State department of social services may receive case management services from that department, as well as from a probation officer or a counselor in a correctional facility.

A team of case managers, each with a different responsibility, often coordinates service delivery and achievement of criminal justice goals for batterers on probation. A probation officer commonly acts as the batterer's primary services broker, court liaison, and monitor, while secondary case managers in domestic violence intervention and substance abuse programs provide counseling and treatment, as well as referrals to other social services. Case managers in intervention and treatment programs may also advocate on the batterer's behalf before the courts if their assessment of the client's progress or compliance differs from that of the probation officer.

The in-house sharing of clients is another common case management approach. Probation officers often share responsibilities to ensure that a client's case management services will continue uninterrupted if one officer must attend to other cases or is otherwise unavailable—on vacation, ill, on maternity leave, and so forth. Two or more officers must be familiar with the client to guarantee continuity of services if the primary case manager is absent.

Criminal justice case management requires the case manager to take on additional tasks that go beyond the traditional "service broker" model. Enos and Southern have proposed a criminal justice model that incorporates seven stages: intake, assessment, classification, referral, intervention, evaluation, and advocacy.[8] The case management tasks described below frequently overlap, as opposed to being discrete and sequential.

Intake. This may involve crisis intervention, establishing a rapport with the client, providing orientation (such as information about how to comply with a treatment plan and to communicate with case managers and treatment providers), and a discussion about sanctions for failure to comply. Intake is best performed face-to-face, but may include printed or videotaped information.

Assessment. This phase usually involves interviews and history-taking and may include substance abuse evaluation or specialized psychological evaluation, home visits, and contacts with family members, employers, and other agencies with which the offender has been involved. When specialized assessments are needed, the case manager arranges for or approves the provider. In general, violent offenders (especially sex offenders and domestic batterers) require more careful evaluation than offenders who commit property crimes.[9]

Classification. Traditionally, offenders were classified by their amenability to treatment; those judged to be poor candidates for rehabilitation were incarcerated and received no services. In some jurisdictions, the "amenability to treatment" test has been replaced with a presumption that all offenders benefit from services, even those considered to be at highest risk for recidivism and those who are incarcerated. Classifications may be based on risk assessments derived from the offender's criminal history. More

complicated cases may include the written assessments of mental health experts, social workers, or addiction specialists; the results of standard psychological evaluation tools, such as the Minnesota Multiphasic Personality Inventory; or empirically based prediction models. Based on classification, offenders may be assigned to particular units within institutional settings or offered specialized services.

Referral. This may take many forms, depending on the status and needs of the offender. Arrestees awaiting trial may be referred to halfway houses that provide more stable community ties, substance abuse treatment, behavior modification programs, and employment training and placement assistance. Inmates may be referred to in-house educational, job-training, or mental health programs. Inmates due for release may be referred to transitional service providers or linked with community-based services, such as substance abuse treatment or mental health counseling, to ensure continuity of services. Case managers refer offenders on probation or parole to community and government agencies that can assist with substance abuse or domestic violence problems and to obtain health care, housing, public assistance, mental health counseling, and assistance with developmental disabilities, HIV/AIDS, or other serious health problems.

Intervention. The case manager matches available resources and services to the offender's identified needs. The offender is responsible for cooperating with program requirements and changing his or her behavior.

Monitoring. Practitioners have identified the keys to successful case management as effective offender monitoring and graduated sanctions for offenders who fail to comply with service plans. Monitoring may incorporate graduated, court-ordered sanctions, such as more frequent court reviews, use of electronic surveillance devices, or short incarcerations to encourage offender cooperation with case management goals. Intensive monitoring may include frequent drug or alcohol testing, weekly (or even daily) phone or personal contact between the case manager and the offender, and frequent communication with service providers to track the offender's compliance with court-ordered conditions or program requirements. The need for intensive offender monitoring should decrease over time—shifting from a highly structured intervention with extensive external controls on relapse or reoffense to a less structured monitoring system that places greater emphasis on personal responsibility and, eventually, a return of all control and responsibility for avoiding relapse or recidivism to the offender.

Evaluation. The case manager must determine if the client has received the services outlined in the case management plan and whether that client has benefited from those services. The most significant indicator of successful case management for criminal justice clients is recidivism. Case managers also may use other measures of behavioral change to gauge response to the intervention: data provided by the offender; urine drug screening; program attendance and compliance reports; and information from victims, family members, employers, or other agencies. Evaluations of case management programs should consider such factors as overall efficiency of

service delivery, cost effectiveness, and any systemic obstacles to service delivery. While case managers are unlikely to evaluate programs, they may assist with data collection. Administrators should share evaluation results with staff and adjust procedures as needed.

Advocacy. Several types of advocacy are required of case managers in a criminal justice setting. The case manager may testify or make recommendations in court on the client's behalf, negotiate pro bono services for clients, or secure priority placements at programs with waiting lists. The case manager also may mediate difficult situations for the offender, such as arranging visitation with children who are no longer in the client's custody. The case manager must review obstructive bureaucratic practices and community conditions. For example, case managers and their supervisors interpret individual and program outcomes and use the information to advocate change and refinement within the criminal justice system. Criminal justice case managers may propose solutions, such as interagency working groups or task forces that work outside their departmental jurisdiction, to address systemic obstacles. Finally, case managers may identify community conditions or parole or probation procedures that contribute to crime or recidivism. They may advocate for changes in law or policy that support their work with offenders. For example, one probation official noted that the majority of drunk drivers under his department's supervision were arrested after attending evening "happy hours" at bars. This officer successfully lobbied the State legislature for legislation banning happy hours, a law that subsequently reduced drunken driving arrests.

Because criminal justice populations are so diverse, case management programs must be diverse. One author and evaluator observed the following:
As might be expected with any new practice form, the nature of case management is unclear. . . . A comparison of settings that [claim] to use case management reveals diversity rather than uniformity. Patterns of case management that are similar, however, seem to be associated with settings that serve similar client populations (mental health, child welfare, physical disabilities).[10]

Research shows that similarities between programs develop to reflect the specific population they serve: drug-addicted offenders, mentally ill offenders, offenders with mental disabilities, and so forth.

One offender, many case managers. Differences in practice are revealed when coordinating the efforts of two or more case managers. As mentioned above, a number of programs described in this report use two case managers— or, more likely, a team of case managers—for each client. One case manager, housed at a substance abuse treatment facility, might coordinate all aspects of drug treatment, education, and social services, while another case manager might be a transitional services worker from the corrections department or a probation officer who helps the offender secure transitional housing, employment, or health care insurance and monitors client compliance with the terms of probation or

parole. One program director observed that in his jurisdiction it was useful to have a mental health/mental retardation counselor and a probation officer—whose roles as case managers were "fluid"—provide case management to mentally ill and retarded offenders. According to the director, "Both provide services. There can be no division in the ranks, no separation of roles. A division upsets the clients. The probation officer cannot always be the 'bad' guy."[11]

By contrast, a formal division of roles between supervision and rehabilitation services is maintained in a Quincy (Massachusetts) District Court program that provides intensive case management to batterers. Probation officers closely monitor probationers' attendance at a domestic violence program and often require that the probationers make daily phone or face-to-face contact with the supervising officer, undergo weekly random drug or alcohol screening, and attend substance abuse programs where indicated. They also advocate for victims. Counselors in the batterers' and substance abuse programs provide rehabilitative services to offenders.

Where should the case manager be located? Case management services are largely defined by the setting in which they are delivered. In Pima County, Arizona, probation officers and drug treatment counselors shared office space at a drug treatment facility. Don Stiles, chief adult probation officer for the Superior Court in Pima County, praises the cooperation that developed between his officers and the treatment staff due to the increased personal contact. "Communication worked 10 times better with people in the same building. Probation officers knew immediately if someone missed treatment. We had better attendance and better results."

Other program administrators were similarly enthusiastic about case management programs that operate within the communities where the clients live.[12] Assertive case management is easier for both the case manager and the client when the program is based in a client's neighborhood, rather than at the probation or social services department's location.

One advocate for the victims of batterers on probation emphasizes the importance of service location. Although she considers victim outreach and advocacy to be a critical component of the case management of batterers on probation, she declines to provide services to victims if secure office space remote from the probation office is not available. "It is not responsible to ask victims to come in for services if they might meet their batterer in the hall or elevator," said the advocate.

Other criminal justice case managers are being trained to assist mental health and substance abuse counselors with onsite treatment and therapy in institutional settings. In the Alexandria (Virginia) jail, case management teams composed of jail officials and representatives of the local mental health authority coordinate treatment for inmates in an onsite unit administered primarily by jail employees.

The Federal Bureau of Prisons (BOP) organized a pilot program to provide substance abuse treatment at six BOP halfway houses around the country. This arrangement removes the need for dual case managers for offenders in treatment.

Automated case management systems. A number of software developers now offer systems designed to assist pretrial service providers, courts, and probation and parole officers with case management recordkeeping. Discipline-specific features offered by software systems include tracking basic case management information (including workload analysis and scheduling); managing fines or restitution; managing warrants; maintaining drug-testing, juvenile, and adult records; managing electronic surveillance; collecting data for research and statistics; and generating notification letters.[13]

System costs vary widely according to the sophistication of the services offered. One basic automated system that helps coordinate the case manager's workload by tracking offenders' obligations, victims, comments, aliases, actions, special good time, and payments—and also generates automatic reports that tell the case managers what specific actions must be taken when—costs as little as $700. Another system that provides "an integrated, comprehensive solution to the information needs" of sheriffs, clerks, judges, court administrators, prosecutors, and probation officers ranges in price from $7,500 to $150,000.[14]

The case management of offenders raises a number of difficult issues, including how to provide continuous services to inmates returning to the community, how to use sanctions to maximize service participation while avoiding unnecessary incarceration, and how to measure program effectiveness. Aside from these structural issues, criminal justice case managers face a number of unique challenges, such as sustaining consistent levels of service while the offender passes through the criminal justice system and back to the community; developing employment resources for offenders reentering the community; preparing offenders to find, qualify for, and retain employment; and helping to resolve such thorny problems as family reunification and the substance abuse problems of other family members.[15]

Providing continuity of services. While the challenge of maintaining service and staff levels as an offender moves through the criminal justice system and back into the community is similar to that facing other social service providers who must track clients moving through hospitals, schools, and jobs, criminal justice case managers must not only track but also anticipate and prepare for each client move to minimize the likelihood of recidivism and the risk to society. The BOP and some local correctional systems piggyback inmate and community corrections treatment contracts onto those already held by the local probation authority, providing offenders with access to the same services upon their release from prison. When it is impossible to use the same service provider, some parole officers seek to create a sense of

continuity by referring offenders to a treatment program that is philosophically similar to the one in which the offender participated while incarcerated. Other institutions offer transitional services for soon-to-be released inmates that link them with service providers in the community before release, including scheduling intake appointments as soon after release as possible.

Successfully reintegrating mentally disordered inmates and probationers into the community is very challenging. In 1989, the New York State Office of Mental Health (OMH) first funded private mental health contractors who helped parolees with mental disorders qualify for supplementary security income (SSI), social security disability income (SSDI), food stamps, and Medicaid. The funding was to assure that the parolee—with the assistance of the private contractor— would qualify for income and services from other State and Federal agencies by the time OMH support payments ceased.[16] The Maricopa County (Arizona) Adult Probation Department uses the Transitional Living Center (TLC), a probation-operated residential psychiatric program for offenders with serious mental illness, to bridge the critical span between release from custody and independent living in the community. The length of stay is determined by the time it takes to link clients to community-based mental health and support services; the average stay at TLC is 60 days.[17]

Sanctions as a case management tool. Case management with criminal justice populations is also different from case management in other contexts because compliance with substance abuse treatment or other provisions of the offender's service plan may be a condition of probation/parole or part of a court-ordered diversion program for mentally disordered, developmentally disabled, or pregnant drug-abusing offenders. Some commentators have suggested that, at the very least, compulsory substance abuse treatment generally results in higher rates of retention in treatment and is associated with better outcomes.[18] Some of the programs described in this report make aggressive use of sanctions and intensive supervision to promote the goals of the service plan; others operate without legal coercion. Literature concerning the use of sanctions as a case management tool emphasizes the need for graduated sanctions and less rigid enforcement with mentally disordered or developmentally disabled offenders, who are more likely to have difficulty complying with treatment goals or the conditions of their release.

Probation and parole officers and service providers must be frank concerning the criminal justice case manager's enforcement policy. Service providers and case managers interviewed for this report expressed frustration over the use of sanctions. Some probation and parole officers suspect that substance abuse treatment program staff are lax in reporting violations because they either may be tolerant of some degree of relapse or have no desire to report client failure and thus risk losing program income. Conversely, therapists and substance abuse treatment providers expressed concerns that probation policies often are relatively inflexible concerning relapse, which is unrealistic. By contrast, batterer treatment program counselors in some jurisdictions expressed concern that

probation violations concerning domestic violence are not taken seriously by the courts, and, as a result, sanctions are rare or inadequate.

In other jurisdictions, sanctions are used successfully as a case management tool. For example, in jurisdictions where batterer treatment program providers and probation officers meet regularly to discuss case management issues, a clear policy concerning the use of sanctions has developed and no conflict arises about the overusage or underusage of sanctions. The drug court model, which is employed in a number of jurisdictions nationally, positions the judge as case manager and uses strict, court-based monitoring and an array of graduated sanctions to motivate the offender to comply with court-ordered treatment goals.[19]

Case management evaluations. Questions concerning the case manager's expectations and attitudes and even the "tone" of the program setting and how these factors affect outcomes resonate throughout case management evaluation literature and were a focus of several interviews for this report. In his evaluation of the Assertive Community Treatment Program, James Inciardi writes the following:

> To a large extent, research on case management is research on case managers, since it is often difficult to separate the two. Although there are different philosophies and techniques to case management, most agencies appear to expect a fair amount of conformity among managers. Therefore, the role of the case manager may be crucial to understanding the varied impact of treatment programs on clients. How do staff members facilitate the therapeutic process? Does staff effectiveness vary by training, philosophy, personality, case load, or charisma? Although impact and outcome analysis will answer some of these questions, it is also necessary to probe their qualitative aspects as well.[20]

Shelli Rossman of the Urban Institute observes that evaluations of pilot programs are inevitably affected by the quality of case management being provided—not just by the type and number of service linkages offered—and that there is "an extraordinary variation in what masquerades as case management."[21] She points to the fact that some case managers have backgrounds in social work, others in mental health, and others have no special qualifications whatsoever. Clinical psychologist Matthew Ferrara calls for the creation of an academic specialty to train criminal justice case managers working in the field of mental health.[22] Another evaluator echoes Rossman's concerns, predicting that one program would be likely to produce better results than its structurally identical sister programs because "the staff got their act together earlier and better than at the other sites."[23]

Enos and Southern identify six classes of offenders whom they consider best suited for case management focusing on behavioral change: juvenile delinquents; offenders with impulse control disorders (kleptomania, pyromania); offenders with specific personality disorders (especially antisocial); substance

abusers; all sex offenders; and offenders who experience problems in personal relationships that affect their ability to function at work, as parents, in the family, or in society.[24]

These broad classifications cover virtually all offenders. At present, the criminal justice populations who most commonly receive case management services are substance abusers, mentally disordered or developmentally disabled offenders, probationers, and inmates and parolees needing transitional services to help them reintegrate with their community.

Substance-abusing offenders. The majority of the criminal justice populations discussed here receive case management services related to substance abuse treatment. Researchers and evaluators have attempted to assess the effect of case management on substance use, risky needle use, and sexual practices contributing to both HIV infection and recidivism in criminal justice populations. Existing studies are cautiously optimistic regarding effects on substance use and recidivism but less encouraging with regard to risky HIV-associated behaviors.[25] Many factors contribute to the tentative tone struck by researchers in the early studies; probably the most important of these was the widely varying quality of case management services provided to offenders and the evaluators' inability to gauge the long-term impact. Nonetheless, individual programs report significant cost savings compared with incarceration, less recidivism, and longer time until rearrest. South Carolina's "Stayin' Straight" program, a day reporting center with an intensive substance abuse treatment component, cost $3.65 per day per probationer to administer (versus $32 per day for incarceration), reduced rearrest by 20 percent after 22 months, and delayed the average time until rearrest by 137 days compared with program dropouts.

Mentally disordered and developmentally disabled offenders. Some of the most promising programs work with mentally disordered or developmentally disabled offenders—the type of client for whom case management has a proven track record in other settings (see sidebar "Case management of mentally disordered or developmentally disabled offenders"). These programs generally use trained personnel and follow traditional mental health case management models. Project Action,[26] an intensive case management program for mentally ill offenders in Houston, Texas, boasted a 5 percent recidivism rate for program participants versus a 64 percent rate for offenders on regular release.[27] Project CHANCE[28] (Case management/ Habilitation/Advocacy/Networking/ Coordinating council/Education and training), a program run by the Association of Retarded Citizens and funded by the Texas Council on Offenders with Mental Impairments, reported equally promising results. The program aimed to reduce recidivism rates through intensive case management. Project CHANCE served both adult and juvenile offenders and accepted referrals from both pretrial services and correctional institutions. The project, which operated for 7 years, helped developmentally disabled offenders understand their legal rights and responsibilities, make informed decisions, set goals (such as ceasing substance abuse or achieving independent living), and identify the resources

necessary to achieve those goals. Project CHANCE also coordinated the transfer of services for developmentally disabled offenders to the local mental health or mental retardation authority and ensured that services were not discontinued or duplicated. The program boasted an 11 percent recidivism rate for participants, compared with nearly 60 percent for comparable groups. The program was cost effective: Services for incarcerated mentally retarded offenders cost the local authorities between $30,000 and $45,000 per person annually, versus $9,000 for Project CHANCE case management. Even if special services for developmentally disabled inmates were not included, Project CHANCE case management costs $32 per day per inmate, compared with $56 per day for county jail incarceration.

Probationers. Both Federal and local probation directors contacted for this report were enthusiastic about probationers receiving case management services and praised the effectiveness of such services with high-risk clients. Don Stiles, chief adult probation officer for the Superior Court in Pima County, when asked for a definition of case management, stated, "That is it. That is what we do here every day. You have just described our probation department."[29] According to Stiles, the Pima County Probation Department currently uses its Specialized Offenders Case Loads Division to provide case management targeting mentally ill, mentally retarded, and substance - abusing offenders and sex offenders.

Loren Buddress, Federal chief probation officer for the Northern District of California, reports that he has 70 officers "doing case management" and 15 providing specialized case management services, such as mental health counseling, drug treatment, housing and employment assistance, treatment for batterers, and a cognitive-behavior course for female embezzlers.[30] Oregon has undertaken a variety of case management-style programs to provide drug treatment, cognitive restructuring training, and social services to inmates and probationers. Initial evaluations suggest that the Oregon approach has had a significant impact on recidivism there.[31]

Inmates due for release. The provision of transitional services to incarcerated offenders is another area of criminal justice well-suited to the case management approach. In its broadest sense, case management for soon-tobe-released offenders could begin with the provision of prerelease services, including substance abuse treatment, and follow the offender to community corrections and community-based substance abuse treatment. (The Federal Bureau of Prisons has a number of programs working on this model; see sidebar "Case management of addicted inmates: The Federal Bureau of Prisons' Drug Abuse Treatment Initiative.") In New York City, the Women's Prison Association draws on public and private funding to provide transitional services, including individual counseling, discharge planning, outreach workshops, and transitional housing.[32]

While the majority of experts, administrators, program directors, and case managers contacted for this report were positive about case management as a

tool for use with criminal justice populations, a few raised concerns about the structure of programs and the overburdening of case managers.
One proponent of case management made the following observation:

> [A] poorly designed case management system will result in increased paperwork, poor compliance by line staff, and failure to help manage your agency. However, a good case management system will help you articulate your priorities to your public policy leaders, give clear direction to line staff on cases that should receive the most attention, help identify time and resources required to maintain minimal standards, provide information to evaluate the effectiveness of programs, and help defend in civil liability [cases].[33]

The most serious challenge for criminal justice case managers is to establish open and positive working relationships with the service providers of choice. Because criminal justice programs may involve more than one case manager, communication and cooperation between key professionals is essential. As discussed in a previous section ("Sanctions as a case management tool"), disagreement between the correctional case manager and program or treatment staff over the use of sanctions for probation or parole violations can create a tense working environment.

There are several possible causes for friction between correctional and treatment case managers. Criminal justice case managers consider some treatment providers to be too tolerant of the cycle of relapse and recovery; often, both sides differ philosophically over the use of incarceration as punishment for drug abuse, and case managers have a self-interest to maintain program participation and perceptions of program success. Some evaluators also questioned the impact of the strict enforcement of sanctions on program outcomes. In interviews, several evaluators suggested that program outcomes measuring client success in absolute terms—no relapses to drug abuse, no further arrests, no further criminal activity—were likely to obscure more subtle successes of case management with difficult populations, such as longer drug-free periods, lower levels of criminal activity, longer time to rearrest, and fewer arrests.

Frequent interagency contact, crosstraining, and clear communication concerning criminal justice expectations should reduce these barriers. One director of transitional services emphasized the power that community corrections agencies possess to choose their own service providers should these efforts fail. "If a treatment program staff is uncooperative, the probation department can just not renew their contract," he said.

Overburdened case managers. Case managers in some programs must manage too many cases with too few resources to provide comprehensive service, says Dr. James Swartz, project coordinator for the National Consortium of Treatment Alternatives to Street Crime (TASC) programs, generally well regarded as one of the earliest and largest case management experiments.[34] A personnel shortage has forced his Chicago case managers to restrict their assistance to substance-abusing probationers to the most basic linking and monitoring activities, instead of expanding case management

services to include educational and vocational training, psychological services, medical services, and housing and job placement. Furthermore, as available resources shrink, fewer services are targeted to high-risk treatment candidates—those whom he feels are most likely to benefit from the services.[35]

Transfer of offender treatment information. Another challenge for case managers is passing basic offender information, treatment plans, and psychological assessments along to the next agency or case manager as the offender travels through the criminal justice system. The Federal Bureau of Prisons Office of Transitional Services is working on ways to ensure that basic information gathering and assessment is done only once and that relevant case-planning documents arrive at the receiving agency before the offender. Information must also flow back to criminal justice case managers from service providers and treatment programs. Management structures—such as formal coordinating committees or policy teams composed of representatives from key criminal justice and service agencies— are needed to ensure that offender information is exchanged in a confidential, timely, and efficient manner.

While offenders are under the supervision of the criminal justice system, a unique opportunity exists to intervene in the offender's lifestyle to reduce future criminal behavior. Case management for criminal justice populations connects offenders with the specific services and counseling they need to resist substance abuse relapse and to break the cycle of criminal behavior.

Various models of case management are being used in a variety of criminal justice settings. Case management's greatest contribution to date has been to reduce recidivism and supervision costs for mentally disordered or developmentally disabled offenders. Case management will also reduce the enormous social, economic, and bureaucratic barriers that contribute to recidivism or substance abuse relapse among inmates returning to the community and offenders sentenced to probation.

While the majority of criminal justice case management programs focus on substance-abusing offenders, existing evaluations do not present a consistent pattern of success with this population.[36] Nonetheless, the impressive reductions in recidivism, time to reoffense, and cost reported by some programs using day-reporting for substance-abusing probationers and parolees suggest that intensive case management can have a significant impact on these high-risk populations and that further research is needed to define the key program and case management elements contributing to these successes. [37] In the meantime, developing case management approaches for those offenders who are part of populations that have traditionally responded well to case management—for example, the mentally disordered or developmentally disabled—should be a priority.

ENDNOTES:

1. Martin, Steve S., and James A. Inciardi, "Case Management Approaches for the Criminal Justice Client," in *Drug Treatment and Criminal Justice,* ed. James A. Inciardi, Thousand Oaks, California: Sage Publications, 1993: 84–86; and Falck, Russell S., Harvey A. Seigal, and Robert G. Carlson, "Case Management to Enhance AIDS Risk Reduction for Injection Drug Users and Crack Cocaine Users: Practical and Philosophical Considerations," in *Progress and Issues in Case Management,* Research Monograph 127, Rockville, Maryland: National Institute on Drug Abuse, 1992: 167–180.

2. One early study of the use of case management techniques by social service workers provides the following definition: "The concept of case management drew on two historically different emphases in provision of service delivery to the multi-need client. . . . The 'liaison resource' and 'client monitor' aspects of service delivery both became incorporated over time into a 'case managing' role for service workers, which was inclusive of planning, coordinating, advocating, and monitoring of client services across a variety of settings and client groups." Caragana, Penelope, and David M. Austin, "Final Report: A Comparative Study of the Functions of the Case Manager in MultiPurpose, Comprehensive and in Categorical Programs," Austin, Texas: University of Texas, School of Social Work, July 1983. Unpublished report submitted to the Office of Human Development Services, Department of Health and Human Services, Washington, D.C.

3. Enos, Richard, and Steven Southern, *Correctional Case Management,* Cincinnati, Ohio: Anderson Publishing Co., 1996: 2.

4. Martin and Inciardi, "Case Management Approaches for the Criminal Justice Client," 83; Falck et al., "Case Management to Enhance AIDS Risk Reduction," 167; and RobertsDeGennaro, Maria, "Developing Case Management as a Practice Model," *Social Casework: The Journal of Contemporary Social Work* (October 1987): 466–470.

5. Enos and Southern, *Correctional Case Management,* 44–45.

6. Telephone interview with James Inciardi, January 1996.

7. Falck et al., "Case Management to Enhance AIDS Risk Reduction," 167; Peters, Roger H., "Drug Treatment in Jails and Detention Settings," in *Drug Treatment and Criminal Justice,* ed. James Inciardi, Newbury Park, California: Sage Publications, 1993: 44–80.

8. Enos and Southern, *Correctional Case Management,* 2–20. These stages, which refer to the case management of individual offenders, may take place in the broader context of a "differentiated case management" court system in which specific types of cases—civil, criminal, drug, property, sexual assault, domestic violence— receive individualized routing, scheduling, or disposition to maximize court resources and efficiency. See Bureau of Justice Assistance, *Differentiated Case Management,* Fact Sheet, Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, November 1995: FS000117.

9. Enos and Southern, *Correctional Case Management,* 8–9.

10. O'Conner, Gerald G., "Case Management: Systems and Practice," *Social Casework: The Journal of Contemporary Social Work* (February 1988): 97–106.

11. Bruce Horvath, lead case manager and senior officer, Project Action, Houston, Texas. Funding for Project Action was not renewed by the State of Texas in August 1998, due to Federal policies prohibiting reimbursement of criminal justice agencies for case management services. Federal funds are available to reimburse case management services to the mentally ill through the Texas Council on Mental Health. The program's services have been replaced with a mental health-based program, New Start, supported by the Harris County, Texas, Mental Health/Mental Retardation Agency, Ethel Perry, director, (281) 863–8170.

12. Several of the Opportunity to Succeed sites (Kansas City and St. Louis, Missouri, and Tampa, Florida) experimented with this approach. Interview with Shelli Rossman, program evaluator, the Urban Institute.

13. Office of Justice Programs, *Directory of Automated Criminal Justice Information Systems, 1993, Vol II: Corrections, Courts, Probation/Parole, Prosecution,* Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, 1993: 449–459.

14. Ibid, 445–446.

15. The U.S. Department of Justice, National Institute of Justice (Washington, D.C.), under its Program Focus series, has published five reports on offender reintegration and education programs across the country by Peter Finn. They are as follows: *The Delaware Department of Correction Life Skills Program* (1998) (NCJ 169589), *Texas' Project RIO (Re-Integration of Offenders)* (1998) (NCJ 168637), *Chicago's Safer Foundation: A Road Back for Ex-Offenders* (1998) (NCJ 167575), *Successful Job Placement for Ex-Offenders: The Center for Development Opportunities* (1998) (NCJ 168102), and *The Orange County, Florida, Jail Education and Vocational Programs* (1997) (NCJ 166820). Other NIJ publications about case management programs include: *Women Offenders: Programming Needs and Promising Approaches,* Research in Brief, 1998 (NCJ 171668); *Work Release: Recidivism and Corrections Costs in Washington State,* Research in Brief, 1996 (NCJ 163706); *Project Re-Enterprise: A Texas Program,* Program Focus, 1996 (NCJ 161448); *Drug-Abusing Women Offenders: Results of a National Survey,* Research in Brief, 1994 (NCJ 149261); *Managing Mentally Ill Offenders in the Community: Milwaukee's Community Support Program,* Program Focus, 1994 (NCJ 145330); *Police Response to Special Populations: Handling the Mentally Ill, Public Inebriate, and the Homeless,* Research in Action, 1988 (NCJ 107273); and *Police Response to Special Populations,* Issues and Practices, 1987 (NCJ 105193).

16. Dvoskin, Joel A., C. Terence McCormick, and Judith Cox, "Mentally Ill Offenders in the Community: Services for Parolees with Serious Mental Illness," in *Topics in Community Corrections, Annual Issue,* Washington, D.C.: U.S. Department of Justice, National Institute of Corrections, 1994: 14–20.
17. Mickel, Kyle, "Mentally Ill Offenders
in the Community: A Little 'TLC': Maricopa County's Transitional Living Center," in *Topics in Corrections, Annual Issue,* Washington, D.C.: U.S. Department of Justice, National Institute of Corrections, 1994: 30–32. Also see Conly, Catherine H., *Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program,* Program Focus, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, forthcoming.

18. See De Leon, George, "Legal Pressure in Therapeutic Communities," *Journal of Drug Issues,* 18 (4) (1988): 625–640; and Cook, Foster, "TASC: Case Management Models Linking Criminal Justice and Treatment," in *Progress and Issues in Case Management,* Research Monograph 127, Rockville, Maryland: National Institute on Drug Abuse, 1992: 368–382.

19. For example, Dade County, Florida, or the statewide drug court program in New Hampshire. For information concerning drug courts, contact the U.S. Department of Justice, Office of Justice Programs, Drug Courts Program Office, (202) 616–5001.

20. Inciardi, James A., Howard Isenberg, Dorothy Lockwood et al, "Assertive Community Treatment with a Parolee Population: An Extension of Case Management," in *Progress and Issues in Case Management,* Research Monograph 127, Rockville, Maryland: National Institute on Drug Abuse, 1992: 361–362.

21. Telephone interview with Shelli Rossman, February 1996.

22. Telephone interview with Matthew Ferrara, Ph.D., clinical psychologist, Austin, Texas, January 1996. Ferrara, Matthew, and Sandra Ferrara, "The Evolution of Prison Mental Health Services," *Corrections Today,* 53 (5) (August 1991): 198–203.

23. For a discussion of staffing see Rhodes, William, and Michael Gross, *Case Management with Drug-Involved Arrestees,* Research Preview, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, January 1996; and Inciardi et al., "Assertive Community Treatment with a Parolee Population," 350–366; for an exception to concerns about case management training, see Falck et al. in relation to the Dayton-Columbus model.

24. Enos and Southern, *Correctional Case Management,* 2. It should be noted that Enos and Southern argue that while it might be more efficient to provide services only to perpetrators of incest or other offenders thought to be most amenable to treatment, the rehabilitation of only one high-risk sex offender could spare multiple victims, making the effort worthwhile. They also point to the cost efficiency of community-based treatment versus incarceration.
25. Mackinem, Mitchell, Karen Goodale, and Sally Caughman, "Modest Program, Modest Gains: An Outcome Study of a Day Reporting Program/Stayin' Straight: South Carolina's Experiment with Day Reporting," South Carolina Department of Probation, Parole, and Pardon Services, undated manuscript. Also see Rhodes and Gross, *Case Management with Drug-Involved Arrestees.*

26. Information in this section is from a telephone interview with Bruce Horvath, lead case manager and senior officer, Project Action, Houston, Texas, and an undated program brochure titled, "ACTION: A Special Project of Harris County Community Supervision and Corrections Department." Project CHANCE and Project Action were evaluated by the Criminal Justice Policy Council in Austin, Texas, (512) 463–1810. See the newsletter article, "Mentally Retarded and Mentally Ill Criminal Offenders: Effectiveness of Community Intervention Programs," *Criminal Justice Policy Council Research Analysis,* March 1993, No. 17: 1–4. This publication is available from the National Institute of Corrections Information Center.

27. Telephone interview with Bruce Horvath, January 1996.

28. Information in this section is from printed program materials provided by the Association for Retarded Citizens and Donna Cole, the interim lead case manager of Project CHANCE, Austin, Texas. Two programs are continuing Project CHANCE's work: Victim and Offender Services, Irene Huq, program director, and Dennis Chapman, project leader, (512) 476–7044, and Anew-Champ, Don Johnson, executive director, (512) 459–7637. Funding for Victim and Offender Services is received through the Austin County Health and Human Services Agency. Victim and Offender Services currently serves mentally retarded or developmentally disabled juveniles but seeks grants to extend services to adult offenders. Anew-Champ works with both mentally ill and mentally retarded offenders to provide case management, discharge planning, individualized training (rehabilitation, independent living skills, and anger management), and psychiatric support services. Anew-Champ had served Project CHANCE's clients on a subcontract basis until August 31, 1998. Anew-Champ is funded in part by the Texas Department of Parole.

29. Telephone interview with Donald Stiles, January 1996.

30. Telephone interview with Loren Buddress, January 1996.

31. Hall, Frank A., "Oregon Tackles a Tough Issue: Department of Corrections Strategies to Reduce Recidivism," *Alternatives to Incarceration,* Spring 1995: 26–27; Finigan, Michael, "Evaluation of Oregon Parole Transition Projects, Executive Report," prepared for Community Programs Division, Oregon Department of Corrections, October 15, 1993.

32. See Conly, Catherine, *The Women's Prison Association: Helping Women Offenders and Their Families,* Program Focus, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 1998 (NCJ 172858).

33. Bemus, Brian J., "Implementation of a Case Management System in Washington State Misdemeanor Courts: An Example of Cooperation and a Guide for the Future," Misdemeanant Corrections Association, unpublished manuscript, December 1993: 18.

34. TASC is supported by the National Institute of Justice, the Bureau of Justice Assistance, Office of Juvenile Justice and Delinquency Prevention, the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and State and local agencies. There are approximately 150 programs in 20 States. Contact number: National TASC, Melody Heaps, president, (312) 787–0208.

35. Telephone interview with Dr. James Swartz, January 1996.

36. See, for example, Inciardi et al., "Assertive Community Treatment with a Parolee Population,"; Rhodes and Gross, *Case Management with Drug-Involved Arrestees;* and Falck, R., R. Carlson, S. Price, and J. Turner, "Case Management to Enhance HIV-Risk Reduction Among Users of Injection Drugs and Crack Cocaine," *Journal of Case Management,* 3 (4) (1994): 162–167.

37. Mackinem, Goodale, and Caughman, "Modest Program, Modest Gains": 1ff.
This research was conducted by Kerry Murphy Healey, Ph.D., a consultant to Abt Associates Inc., Cambridge, Massachusetts.

The National Institute of Justice is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, the Bureau of Justice Statistics, the Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime.

Philosophy of Case Management

(Commission for Case Manager Certification)

"Not a profession but an area of practice with an underlying premise that everyone benefits when the client reaches an optimal level of wellness and functional capability."

Case Management:

- involves advocacy
- involves education
- involves identification of resources
- involves service facilitation
- it is throughout the continuum
- it is timely and cost-effective
- it is direct communication with all parties
- it is a practice that requires education, skills, experience

3 Models of Case Management Programs

(*Ross*)

MINIMAL
- outreach
- assessment
- planning
- referrals

COORDINATION
- outreach
- assessment
- planning
- referrals
- advocacy
- casework
- support
- re-assessment

COMPREHENSIVE
- outreach
- assessment
- planning
- referrals
- advocacy
- casework
- support
- re-assessment
- resource development
- monitoring quality
- public education
- crisis education/intervention

Three Basic Principles of Substance Abuse Prevention

(NAADAC)

1. Alcoholism and other drug dependency must be addressed primarily as a public health problem.

2. Access to appropriate care delivered by credentialed professionals must be provided.

3. A benefit for alcohol/drug treatment must be part of any national health care reform.

Case Management Defined as "A Collaborative Process"

(*The Commission for Case Manager Certification*)

A collaborative process that includes:

- assessment
- planning
- implementation
- coordination
- monitoring
- evaluation *(of the options and services required to meet an individual's health needs)*
- communication
- use of available resources
- promotion of quality
- promotion of cost-effective outcomes

Case Management Defined as "A System"

(*Texas Department of Mental Health and Mental Retardation*)

A system in which there's:

a single accountable individual (case manager)
(for client and system who monitors changing needs, negotiates services, assists in problem solving and is responsible for linking and coordination leading but does not provide all services, usurp the roles of the client/family or nullify any aspects of teaming or interdisciplinary process);

access
(which is a shared responsibility between the client and the case manager, outside of standard working hours of 8-5, there must be some kind of system to respond at all times-nights, weekends, holidays);

resources and services
housing, transportation, food, employment, financial assistance, legal guidance, relationships, etc.) (medical, dental, psychiatric, substance abuse, inpatient, outpatient, partial hospitalization, residential, detox, etc.) not necessarily provided by a single agency; and

a goal of optimal level of functioning
(highest level of functioning and highest level of community integration).

5 Principle Aspects of Case Management
"BSS" (Balanced Service Systems) Model

J.C.A.H.O. (*Joint Commission on Accreditation of Healthcare Organizations*) *and the CMHC* (*Community Mental Health Center*) *Act*

A - Assessment
P - Planning
L - Linking
M - Monitoring
A - Advocacy

Case Management Health Screening

(*Criminal Justice Addiction Services*)

CONFIDENTIAL

Hepatitis A Screening

If one or more items are checked below in this section, the client meets the criteria for risk status for exposure to hepatitis A and should be referred to the health department or another qualified healthcare professional to be tested for this infection.

___ household/sexual contact of hepatitis A infected person(s)

___ international traveler

___ resident of American Indian reservation or Alaska Native village or other region with endemic hepatitis A

___ employee of day care center during outbreak of hepatitis A

___ gay male sex during outbreak of hepatitis A

___ injecting drug user during outbreak of hepatitis A

___ resident of correctional facility/other residential program or day treatment program during outbreak of hepatitis A

Hepatitis B Screening

If one or more items are checked below in this section, the client meets the criteria for risk status for exposure to hepatitis B and should be referred to the health department or another qualified healthcare professional to be tested for this infection.

___ has ever had a sexually transmitted disease

___ has had sex with more than one (1) partner in the past six (6) months

___ has ever shared needles

___ has ever been an injecting drug user

___ has undergone kidney dialysis

___ has received blood transfusions

___ household/close contact with someone who has hepatitis B

___ resident of or traveler to Africa, China, Middle East, South America, Southeast Asia, the Pacific Islands, or other high risk parts of the world

___ has undergone any body piercing or tattooing

___ has ever shared toothbrushes or razors with anyone

___ employee or volunteer in healthcare facility who comes in contact with blood or other body fluids

Hepatitis C Screening

If one or more items are checked below in this section, the client meets the criteria for risk status for exposure to hepatitis C and should be referred to the health department or another qualified healthcare professional to be tested for this infection.

___ has received blood from a donor who later tested positive for hepatitis C

___ has received a blood or blood component transfusion (including during childbirth) before July, 1992

___ has received a solid organ transplant before July, 1992

___ has received clotting factor before 1987

___ has ever injected illegal drugs

___ has ever been on long term kidney dialysis

___ has ever been a healthcare worker who has had a needle stick, sharp or mucous membrane exposure to hepatitis C positive blood

___ born to a mother infected with hepatitis C virus

HIV/AIDS Screening

If one or more items are checked below in this section, the client meets the criteria for risk status for exposure to HIV/AIDS and should be referred to the health department or another qualified healthcare professional to be tested for this virus.

___ had sex without knowing for certain that the person or persons do not have HIV

___ had sex with someone who does have HIV or AIDS

___ had any disease passed on by sex, such as genital herpes or syphilis

___ had sex with many men or women or had sex with someone else who has had sex with many men or women

___ had sex with someone who has used needles to take drugs

___ shared needles or works to take drugs

___ shared items such as toothbrushes, razors, and devices used during sex which may be contaminated with blood, semen, or vaginal fluids

TB Screening

If one or more items are checked below in this section, the client meets the criteria for risk status for exposure to TB and should be referred to the health department or another qualified healthcare professional to be tested for this disease.

___ has or is at risk for HIV infection (one or more items checked above in previous section)

___ close contacts with someone who has infectious active TB

___ has medical conditions such as end-stage renal disease, gastrectomy, and immunosuppressive therapy

___ injection drug user

___ foreign born in endemic area

___ medically underserved, low income individual

___ farm worker or homeless individual

___ resident of long-term care facility

To be placed in client record without a name in case the form is ever separated from file.

Clinical Case Management Screening for Adult Offender Personality and Addiction

(*American Psychiatric Association, Criminal Justice Addiction Services*)

Part 1: Antisocial Personality Disorder (APD) Screening
(All 4 blanks must be checked to meet APD screening criteria)

_____ Before the age of 15 years, at least 3 of the following are indicated within 12 consecutive months (meaning that there was evidence of "Conduct Disorder") *(circle the 3 or more that apply):*

- aggression to people or animals
- destruction of property
- deceitfulness or theft
- serious violations of rules or laws

_____ Is at least 18 years-old currently.

_____ Since the age of 15 years, at least 3 of the following are indicated *(circle the 3 or more that apply):*

- repeatedly performs acts that are grounds for arrest
- repeatedly lies, uses aliases or cons others for personal profit or pleasure
- repeatedly fails to plan ahead
- repeatedly angry, annoyed or irritable
- repeatedly involved in physical fights or assaults
- repeatedly unsafe or dangerous with self or others
- repeatedly fails to sustain consistent work behavior or honor financial obligations (and/or to maintain an enduring attachment to a spouse or romantic partner and/or to be a responsible parent)
- repeatedly indifferent to or rationalizing having hurt, mistreated, or stolen from another

_____ The 3 or more indicators seen above do not occur exclusively during the course of Schizophrenia or a Manic Episode (and are not better explained by a drug of abuse or a physical/medical injury or illness).

(*American Psychiatric Association, Criminal Justice Addiction Services*)

Part 2: Substance Use Disorder (SUD) Screening
(At least 1 blank must be checked to meet SUD screening criteria)

_____ Within the past 12 months, at least 3 of the following are indicated for

Substance Dependence (circle the 3 or more that apply):

- increased tolerance
- withdrawal
- increased quantity or duration
- persistent desire or inability to decrease or discontinue use
- increased time to obtain or recover
- social/occupational/recreational impairment
- continued use despite awareness of related physical or psychological problems

_____ Within the past 12 months, at least 1 of the following are indicated for

Substance Abuse (circle the 1 or more that apply):

- recurrent use resulting in social/occupational/educational problems
- recurrent use in physically hazardous situations
- recurrent substance-related legal problems
- continued use despite awareness of related social or interpersonal problems

Case Management Admission Summary

(*Colorado ADAD*)

Client Name _____

DOC/Case Number _____

Social Security Number _____

Date of birth _____

(Type of admission; Referral source; Age; Sex; Race; Marital status; Living situation; Employment status; Educational history; Chemical dependency history; Medical history; Psychiatric history; Social history; Problem areas; Initial treatment goals-preliminary short term objectives based on primary problem areas and expected results)

_____

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_____

Signature of Client: _____

Date: _____

Signature of Staff/Witness: _____

Date: _____

How Case Managers Can Do or Assist With Mental Health Screenings

(*SDDS-PC, Symptom-Driven Diagnostic System - Primary Care*)
(*Primary Psychiatry*)

- ✓ Increase in managed care leads to decrease in access to mental health services for some clients.

- ✓ More family/general physicians or PCPs doing mental health care in their offices.

- ✓ Case managers can help with this pressure on primary care physicians and their patients by doing or assisting with mental health screenings (if the case manager has the appropriate education, training, experience and credentials).

Ask the right questions!

Physicians (MD and DO) don't always know how to question their patients about the possibility of depression. Case Managers can help by using this list from the Symptom-Driven Diagnostic System or other such instruments.

Instead of simply asking a patient if he or she is "depressed," also ask about:

- unhappiness?
- loss of pleasure?
- feeling blue?
- crying?
- feeling sad?
- lost interest in things?
- change in appetite or weight?
- change in sleep patterns?
- agitated, fidgety or pacing?
- tired?
- less energy?
- feeling worthless or guilty?
- trouble concentrating?
- thinking about death?

Substance Abuse Evaluation
Case Study #1

History

This 42-year-old "American" (Caucasian) male is on probation in _____ for one year (from June 2002 to June 2003) for possession of drug paraphernalia. He self reports being arrested in his hotel room at _____ during the summer of 2002 after the police received an anonymous tip about "drug use." The client states that his ex wife now admits to making that call. He took two cocaine pipes, some tubing, a scale and plastic bags from the kitchen table of his ex wife and her new boyfriend earlier that day. He also admits to hitting the boyfriend in the face. He says he did these things because he was angry with them for using drugs and causing marital and financial problems for him, as well as for living in his house. The client says he was not represented by an attorney in this matter because he was unemployed and had no money. He pled guilty "hoping that the judge would understand what happened." In addition to probation and receiving a $250 fine, he was reportedly ordered to complete a substance abuse evaluation because of the drug-related offense.

The client says that this is his second such evaluation and that he did not like the findings or recommendations of the first evaluation (completed at _____ in _____ about six months ago). That evaluator supposedly recommended 12 sessions of relapse prevention counseling, something the client is adamantly opposed to because he denies having a current alcohol or other drug problem, doesn't want to pay for something he does not need and because it would interfere with a planned move out of state. He only has a part time, temporary job at _____ at this time. He is eager to return to _____, _____ where he says he has been offered a job as plant manager at _____. He states that he may get permission from probation to move before June.

The client informed this evaluator that his only other arrest ever was for a DUI in 1985. He remembers a BAL of 0.16. He said he had been drinking heavily in a bar and was driving home when he was stopped for an illegal lane change and also because the police officer could not read the temporary license plate displayed in his tinted window. He pled guilty without counsel that time, too, and was ordered to complete alcohol/other drug education and therapy groups. He states that he successfully completed both programs at an unknown state designated treatment facility located in _____. DMV reportedly reinstated his driver's license after a six-month suspension. He says he relapsed two weeks after graduating from the therapy class in 1985, drank heavily for one month and then started AA voluntarily on a regular basis for seven years. He stopped attending after other people in meetings confronted him about thinking he could play pool tournaments in bars and not give into the temptation to start drinking again. "I think some people can become addicted to AA." He insists that he has

not had a single drink in 18 years and that his current girlfriend and the rest of his support system are sober.

The client says that he used marijuana (THC) one time in high school. "I just tried it once. I didn't like it. I played football and was healthy. It was stupid. I didn't like the way it made me feel."

He denies ever trying cocaine or using any other drugs, including prescription medications (unless prescribed and taken as directed).

He has smoked one pack of tobacco cigarettes every two days since the age of 24. He has never tried to quit. He said he is interested in doing so and was told about the cessation programs at _____ County Department of Health and Environment.

Findings

The client consented in writing to being asked a series of confidential questions about health and substance abuse behaviors. He also signed a release of information form allowing disclosure of the results to his probation officer. He does not meet the criteria for risk status for exposure to HIV/AIDS, Hepatitis A, Hepatitis C, or TB (assuming that he answered the questions truthfully). However, he does meet the criteria for risk status for exposure to Hepatitis B because of tattooing (three tattoos on both shoulders and back from 1986 until 1999) and body piercing (two places done at the same time on left ear ten years ago). He says that the piercing and all tattooing were done in licensed shops using sterile needles and gloves. The client was told in this interview that he could contact the _____ County Department of Health and Environment or another qualified healthcare professional for Hepatitis B testing and counseling if interested.

The client denies any major medical problems except that he estimates being overweight by about 40 pounds (and again, he smokes). He was told that the health department also has programs for weight loss. The client also has what he calls a muscle deficiency in both of his eyelids (a.k.a., "sleepy eyes" or "bedroom eyes"). He says he has no known drug allergies/other allergies and is not taking any medications.

The client had a normal mini mental status exam (he received a score of 29 out of 30). The only item missed was name of this agency.

There is no evidence of Conduct Disorder before the age of 15 (i.e., the client states that he was not aggressive to animals, he was not destructive of property, he did not have serious violations of rules and laws, and he did not have

problems with deceitfulness or theft). He admits to some fistfights but only when he was teased about his eyes and he says no one was injured.

As an adult, he has engaged in breaking rules and laws by his current case and his DUI 18 years ago. He also owes about $3,000 to his bank (he says his ex wife used his line of credit on his checking account and now he has to pay it back with 16% interest). He also had a motor vehicle repossessed in 1988 because of defaulting on car loan payments. He is currently involved in a division of property case against his ex wife regarding the house that they recently sold. His next court date about this in _____ County is pending (again, he does not have an attorney).

Diagnoses

Adult Antisocial Behavior (current legal problems not due to a mental disorder such as Conduct Disorder, Antisocial Personality Disorder or an Impulse Control Disorder).

Nicotine Dependence.

Alcohol Dependence, Sustained Full Remission (has not used the substance for more than 18 years).

Strengths

The client likes his probation officer, reports a good relationship with his girlfriend, is optimistic about moving to _____ for a new job and is willing to attend a one-day class to learn different ways to communicate, make decisions and solve problems (versus hitting his ex wife's boyfriend and taking their drug paraphernalia). The client is a high school graduate and he completed three years of college at the University of _____ (where he had a football scholarship until he broke his back when home for Christmas break).

Recommendations

A one-day (8:30 a.m. to 4:00 p.m.) class on conflict management at _____ for $60, for the reasons specified above. They can be reached at (_____) _____-_____. (The client was given this telephone number already.) The client is aware that he could have been arrested for assault (and theft, except the items he stole were illegal so they were not reported as stolen). However, he needs to

have increased awareness of other options and alternatives with coping, managing and dealing with the problems with his ex wife (especially now that they are in court again over the sale of their house). He says that she continues to use cocaine on a daily basis and that her boyfriend is in jail for distribution.

The client should be referred to outpatient substance abuse treatment only if he has a positive urine drug screen or a positive breath test result, another drug related offense, if he admits to drinking alcohol or using other drugs, and/or if he requests such a referral on his own to prevent relapse.

Please contact this evaluator as needed with any questions. I can be reached at (_____) _____-_____. Thank you for the referral.

Substance Abuse Evaluation
Case Study #2

History

This 47-year-old Caucasian female is on probation for one year for assault. She was sentenced on _____. In July 2002 she was in a "fight" with her sister. She admits to hitting her sister in the head with a phone. The sister's head was cut and bleeding. According to the client, no medical attention was required. She insists that it was self defense, that her sister grabbed her out of her own bed when she was sleeping. She admits to having one mixed drink a few hours earlier that night. The client had confronted the sister that same day about letting the sister's son and daughter drink alcohol and smoke marijuana. The client called her sister an "unfit mother." The client's nephew has had chronic legal problems and the client and her husband have let him live with them in the past. The arresting police officer reportedly smelled alcohol on her breath the night that the client was arrested. For this reason, the client states that the court ordered a substance abuse evaluation. She is also submitting random, unannounced breath tests at _____ three times weekly. She states that she has paid all court fees already and that she is prohibited from consuming any alcoholic beverages "because my sister convinced everyone that I have a problem with alcohol."

The client has been married for 24 years. She lives with her husband and their two adult children (ages 20 and 22), both of whom have completed high school and are working currently. The client is a master's level _____ in the _____ unit at _____ in _____. She has been employed there for 23 years.

The client admits to having one glass of wine on Easter Sunday. She reports that this is her most recent use of alcohol or any other drugs. She states that she has been drinking no more than once a week since she was arrested last summer (but nothing after her sentencing). She says that she started drinking beer, wine coolers and fruit flavored mixed drinks in college at the age of 20. She would drink occasionally on weekends, but never during the week. She says she was drunk a couple of times but did not like it. The past couple of decades she has consumed alcohol at home with her husband or when going out to dinner or to a party, however, she denies drinking more than two to three drinks, "because three to four will do it for me" (cause her to be intoxicated).

The client used marijuana (THC) in college. She would share one joint with friends twice monthly. She also used sporadically when first married. She denies any use of THC for about 15 or 20 years until four years ago. Her last use was with her sister in 1999 after the funeral of their father. The father died unexpectedly and the client was severely depressed.

She has never smoked cigarettes or used other tobacco products. She denies any other drug use except the alcohol and THC already discussed.

Findings

The client consented in writing to being asked a series of confidential questions about health and substance abuse behaviors. She also signed a release of information form allowing disclosure of the results to her probation officer. She does not meet the criteria for risk status for exposure to HIV/AIDS, TB, Hepatitis A, Hepatitis B or Hepatitis C (assuming that she answered the questions truthfully). The possible risk factors were international travel (but to Mexico only) and body piercing (both ears, but many years ago). A referral to the health department for testing or counseling is not appropriate or necessary. As a healthcare worker, she has received all three vaccinations for Hepatitis B and is tested annually for TB. She is interested in the possibility of receiving the two Hepatitis A vaccinations after being informed of that option and may follow up with her own physician or other provider.

The client has hypertension and takes Lisonipril for this. She also has hyperthyroidism and is on Synthroid. She reports taking both medications as directed on a regular basis. She is allergic to Inapsine. When asked what happens when she takes this, she replied, “I have no blood pressure.”

The client was in psychotherapy and taking an antidepressant (Trazodone) with a local psychiatrist after her father’s death until as recent as February of this year. She has never received any other mental health or substance abuse counseling.

The client had a normal mini mental status exam (she received a score of 29 out of 30). The only item she missed was “city.” She thought we were in _____ instead of _____.

There is no evidence of Conduct Disorder before the age of 15 (i.e., the client states that she was not aggressive to people or animals, she was not destructive of property, she was not involved in deceitfulness or theft, and she did not engage in serious violations of rules).

The client insists that she has never been arrested or convicted of any crime until the current offense and that she even has a perfect driving record.

Diagnoses

Adult Antisocial Behavior (a single arrest and conviction for assault as discussed above that is not due to a mental disorder such as Conduct Disorder, Antisocial Personality Disorder or an Impulse Control Disorder).

No evidence of substance abuse.
No evidence of substance dependence.

Strengths

The client likes her probation officer; she likes the staffer at the drug-testing agency; she has a close relationship with her husband, children and mother; she has an advanced college degree and a successful long-term career. She has the insight and willingness to ask for help, as well as the resources to arrange and pay for treatment if and when she becomes depressed again (not a current problem).

Recommendations

Only if the client uses alcohol or other drugs while on probation (or changes her presentation and suggests that she may have a problem after all), should she be referred to outpatient substance abuse treatment.

No substance abuse therapy, education or support is indicated at this time.

Please contact this evaluator as needed with any questions. I can be reached at (_____) _____-_____. Thank you for the referral.

Case Management Treatment Plan

(*Criminal Justice Addiction Services*)

Client Name _____

DOC/Case Number _____

Social Security Number _____

Date of birth _____

- Goals must be *achievable* and *measurable*.
- Goals must be *specific.* There must be a "who," "what," "where," "why," "when/when/when" (start date, frequency and duration), and "how" for each goal.
- Goals must be *positively stated.* Talk about what the client WILL DO not what he or she won't do (can't do, shouldn't do, etc.).

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Client: _____

Date: _____

Signature of Staff/Witness: _____

Date: _____

Referral versus "Linking"

(*Rothman and Sager*)

Linking to formal organizations (providers or professional agencies) and/or informal support networks (friends/neighbors, community organizations or self help groups)

Referral

- providing resources (information or suggestions) to the client
- usually a single action done by referring individual
- usually performed by paraprofessionals, interns or case aides

Linking

- connecting or matching the client ("hooking them up") based on an assessment of needs by professional who is aware of formal and informal resources and can influence organization/network decision based on credentials
- an ongoing process that may require writing of letters, completion of forms, transportation coordination, payment assistance, all of which is done with client (this includes monitoring to confirm that connection is made and fit is a good one)
- involves encouraging and supporting client (by preparing them for first appointment or meeting, or even accompanying them as appropriate and necessary)
- involves reviewing experience with client, getting feedback from organization or network and ensuring service if client denied access

Case Management and Substance Abuse Confidentiality

(*Title 42* CFR Part 2)

Federal Rules Regarding Confidentiality of Alcohol and Drug Abuse Clients

- The program may not say to a person outside the program that a client attends the program.

- The program may not disclose any information identifying a client as an alcohol or drug abuser.

Unless,

- the client has signed a written release or consent form,
- there is a court order allowing disclosure,
- there is a medical emergency or immediate danger to self issues,
- qualified personnel are conducting a program audit or evaluation,
- the client commits or threatens to commit a crime at the program or against any person who works for the program,
- there is suspected child abuse or neglect.

There is also a duty to warn individuals who have been threatened by clients and these situations must be reported to and coordinated with referral agents **immediately**.

Clinical Case Management
Sample Release of Information Form

Client name _____

DOB _____ SSN _____

I (client name),_____ , hereby authorize

(individual/agency name) _____

(relationship to client) _____

(address) _____

(telephone number) _____

to release the confidential information identified below to:

(individual/agency name) _____

(relationship to client) _____

(address) _____

(telephone number) _____

(for the purpose of)

_____.

Check all items that apply:

_____admission summary
_____alcohol/drug use history
_____assessments/evaluations/screenings
_____treatment plan
_____progress notes/reports
_____discharge summary
_____class attendance record
_____incident report forms
_____case management summary
_____pre-sentence investigation report
_____probation/parole history and reports
_____referral form
_____urine drug screens/breath analysis results
_____other test results
_____medical history and treatment summary
_____psychiatric history and treatment summary
_____other (must be specified:_____).

This release shall remain in effect for the duration of treatment or until:

_____(whichever comes first).

- I understand that I may revoke this release in writing at any time.
- I understand that the confidential information requested may be communicated verbally, in writing by mail, in writing by electronic mail, or in writing by facsimile transmission.
- I understand that my records are protected under the federal regulations 42 CFR Part 2 governing confidentiality of alcohol and drug abuse client records and that they cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I also understand that the same regulations mentioned above prohibit further disclosure of the records to other individuals/agencies without additional written consents from me.

_____ _____
Client signature Date

_____ _____
Staff/Witness signature Date

Case Management Monitoring

(*Rothman and Sager*)

FORMAL

- checklists,
- rating scales,
- questionnaires,
- surveys.

INFORMAL

- letters,
- calls,
- visits,
- chart reviews. *"Goal is to ensure that the client has a satisfactory and satisfying life" by paying attention to:*

The client - Monitor his/her:

- progress
- changes
- problems
- satisfaction

(not simple tracking or follow-up only)

The support system - Monitor its:

- relationship with client
- concerns
- complaints
- resources

(day-to-day contact with client)

The providers/programs - Monitor their:

- effectiveness
- efficiency
- resources

(as professional agencies)

How Case Managers Can Evaluate and Promote Quality Behavioral Health Clinicians

(*ICMA, 1994*)

- Need to give them feedback.
- Need to know the experts.
- Need clinicians with community resources.
- Need clinicians who document well.
- Need clinicians who know insurance policies.
- Need to explain that value equals quality plus cost.
- Need to explain that when care increases claims decrease.
- Need to look at their licensure, certification.

Case Management Progress Notes

(*Colorado ADAD*)

Client Name _____

DOC/Case Number _____

Social Security Number _____

Date of birth _____

S=subjective (what the client says regarding feelings, concerns, progress with treatment goals; direct quotes for client statements)

O=objective (what the case manager observes regarding client during group, meeting, activity; test results; report information)

A=assessment (interpretation by the case manager of information in subjective and objective sections)

P=plan (regarding problems, goals, next meetings, etc. based on information in subjective, objective and assessment sections)

Date/Day/Time Type and Length of Meeting Goal Number/Name

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Staff _____

Date _____

Case Management Advocacy

Other terms:

- *"representative"*
- *"reformer"*
- *"defender"*
- *"supporter"*
- *"guardian"*

Case Management Advocacy
5 Power Categories

(*Moxley*)

5 Power Categories for Case Managers
(strategies/approaches when clients are denied services)

1. *AUTHORITY*
   (access to services standards of care, legislative, legal, administrative)

2. *HUMAN RESOURCES*
   (encouraging cooperation from other professionals, consumer groups, organizations)

3. *SKILL & KNOWLEDGE*
   (using details- eligibility, licensing, standards)

4. *SOCIAL PSYCHOLOGICAL FACTORS*
   (taking advantage of charisma, influence, reputation)

5. *MATERIAL RESOURCES*
   (using funds to pay for services or withdrawing as needed)

Advocacy Levels

(*Rothman and Sager*)

LOW CONFLICT
Discussion and Persuasion

MODERATE CONFLICT
Prodding

HIGH CONFLICT
Coercion

Case Management Discharge Summary

(*Colorado ADAD*)

Client Name _____

DOC/Case Number _____

Social Security Number _____

Date of birth _____

(Type of admission; Referral source; Age; Sex; Race; Marital status; Living situation; Employment status; Educational history; Chemical dependency history; Medical history; Psychiatric history; Social history; Problem areas; Treatment goals; Treatment summary; Discharge reason and condition; Further treatment or post treatment plan; If consent, follow-up plan with methods, dates, treatment staff to do, etc.)

_____

_____

_____

_____

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_____

_____

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_____

_____

_____

_____

_____

_____

_____

Signature of Staff _____

Date _____

Case Manager Ethics

(*Case Management Society of America*)

- Promote autonomy.
- Place client's needs first.
- Empower growth.
- Promote good.
- Be fair.
- Be moral.

Ethical Dilemmas/Discussion Questions for Case Managers and Counselors

(*Kannenberg, 2003*)

Dilemma #1 Confidentiality

Your client's children go to the same school as your children or your relative's children. He or she attends PTA meetings with you or your relative.

What do you tell your relative, the PTA officer(s), or principal/other school officials about the client?

Why?

Dilemma #2 Cultural Diversity

Your client has mental health treatment as a condition of placement and a goal on his or her case management service plan. You link the client to the same provider you usually do. However, the client reports back to you after just a few sessions that it's not a good fit or match. "I can't connect with him. He can't begin to understand where I've been. We grew up in totally different parts of town."

Do you agree to transfer the client to a practitioner or program that specializes in working with individuals and families from his or her race or ethnicity?

Why or why not?

Dilemma #3 Grievances

Your client tells you that his or her previous case manager (still your coworker) was negligent in handling his or her responsibilities as case manager. He or she gives specific examples of having several weekly meetings canceled, notes and telephone calls unanswered, and failing to refer to treatment. There seems to be a pattern of neglect of case management obligations.

Do you report this colleague to a supervisor?

Why or why not?

Dilemma #4 Inappropriate Relationships

Your client is self-employed as a carpet and furniture upholstery cleaner and auto detailer. He or she would like you to use his or her business services at the facility, at your home, and/or for you to hand out his or her company brochures and business cards.

Do you agree to do any or all of these things?

Why or why not?

Dilemma #5 Counselor Relapse/Recovery

Your client tells you that his or her current case manager (your coworker) cried during the intake when the client was talking about being a victim of childhood abuse. He or she adds that the case manager reportedly said, "I think that all child abusers should be killed!" He or she also says that another resident saw the case manager "very drunk" at a local sporting event recently. You have seen this same coworker cry at team meetings and observed him or her drinking excessively at one or more parties after work.

What do you do?

Why?

Dilemma #6 Scope of Practice

You have never worked with someone like this client before (age/sex/race specific issues; type and nature of crimes; severity of physical disability, developmental disability, mental illness/chemical dependency, etc.). You do not feel qualified to work with him or her.

What do you do?

Why?

Behavioral Health Case Management

An understanding of behavioral health case management includes:

- *treatment protocols for psychiatry and addictions;*
- *disease process for major medical illnesses;*
- *levels of care required for different phases of mental illness and chemical dependency;* and
- *different physical health care options available in the community.*

Case Managers and Four Types of Negligent Referrals

(*Hyatt*)

Case Managers may be liable to clients who are injured as a result of a substandard utilization such as*:*

- referral to an incompetent ("bad") provider
- substituting a less expensive/inadequate referral (okay if less expensive/adequate)
- referral to an inappropriate ("wrong") provider
- failure to refer at all when needed

Case Managers and Another Type of Negligent Referrals

Excessive (too many) referrals

> Example: A client may need GED, life skills, drug/alcohol education and therapy, domestic violence, parenting and work orientation; however, he or she will probably not be successful and satisfied if placed in all of these groups, meetings and activities
> at the same time.

How to Minimize Making Negligent Case Management Referrals

(*Hyatt*)

- Check for license, certification or registration.
- Verify skill areas.
- Take tours.
- Ask for references.
- Discuss with the client's family.
- Review in rounds or treatment planning conference.
- Document the need for referral.
- Ask for help as needed.

How Case Managers Can Minimize Liability

(*Hinden*)

1. Document PCP approval in case management records.
2. Document ongoing reviews by PCP.
3. Have case management policy and procedure manual and comply.
4. Follow through on time.
5. Communicate to all parties at the same time.
6. Do NOT say the following:“authorize”
    - “approve”
    - “required”
    - “certified”
    - “best”
    - “highest”
    - “guarantee”

Do use professional but not overly clinical or final language when talking to patients.

Case Managers and Liability Insurance

Case Management liability insurance policies (available through several professional case management associations) can cover the following activities:

- UR and concurrent reviews
- Fee disputes
- Quality questions
- Discharge planning
- Chart and bill audits
- Telephone calls
- Face-to-face meetings

Case Manager Caseload Size Variables

Factors to consider:
(by client group, program and case manager)

- Acuity of clients
- Intensity of service
- Age/experience of agency
- Experience/training of case manager

Case Management and Caseload Size

(*Graham*)

- increased size leads to *decrease* in case management frequency
- increased size leads to *decrease* in case management involvement
- increased size leads to *decrease* in overall case management quality

Ideal Case Management
Caseload Numbers

- 4 – inpatient children
- 14 – residential adolescents or adults
- 40 – outpatients

Team versus Individual Case Management

(Test and Stein)

TWO TEAM OPTIONS

- Team is made up of all case managers.
- Team is made up of case manager(s)
- and social workers, nurses, therapists, physicians, other staff.

THREE ADVANTAGES OF TEAMS

- More continuous coverage and coordination.
- More points of view, energy and creativity.
- Less isolation and less burnout.

Two More Advantages of Teams

- Better/more thorough assessments.
- Sharing of serious responsibility and important decisions.

How Case Managers Can Prevent Unnecessary Prescription Problems

(*Vohs*)

1. KEEP A LIST
   (of allergies, medications in past, current orders/over the counter drugs, etc.)

2. USE A SINGLE PHARMACY
   (for all medications and request a list of side effects/adverse reactions)

3. USE “PILL BOXES”
   (for clients of all ages to label days, times and directions)

4. EXPLAIN GENERICS
   (by asking the pharmacy to place the medication name that patient knows on the label)

5. DECREASE FREQUENCY
   (ONLY if physician approves allowing patient to take most or all of the medication at the same time when safe to do so)

6. TALK WITH ALL DOCTORS
   (because PCP needs to see list of medications from others and vice versa)

What do Case Managers and Counselors Provide?

(*Rothman and Sager*)

- motivation and support
- "help" giving
- "here and now" problem-oriented advice, guidance and information sharing
- teaching in areas of problem-solving, communication, decision making
- personal/social, basic living/life skills instruction
- vocational skills instruction
- crisis intervention

Services That Case Managers Do <u>Not</u> Provide

- extensive exploration of feelings or experiences, or meanings of all symptoms
- individual therapy
- couple or marital therapy
- family therapy

Eight Appropriate Case Manager Attitudes with Clients with Persistent and Continuous Mental Illness

(*Pepper*)

1. NON-JUDGMENTAL
   (no blaming, no personal values, positive language)
2. UNDERSTAND WEAKNESSES
   (evaluate problems and influences)
3. ACCESSIBILITY
   (someone or some system needs to be there 24 hours a day)
4. ACCEPTANCE
   (establish rapport and a functional, friendly working relationship)
5. MUTUALITY
   (make agreed upon goals; be professional, honest; trust each other; share information)
6. CONTINUITY
   (know that some or most will not be cured but people can get better with time)
7. INDIVIDUALITY
   (not just "cases" or "clients" or "patients," but "people" instead)
8. OPTIMISM
   (for all people, their families, agencies, other case managers and self)

Multicultural Recommendations for Case Managers

(*Banja*)

ASSESS THE CLIENT'S UNDERSTANDING OF:

<u>Western disease terminology</u>
Don't say "treatment" "therapy" or "detox" if the client says "hex" "loss of soul" or "evil eye." Listen carefully and ask for explanations.

<u>Personal/subjective meaning of illness</u>
Don't hesitate to refer to the hospital chaplain or to a pastoral counselor if the client talks about his/her "higher power" "God" or "test of faith." Ask any questions about religious beliefs.

<u>Disability and sense of community</u>
Don't assume that all people see disabilities the same way and allow a higher degree of family involvement if that's the norm for the culture, even if seemingly "difficult/demanding." Alienation could result in no long-term support after discharge.

Case Management Cultural Diversity and Multicultural Sensitivity

(*Banja*)

If Case Managers ignore the practices and beliefs of their clients, their clients may perceive that they are being harmed.

Six Cultural Examples for Case Managers

1. Some Japanese, Italian, Russian clients may believe that medical disclosure of any kind is harmful to them.

2. Some Native American clients may consider direct eye contact disrespectful.

3. Some Italian, Hispanic and African clients may consider close personal space/social distance better.

4. Some Vietnamese clients may believe that touching a baby's head is true evil.

5. Some Native or Central American clients may wish to be silent and expect you to honor that silence.

6. Some Northern Cheyenne clients may think that disability is a bad, negative word.

Case Manager Reaction To Their Client's Perceived Lack of Progress

(Menninger)

Problems

- slow progress from client
- unresponsive client
- difficult/demanding client

Responses

- burnout of case manager
- negative and/or angry case manager
- case manager challenges treatment

Answers

- supervision (peer okay if better)
- case conferences (with client too if possible)
- rounds with team
- journaling of case manager feelings (but keep it at home or in car if private/personal)

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Appendix A: Post Test and Evaluation for ***The Offender and Addiction – Clinical Case Management***

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in any **one** of the following manners:

1. *Submit your test via the Internet.* All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions using the answer sheet found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Take Exam' and you will be presented with the electronic exam.

   To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. , which is the final step in the process. Once you submit the evaluation, you will receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

   If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

   OR

2. *Submit your test by mail using the answer sheet found at the end of this package.* First, complete the cover page that will identify the course and provide us with the information that will be included in your Certificate of Completion. Then, answer each of the questions by selecting the best response available and marking your answers on the sheet. The final step is to complete the course evaluation (most certifying bodies require a course evaluation before certificates of completion can be issued). Once completed, mail the information, answer and evaluation sheets to this address:

   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

   Once we receive your exam and evaluation sheets, we will grade your test and notify you of the results.

   If successful, you will be able to access your Certificate of Completion and print it. Access your browser and go to the Student Center located at:

   http://www.ceumatrix.com/studentcenter

   Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'Certificate' and you will be presented with a download of your Certificate of Completion that you may save / and or print. If you would rather have your Certificate of Completion mailed to you, please let us know when you mail your exam and evaluation sheets; or contact us at ceumatrix@ceumatrix.com or 800.421.4609.

   If you do not obtain the required 80% score, we will provide you with feedback and instructions for retesting.

   OR

3. *Submit your test by fax.* Simply follow the instructions above, but rather than mailing your sheets, fax them to us at **(**(512) 863-2231.

If you have any difficulty with this process, or need assistance, please e-mail us at **ceumatrix@ceumatrix.com** and ask for help.

Answer the following questions by selecting the most appropriate response.

1. Case management involves which of the following:

    a. evaluation of options and services;
    b. coordination and monitoring of options and services;
    c. direct counseling and therapy or other clinical treatment;
    d. both a. and b.
    e. none of the above.

2. Case management meets an individual's health needs by:

    a. providing medical and/or behavioral health care referrals or links;
    b. using communication and available resources;
    c. promoting quality, cost-effective outcomes;
    d. all of the above.
    e. none of the above.

3. The ultimate goal of case management is optimal level of functioning.

    a. True
    b. False

4. In a case management model the physician is the so called, "single accountable
   individual."

    a. True
    b. False

5. The premise of case management is that when an individual reaches the optimum level of wellness and functional capability, the following party or parties benefit:

    a. the support systems;
    b. the healthcare delivery systems;
    c. the reimbursement sources;
    d. the individuals being served;
    e. all of the above.

6. The case manager helps identify which of the parties listed below:

    a. appropriate providers/practitioners;
    b. appropriate facilities;
    c. available resources;
    d. all of the above;
    e. none of the above.

7. Case management work activities include all of the following: documentation, evaluation, identification, communication, assessment and referrals/linking.

    a. True
    b. False

8. A case manager is exemplified as a:

    a. parent.
    b. partner.
    c. therapist.
    d. supervisor.
    e. none of the above.

9. A clinical case manager in behavior health should demonstrate a cultural sensitivity and appreciation for the elderly, disabled persons, the unemployed and the injured.

    a. True
    b. False

10. An understanding of behavioral health case management would include which of the following?

    a. treatment protocols for psychiatry and addictions.
    b. disease process for major medical illnesses.
    c. levels of care required for different phases of mental illness and chemical dependency.
    d. different physical health care options available in the community.
    e. all of the above

11. In monitoring, the case manager pays attention to:

    a. the client.
    b. the support system.
    c. the providers/programs.
    d. all of the above
    e. none of the above

12. Though often considered one and the same, referral and case management linking are actually very different functions.

    a. True
    b. False

13. The advantages of case management teams include which of the following:

    a. more continuous coverage and coordination
    b. more points of view, energy and creativity
    c. better/more thorough assessments
    d. sharing of serious responsibility and important decisions
    e. all of the above

14. The Three Basic Principles of Substance Abuse Prevention include addressing alcoholism and other drug dependency primarily as a public health problem, providing access to appropriate care delivered by credentialed professionals, and including a benefit for alcohol/drug treatment as part of any national health care reform.

    a. True
    b. False

15. It is not appropriate for a case manager to substitute a less expensive referral source even if the care is adequate.

    a. True
    b. False

16. Which of the following general statements regarding case management caseload sizes are correct?

    a. increased caseload size can lead to a decrease in case management involvement
    b. increased caseload size can lead to a decrease in case management frequency
    c. increased caseload size can lead to a decrease in overall case management quality
    d. all of the above
    e. none of the above

17. Case manager reaction to their client's perceived lack of progress may include the burnout of the case manager, a negative or angry case manager, and a case manager whom challenges treatment.

    a. True
    b. False

18. The five (5) principle aspects of case management according to the Balanced Service Systems Model by JCAHO and the CMHC Act are assessment, planning, linking, monitoring and advocacy.

    a. True
    b. False

19. Case management programs vary tremendously in size. The following are the case management models that are based on the resources, approach to services and other factors: Coordination, Minimal, and Comprehensive.

    a. True
    b. False

20. The following are services that both case managers and counselors provide: crisis intervention; teaching in areas of problem-solving, communication, decision making; "here and now" problem-oriented advice, guidance and information sharing; motivation; support; extensive exploration of feelings or experiences or meanings of all symptoms; individual therapy; couple or marital therapy; family therapy.

    a. True
    b. False

21. Access (defining and then compliance with a system that responds during off standard working hours on nights, weekends and holidays) is a shared responsibility between the client and the case manager.

    a. True
    b. False

22. The goal of case management monitoring is to ensure that the client has a satisfactory and satisfying life.

    a. True
    b. False

23. Case management monitoring is one and the same with the concepts of both tracking and follow-up.

    a. True
    b. False

24. Which of the following statements regarding case management advocacy are incorrect?

    a. moderate conflict requires coercion by case manager.
    b. high conflict requires discussion and persuasion by the case manager.
    c. low conflict requires prodding by the case manager.
    d. all of the above
    e. none of the above

25. A referral generally involves a single action only.

    a. True
    b. False

26. Case management caseload size can be influenced by the following factors: age group of client, type of population being served, acuity, severity of illness, intensity of service, age and experience of program, and experience and training of case manager.

    a. True
    b. False

27. A case management team may be made up of all case managers or a case manager and other professionals.

    a. True
    b. False

28. The Three Basic Principles of Substance Abuse Prevention in no way emphasizes the importance of addiction counselor certification or licensure.

    a. True
    b. False

29. Case manager burnout may be avoided if recognized early and addressed appropriately.

    a. True
    b. False

30. Case manager advocacy means representing, defending or supporting the client when he or she is denied necessary, appropriate and eligible services.

    a. True
    b. False

31. Case managers can minimize liability by having PCP approval in case management records and PCP involvement in ongoing reviews.

    a. True
    b. False

32. Substituting a less expensive and inadequate referral is allowed.

    a. True
    b. False

33. Which of the following statements regarding case management cultural diversity and multicultural sensitivity are correct?

    a. case managers should listen carefully to their clients and ask for explanations
    b. case managers may ask questions about the religious beliefs of clients if related to care
    c. clients may perceive that they are being harmed if case managers ignore their practices and beliefs
    d. all of the above
    e. none of the above

34. Case management can prevent unnecessary prescription problems by doing which of the following?

    a. keeping a list of allergies, medications in past, current orders, etc..
    b. by using a single pharmacy for all medications and requesting a list of side effects from the pharmacist,
    c. by encouraging use of pill boxes for clients of all ages to separate and store doses of medications by day and time,
    d. by explaining generics and asking the pharmacy to place the medication name that the patient knows on the label,
    e. all of the above

35. Examples of case manager ethics include being moral; being fair; promoting good; empowering growth; placing the client's needs first; and promoting autonomy.

    a. True
    b. False

36. There is no difference between referring to an incompetent provider and referring to an inappropriate provider.

    a. True
    b. False

37. On June 15, 1998 the U.S. Supreme Court ruled that prisons and prisoners (and jails and inmates) are covered by the Americans with Disabilities Act (ADA) of 1990.

    a. True
    b. False

38. In the same ruling mentioned above, the Supreme Court stated that correctional facilities could make reasonable accommodation on a case-by-case basis or by segregation (i.e., that all living units, educational and vocational programs did not require reasonable access by any and all disabled inmates).

    a. True
    b. False

39. Which of the following statements about case management admission summaries are correct?

    a. type of referral and referral source is the same information
    b. substance abuse history and mental health history is the same information
    c. case managers and counselors would not use the same or similar format
    d. they have information that is very similar to what would also be found in a discharge summary
    e. all of the above

40. A case management service or treatment plan should include the Start date, Frequency, and Duration for each client goal.

    a. True
    b. False

Fax/Mail Answer Sheet

CEU Matrix - The Institute for Addiction and Criminal Justice Studies

Test results for the course "**The Offender and Addiction – Clinical Case Management**"

If you submit your test results online, you do <u>not</u> need to return this form.

Name*:_____

(* Please print your name as you want it to appear on your certificate)

Address: _____

City: _____

State: _____

Zip Code: _____

Social Security #*: _____

(*Most certifying bodies require a personal identification number of some sort – last 4 digits or License is perfect.)

Phone Number: _____

Fax Number: _____

E-mail Address: _____

On the following sheet, mark your answers clearly. Once you have completed the test, please return this sheet and the answer sheet in ***<u>one</u>*** of the following ways:

1. Fax your answer sheets to the following phone number: (512) 863-2231. This fax machine is available 24 hours per day. **<u>OR</u>**

2. Send the answer sheet to:
   CEU Matrix - The Institute for Addiction and Criminal Justice Studies
   P.O. Box 2000
   Georgetown, TX 78627

You will receive notification of your score within 48 business hours of our receipt of the answer sheet. If you do not pass the exam, you will receive instructions at that time.

Name: _____

Course: ***The Offender and Addiction – Clinical Case Management***

1. [A] [B] [C] [D] [E]
2. [A] [B] [C] [D] [E]
3. [A] [B] [C] [D] [E]
4. [A] [B] [C] [D] [E]
5. [A] [B] [C] [D] [E]
6. [A] [B] [C] [D] [E]
7. [A] [B] [C] [D] [E]
8. [A] [B] [C] [D] [E]
9. [A] [B] [C] [D] [E]
10. [A] [B] [C] [D] [E]
11. [A] [B] [C] [D] [E]
12. [A] [B] [C] [D] [E]
13. [A] [B] [C] [D] [E]
14. [A] [B] [C] [D] [E]
15. [A] [B] [C] [D] [E]
16. [A] [B] [C] [D] [E]
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18. [A] [B] [C] [D] [E]
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32. [A] [B] [C] [D] [E]
33. [A] [B] [C] [D] [E]
34. [A] [B] [C] [D] [E]
35. [A] [B] [C] [D] [E]
36. [A] [B] [C] [D] [E]
37. [A] [B] [C] [D] [E]
38. [A] [B] [C] [D] [E]
39. [A] [B] [C] [D] [E]
40. [A] [B] [C] [D] [E]

CEU Matrix

The Institute for Addiction and Criminal Justice Studies

Course Evaluation – Hard Copy Format

The final step in the process required to obtain your course certificate is to complete this course evaluation. These evaluations are used to assist us in making sure that the course content meets the needs and expectations of our students. Please fill in the information completely and include any comments in the spaces provided. Then, if mailing or faxing your test results, return this form along with your answer sheet for processing. **If you submit your evaluation online, you do <u>not</u> need to return this form.**

NAME:_____

COURSE TITLE: **The Offender and Addiction – Clinical Case Management**

DATE:_____

<u>COURSE CONTENT</u>		
Information presented met the goals and objectives stated for this course	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was relevant	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information was interesting	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Information will be useful in my work	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Format of course was clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
POST TEST		
Questions covered course materials	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Questions were clear	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Answer sheet was easy to use	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good

COURSE MECHANICS		
Course materials were well organized	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Materials were received in a timely manner	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
Cost of course was reasonable	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
OVERALL RATING		
I give this distance learning course an overall rating of:	☐ Start Over ☐ Good ☐ Excellent	☐ Needs work ☐ Very Good
FEEDBACK		
How did you hear about CEU Matrix?	☐ Web Search Engine ☐ Mailing ☐ Telephone Contact ☐ E-mail posting ☐ Other Linkage ☐ FMS Advertisement ☐ Other: _____	
What I liked BEST about this course:		
I would suggest the following IMPROVEMENTS:		
Please tell us how long it took you to complete the course, post-test and evaluation:	_____ minutes were spent on this course.	
Other COMMENTS:		