

5 Case Management for Clients With Special Needs

Case management is an appropriate intervention for substance abusers because they generally have trouble with other aspects of their lives. This is especially true for those clients whose problems or issues can be overwhelming even for non-addicted people. Among these special treatment needs are HIV infection or AIDS, mental illness, chronic and acute health problems, poverty, homelessness, responsibility for parenting young children, social and developmental problems associated with adolescence and advanced age, involvement with illegal activities, physical disabilities, and sexual orientation.

In an ideal world, case managers would be knowledgeable about all those problems and needs. However, understanding the ramifications of even one can be a staggering task. For example, a case manager dealing with a client who has AIDS would need to be conversant in epidemiology, transmission routes, the disease's clinical progression, advances in treatment regimens, financial and legal ramifications, available social services, as well as psychotherapeutic approaches to AIDS patients' grief and fear. Given the many other special needs the case manager confronts, it is apparent that no one individual can be an expert in every area. In the absence of such comprehensive knowledge, several general attitudes and skills provide a basic foundation

for the professional delivering case management services to "special needs clients." The case manager serving special needs clients should

- Make every effort to be competent in addressing the special circumstances that affect clients typically referred to a particular substance abuse treatment program
- Understand the range of clients' reactions to the challenges associated with particular special circumstances
- Remain aware of the limits of one's own knowledge and expertise
- Evaluate personal beliefs and biases about clients who have special problems
- Maintain an open attitude toward seeking and accepting assistance on behalf of a client
- Know where additional information on special problems can be accessed

While it is impossible to discuss all the special needs that case managers confront, several occur repeatedly. This information is not intended to be a comprehensive treatment of any of these areas, but rather an introduction to the issues that most directly relate to the implementation of case management.

Minority Clients

Demographic realities in the United States dictate that case managers will be called on to work with individuals of different gender, color,

ethnicity, and sexual orientation. Some will be persons of color; some will be poor, not conversant in English, disadvantaged, and over-represented in many areas of the social services system. Case managers must “respond proactively and reactively to racism, ethnocentrism, anti-Semitism, classism, and sexism . . . ageism and ‘ableism’” (Rogers, 1995, p. 61).

There are five elements associated with becoming culturally competent: (1) valuing diversity, (2) making a cultural self-assessment, (3) understanding the dynamics when cultures interact, (4) incorporating cultural knowledge, and (5) adapting practices to the address of diversity (Cross et al., 1989). According to Rogers, culturally competent case managers have the

- Ability to be self-aware
- Ability to identify differences as an issue
- Ability to accept others
- Ability to see clients as individuals and not just as members of a group
- Willingness to advocate
- Ability to understand culturally specific responses to problems (Rogers, 1995)

Case managers should either speak any foreign languages common in their locale or refer non-English speakers to someone who does. It is also crucial for the case manager to be aware of what may inhibit minorities’ participation in the substance abuse treatment continuum. For example, while “accepting one’s powerlessness” is a central tenet of 12-Step self-help programs, members of oppressed groups may not accept it, given their own societal powerlessness. The case manager must always be sensitive to such cultural differences and identify recovery resources that are relevant to the individual’s values. Some minority group members may be inclined to seek help for a substance abuse problem from sources outside the treatment continuum, such as clergy, group

elders, or members of their own social support networks. Others may prefer to be treated in a program that uses principles and treatment approaches specific to their own cultures. Case managers must advocate for culturally appropriate services for their clients.

Clients With HIV Infection and AIDS

The usual functions and activities associated with case management in substance abuse treatment—engagement, helping orient the client to treatment, goal planning, and especially resource acquisition—are made more difficult in dealing with clients who have HIV or AIDS by

- Providers’ and other clients’ fear of contracting HIV
- The dual stigma of being a person with both a drug abuse problem and HIV
- The progressive and debilitating nature of the disease
- The complex array of medical, especially pharmacological, interventions used to treat HIV
- The onerous financial consequences of the disease and of treatment
- The hopelessness—and lack of motivation for treatment—among the terminally ill

Case managers who provide services to this population must be prepared to work with “a base of diverse resources, enhancement or adaptation of the capabilities of existing resources, or the development of new service programs specifically designed to address [the HIV-infected individual’s] needs” (Sonsel et al., 1988, p. 390). The Linkage Program in Worcester, Massachusetts, is typical of this arrangement. It engaged 19 diverse agencies—including drug treatment programs, area churches, AIDS advocacy and support agencies, the city’s department of public health and a regional medical center—in a consortium of care

for substance abusers who also had HIV infection (McCarthy et al., 1992). The Worcester consortium and other linkage programs demonstrated a positive relationship between the amount of case management services provided and the receipt of drug abuse, health care, and other services (Schlenger et al., 1992).

While one person should assume primary case management responsibility for clients with HIV or AIDS, a team approach is particularly useful in combating the feelings of frustration, abandonment, grief, over-identification with the client, and anger that frequently confront professionals in this setting (Shernoff and Springer, 1992). To avoid staff burnout, providers should avoid designating the same individual as case manager for all clients with AIDS and HIV infection.

The overwhelming nature of life for a person with two life-threatening conditions—AIDS and addiction—cannot be overstated. The magnitude of even daily tasks holds significant stress for both the client and the case manager. Addicted people with AIDS or HIV need help with physical functioning, interpersonal relationships, adjustment to the treatment program, housing, and practical and psychological adjustment to the two conditions.

Part of the case manager's linking function in working with an HIV-positive client is to educate the network of service providers, including substance abuse treatment staff, to recognize the competing demands of staying sober and dealing with the social and physical sequelae of HIV disease.

Clients With Mental Illness

Almost 40 percent of people with an alcohol disorder meet criteria for a psychiatric disorder, and more than half of those with other drug disorders report symptoms of a psychiatric disorder (Regier et al., 1990). Not unexpectedly,

the prevalence of coexisting disorders is significantly higher in treatment populations than in the general population, approaching 80 percent in some studies of substance abuse patients (Khantzian and Treece, 1985; Ross et al., 1988; Kosten and Kleber, 1988). Given those high comorbidity rates, substance abuse treatment staff must be prepared to address the problems of dual-diagnosis clients.

Treatment services for clients with a dual diagnosis are organized in sequential, parallel, or integrated models (CSAT, 1994b). In the integrated model, both disorders are dealt with at the same time and in the same program. Case management's primary role includes facilitating clients' transition from residential programs to the community, helping them identify and access needed resources, and providing long-term support for their functioning in the community.

In the case of sequential treatment, the case manager helps the client move from either substance abuse to mental health treatment or from mental health to substance abuse treatment. In parallel treatment, the case manager must facilitate communication and service coordination between two agencies whose treatment approaches may be based on different assumptions. Examples of the possible issues the case manager may have to address on behalf of a client in mental health treatment programs include the following:

- Bias against substance abusers affects the provision of mental health services
- Many inpatient facilities establish an arbitrary minimum number of days of sobriety for their clients
- Some service providers will not accept clients who are on medication, including methadone

Conversely, issues in substance abuse treatment programs that might be counterproductive to mental health treatment include

- Treatment approaches may rely on insight and introspection that some mental health clients are intrinsically incapable of achieving
- The approach used in substance abuse treatment may be too confrontational
- The treatment program and other clients may reject clients taking psychotropic medication

Many of the special case management issues for clients with mental illness center on the client's use of prescription drugs to stabilize mood and reduce the negative effects of the mental disorder. Some substance abuse treatment providers oppose the use of any psychotropic drugs, fearing that they will interfere with the recovery process and become a new source of chemical dependency or that the prescribing physician is not adequately aware of the client's problems with addiction. Some treatment programs unwittingly precipitate a client's relapse by requiring the client to stop taking all medications as a condition of acceptance to a treatment program. Participants in 12-Step meetings may pressure clients to be free of the "crutch" of prescription drug use.

As substance abuse treatment providers become familiar with prescribed neuroleptic drugs, they are more likely to accept the medical management of the client's illness and communicate more with the professionals providing the client's medical care. To manage client symptoms and behaviors, anticipate problems, and reinforce the medical management of the client, all staff who work with dual-diagnosis clients need some knowledge of the benefits of commonly prescribed drugs, their potential side effects, actual abuse potential, and their interactions with other drugs.

Aftercare tends to be long-term for clients with mental illness because of the continuing possibility that the client will stop taking medications when he begins to feel more stable and then take illicit drugs to cope with the re-emergent symptoms of mental illness. 12-Step

programs such as Double Jeopardy, Double Trouble, and Dual Recovery Anonymous designed specifically for people with mental health and substance abuse problems can be valuable sources of support.

While case managers may not be experts in the treatment of any one of these disorders, it is vital that they know enough to work with the client in identifying her needs and be able to translate and coordinate those needs with the two types of treatment.

Homeless Clients

Alcoholism rates among the nation's homeless are estimated to be as much as two to four times the levels for individuals of the same gender in the general population. Besides alcohol, the substances most frequently used by homeless people are marijuana, cocaine, and crack cocaine (National Institute on Alcohol Abuse and Alcoholism, 1989). Crack use in particular has increased in the last 10 years, primarily among younger homeless people (Crystal, 1982). Numerous efforts at engaging homeless individuals in substance abuse treatment have been undertaken, many involving case management as a central component (Braucht et al., 1995; Conrad et al., 1993; Sosin et al., 1995; Stahler et al., 1995).

The need for case management with this population is obvious. Clients need suitable short- and long-term housing; many have mental disorders. Homeless individuals frequently suffer from significant health problems secondary to their lifestyle, including tuberculosis, HIV, and AIDS. Unemployment is high. This constellation of tangible needs can best be addressed by one individual at the interface between the streets and social service agencies.

A case manager always begins by working on issues the client feels are most pressing, and the need for stable shelter may not be at the top

of the client's list. Many homeless people feel safer and more comfortable on the streets than in a shelter because the streets are familiar to them and because they have established routines and a network of people to watch out for them. While this setting is hardly ideal, it may be one in which the client can function well enough to benefit from treatment. However, some programs may claim they cannot help homeless individuals until their other life problems are solved, requiring the case manager to advocate on the client's behalf (Sosin et al., 1994).

The case manager's rapport-building skills are critical to break through the many defensive behaviors and protective attitudes that clients develop to survive in shelters and on the streets. These behaviors—looking tough, acting with bravado, wariness of social services, maintaining a hard exterior, and letting go of social graces—make homeless clients difficult to engage and interfere with their ability to succeed in treatment or maintain stable housing. One solution to this difficulty in engaging homeless clients is through the use of *peer case managers*: homeless individuals who are in recovery themselves and are based in shelter care facilities. In one such setting, peer case managers proved to be as successful as degreed professionals or an intensive residential treatment program in assisting homeless individuals in the areas of substance use, housing stability, employment, and psychological functioning (Stahler et al., 1995). In addition, clients were more satisfied with the services provided by the peer case managers than by the degreed professional case managers. This finding may be explained by clients' beliefs that case managers who have experienced homelessness first-hand are more likely to provide needed services.

To meet their linking and advocacy responsibilities, case managers must recognize that some services generally available to

substance abusers are not available to homeless people and that new services may need to be created to fill those gaps. For example, Louisville's Project Connect used case management to help homeless alcoholic and drug abusing men move from a sobering-up shelter (the pretreatment phase of the treatment continuum) through a vocational program at the exit point of treatment (Bonham et al., 1990). Another substance abuse program at the Coatesville Veterans' Affairs (VA) Medical Center picks up homeless veterans at local shelters, takes them in vans to the VA for day treatment, feeds them, and takes them back to the shelter. This has helped to keep veterans engaged in treatment as they await placement in a VA domicile or other housing arrangement. The Department of Veterans' Affairs conducts stand-downs in its homeless program, during which veterans temporarily housed in tents receive medical services and are assessed for treatment needs. They are brought into residential care for treatment as needed.

The delivery of social services is complicated by the fact that homeless clients usually are turned out of shelters from 9:00 a.m. until 4:00 p.m. The client's social network during these hours consists of other people, often not sober, who are also out of the shelter. Providers may find it useful to provide a day room with snacks and a television where clients can stay during the day or some sort of day work where clients can earn a few dollars. Case finding can be accomplished by mobile case management teams who seek out homeless substance abusers in shelters and other areas where they sleep and congregate (Rife et al., 1991).

Women With Substance Abuse Problems

Case-finding is an especially important case management activity with female substance abusers, who seem to follow a different path to

treatment than males. Because women are often referred by other service providers (Beckman and Amaro, 1986), case managers affiliated with substance abuse treatment programs must help their counterparts in other social service agencies identify women in need of treatment. Women with children are likely to be involved in numerous child-related services; women who have been victims of domestic violence present for services at battered women shelters; other women may appear at mental health centers and women's health centers. A significant number of women clients have suffered physical, verbal, psychological, or sexual mistreatment (Miller and Rollnick, 1991; Mondanaro et al., 1982), and many who present for treatment live in an unsafe environment.

Once identified, women with substance abuse problems may be difficult to engage in treatment. Society judges substance-abusing women more harshly than male substance abusers. A woman's substance abuse problem is likely to have progressed significantly before being identified, and treatment may be complicated by factors like psychological functioning, situational realities, and systemic barriers (Wildwind, 1984). Other issues such as sexual abuse, victimization, and emotional dependency are frequently associated with women who have substance abuse problems (Markoff and Cawley, 1996). Transportation is a common barrier, especially in primary outpatient and aftercare treatment.

Women substance abusers who have children confront these problems and more when considering treatment. A mother's decision to enter treatment means the case manager must either identify a program that will take both the woman and her children or assist the woman in finding appropriate child care. These mothers may avoid treatment out of guilt and shame for the activities in which they have engaged to acquire drugs and the situations in which they have placed their

children. Compounding a mother's shame is the fear that authorities will take her children away from her. As a result, an assessment of such a mother's needs is complicated by the fact that she is likely to lie to the case manager about her addiction and the way her family lives.

The basic functions and tenets of case management are well suited to improving retention and outcomes for women in treatment. There is evidence that women in particular do not adequately focus on their substance use and recovery until their needs for such resources as housing, food, medical care, and personal safety are adequately addressed (Hepburn, 1990). Case managers should assist female clients in developing a safety plan setting out well-defined steps to take should she fear, or be subjected to, violence. It is imperative to determine if women are living in a safe environment. Women who have children are even more extensively involved, or need to be, with community resources, including the school system, pediatric physicians, and children's protective services if their substance use has resulted in neglect or abuse. Case managers are responsible for facilitating the acquisition of these resources as their clients move through the treatment continuum.

A woman's involvement with community resources frequently places the case manager in a position to advocate for her needs. Advocacy means securing resources not only outside the treatment program, but also within the program, especially if the program primarily treats male clients (Brindis and Theidon, 1997). Advocacy not only improves the woman's acquisition of needed resources, but also empowers her to become more assertive on her own behalf and builds a closer relationship with the case manager. Advocacy cannot, however, stop the case manager from fulfilling her legal obligation to report child abuse or neglect.

Two excellent sources of information on the role that case management plays in the

treatment of women substance abusers are *Pregnant, Substance-Using Women* (CSAT, 1993) and *Case Management in Substance Abuse Treatment: Improving Client Outcomes* (Sullivan et al., 1992).

Adolescent Substance Abusers

Substance use and dependence are significant problems among adolescents in the United States. Some substance use is due to a developmental tendency to experiment, results in few consequences, and abates with maturity. However, a number of adolescents progress to the point of substance abuse or dependence. Because of the problems associated with abuse and dependence these adolescents are frequently involved with multiple systems, including child welfare, juvenile justice, mental health, and special education (CSAT, 1993).

A case manager is in a unique position to help adolescents and their families interact with those systems. The case manager of a teenager must have a thorough understanding of the developmental issues pertinent to adolescence, an ability to establish rapport with young people, a knowledge of family dynamics, and the ability to provide support and skills training.

The case manager working with adolescents will almost inevitably provide extensive case management services to the entire family as well. Problems such as poverty, child neglect, or parental substance abuse cannot be ignored. Acquiring an entire family as clients has numerous implications for caseload size, available resources, confidentiality, and whether the client is the adolescent, the family, or both. Challenges can arise in numerous contexts, for instance when an adolescent tells the case manager she plans to have an abortion. When State or Federal laws do not provide explicit guidance, the case manager must carefully

consider who is actually the client and what are the best interests of the adolescent.

One case management model describes a three-phase approach, providing services during pre-treatment/screening, residential treatment, and continuing care (Godley et al., 1994). The goal of case management services during pre-treatment/intake is to improve access to services, provide initial orientation to the treatment process, and begin skills training. Case management for clients in residential programs links the client to needed services outside the residential facility and ensures a coordinated response by multiple agencies involved in an adolescent's life. During aftercare, the professional implementing case management continues the linkage and monitoring process and provides booster relapse prevention skills training with the goal of decreasing the likelihood of relapse or interrupting a relapse episode.

Family engagement in transition and aftercare activities is paramount for the adolescent juvenile justice client. The transition work with the family needs to begin before the end of the primary treatment episode, and preferably occurs throughout the treatment episode.

Clients in Criminal Justice Settings

The number of substance abusers in the criminal justice system is staggering. The Drug Use Forecasting Project, which tested arrestees in 26 major U.S. cities for illicit drug use, found positive results ranging from 48 percent to 80 percent. In one jurisdiction, 80 percent of all women arrested tested positive for at least one illicit drug. The Bureau of Justice Statistics (U.S. Department of Justice, 1991) reported that 54 percent of State prisoners reported drug use at the time of the offense, and 52 percent reported use during the previous month.

Case management for substance abuse clients in the criminal justice system evolved in a unique fashion, bringing together two complex systems with different goals and philosophies. While the criminal justice system is interested in the rehabilitation of offenders, its main focus is on public safety, which is maintained with punishment and legal sanctions. Likewise, while the substance abuse treatment system supports public safety goals, its primary mission is to change individual behaviors. These goals are not mutually exclusive; in fact, experience has demonstrated that integrating the techniques of these two systems can have a powerful effect on reducing the drug use and criminal activity of drug-involved offenders. Because participation in substance abuse treatment and other social services is often mandated, case managers have the opportunity to engage clients over a longer period of time and may be more likely to effect successful change.

Integrating the two systems requires some effort, however. The need to establish and maintain a therapeutic relationship with clients while integrating the sanction and control obligations of the criminal justice system poses particular challenges. Ambiguities about the case manager's role in client supervision and confidentiality considerations surface frequently.

The criminal justice system is fragmented into numerous components through which offenders may be assigned. In most jurisdictions, supervision can be provided for certain pretrial offenders who have not yet gone to trial. In other jurisdictions, such offenders may be given the option of diversion, in which successful completion of certain activities will avoid a conviction. Convicted offenders may be sentenced to county jails, state prisons, or probation; probation can include halfway house supervision, intensive probation, or electronic monitoring. Released offenders may be on

parole or some other sort of post-incarceration supervision; in some jurisdictions probation sentences may follow sentences of incarceration. Linkages between prison and probation, or between county jails and community-based supervision, may be weak; databases are often not connected; and entities often report to different management structures. For example, probation offices are part of the court system in some jurisdictions, the corrections department in others. Case management efforts are critical to ensuring continuity when offenders move from one supervision level to the next, or between one status or location and another. Managing offenders who are changing status within this system while they are participating in substance abuse treatment services (both inside institutions and in the community) is exponentially more complicated.

Case management with offender populations may be implemented at any point in the criminal justice continuum. Case management can assist offenders in securing resources that are not only vital to their recovery and overall well-being, but also required by their deferred sentencing or probation. Establishing appropriate housing that will facilitate sobriety and helping the offender develop job-seeking skills are but two of the specific activities that may form the basis of the case management relationship. Offenders incarcerated in State and local correctional facilities frequently need assistance in managing their lives as they reenter the larger community. Institutional life is highly regimented, presenting special problems when offenders are released. In working with paroled individuals, the case manager must recognize that prison life encourages behaviors that are not appropriate on the outside. Parolees who have been imprisoned longer than a year may require more time in a semi-structured setting (for example, a halfway house) in order to make the transition from institution to community.

The case manager should address the needs of clients released from institutions in order of importance. The first priority is immediate stability, which can be facilitated by safe housing, access to either primary substance abuse treatment or aftercare, and social networks that facilitate positive behavior. Second, the case manager should either provide or make referral to sources of skills training, since individuals who have served lengthy sentences will likely need either habilitation or rehabilitation training in the areas of job searches, interactions with non-offender social groups, and problem-solving strategies. Third, the case manager should train or find training in setting and accomplishing short- and long-term goals. Incarceration often leads offenders to believe that the locus for control of their lives lies totally with other persons or institutions. While goal-setting is important to any client group, it is particularly important to clients who have had most basic needs provided for them. Ideally, the case manager will begin providing these services several weeks or months before a scheduled release, then follow the offender into the community. Lastly, the case manager can advocate for the offender both in the treatment environment and the criminal justice system.

In order to maximize effectiveness, several configurations of case management functions have been attempted, including:

Case management provided by the justice system. Justice system case managers are assigned caseloads at specific stages of the system, such as probation or parole. An advantage of this model is that justice system officials are invested in the process because their staff members are implementing it and reporting back to them. Major disadvantages are the expense and the fact that there may be conflicts between the philosophies and goals of the substance abuse and criminal justice systems. Another issue in this model is whether the case manager has actual training in

substance abuse treatment approaches and community referral techniques, as opposed to primarily correctional interventions.

Case management provided by a treatment agency. The advantage of a community-based treatment model is that the case manager has a thorough understanding of the substance abuse treatment process. The disadvantages include, again, the expense and the possibilities that the case manager may not be familiar with the criminal justice system or that the treatment agencies may not have the resources for effective case management.

Case management provided by an agency separate from the treatment and justice systems. To reduce costs, a case management coordinator may be employed, with or without a caseload, to conduct intake interviews and supervise paraprofessional staff. The disadvantages of this approach include the addition of another agency to the collaboration.

Case management provided by a coordinator from the justice system who provides consulting services and technical assistance to support existing criminal justice case management. One advantage of this model is system ownership. A coordinator, with or without a caseload, oversees the work of a paraprofessional staff. The coordinator can move the criminal justice system toward a greater awareness of treatment issues by providing technical assistance that demonstrates service coordination.

Case management provided by multidisciplinary groups in the criminal justice system for offender management. This type of group may meet regularly and during crises. This model is the most inexpensive; however, it is the most difficult to successfully operate because no one is assigned overall responsibility for the offender (CSAT, 1995b).

One of the earliest models for case management services in the criminal justice system was created in 1972, when the White

House launched a demonstration program known as Treatment Alternatives to Street Crime (TASC) to divert offenders from the criminal justice system into substance abuse treatment. (The program name has since been changed to Treatment Alternatives for Safe Communities.) TASC was initially designed to identify appropriate offenders from the criminal justice system, assess their needs for drug and alcohol treatment, refer them to treatment services, monitor their progress in treatment (including conducting regular and random urinalysis testing), and report that progress back to the criminal justice system. In order to meet its goals of ensuring continuous treatment for offender clients, increasing treatment retention, improving treatment outcomes, and reducing criminal recidivism, TASC developed a set of core functions or critical elements, including

■ Organizational Elements

- ◆ A broad base of support within the justice system with a protocol for continued and effective communication
- ◆ A broad base of support within the treatment system with a protocol for continued and effective communication
- ◆ An independent TASC unit with a designated administrator
- ◆ Policies and procedures for required staff training
- ◆ A data collection system for program management and evaluation

■ Operational Elements

- ◆ Agreed-upon offender eligibility criteria
- ◆ Procedures for the identification of eligible offenders that stress early justice and treatment intervention
- ◆ Documented procedures for assessment and referral
- ◆ Documented policies and procedures for random urinalysis and other physical tests

- ◆ Procedures for monitoring offenders, including criteria for success/failure, required frequency of contact, schedule of reporting and notification of termination to the justice system

One helpful development is that recent research has convincingly documented the success of compulsory and coerced treatment for drug involved offenders (Leukenfeld and Tims, 1988; Hubbard et al., 1989; Platt et al., 1988; DeLeon, 1988). TASC clients tend to remain in treatment longer than other criminal justice-referred clients and than voluntary clients; retention in treatment is linked to better treatment outcomes (Toborg et al., 1976).

TASC programs have been successful in identifying a large number of offenders in need of substance abuse services (Cook, 1992). The TASC evaluation conducted in 1976 stated that various programs had achieved success in identifying a large number of offenders qualified for TASC services and that self reports, urinalysis, and referrals from lawyers and judges seemed to increase client flow (Toborg, 1976).

This type of structured case management between the criminal justice and treatment systems has facilitated the traditional goals of each system. Case management benefits the criminal justice system by

- Increasing supervision through drug testing
- Reducing drug use and criminal behavior
- Broadening the range of sanctions available to the criminal justice system
- Providing systems of graduated interventions
- Offering treatment in lieu of or in combination with punishment
- Providing information to the criminal justice system
- Providing a basis for judicial decisionmaking
- Extending the power of the court to influence drug-using behavior

Case management has benefited the treatment system by

- Increasing treatment outreach
- Providing assessments and making appropriate referrals
- Utilizing resources more effectively
- Orienting clients to treatment
- Retaining clients in treatment by utilizing criminal justice leverage
- Supporting treatment compliance
- Facilitating access to additional services
- Providing a framework and structure for managing criminal justice clients (Cook, 1997)

Over the years, the TASC model has been expanded to include offenders throughout the criminal justice system, including mixed offender populations and specific populations such as women or adolescents. Depending on a TASC program's administrative and programmatic structure, the approach to delivery of services may vary. The various models include operation as a separate administrative entity within a court system or functioning as a separate nonprofit organization. Acknowledging the diversity of program design, Cook noted:

"There are clear variations in the management of TASC clients. Some TASC programs are more 'system centered' as an extension of criminal justice system control. Other TASC programs are more 'client centered,' focusing on the rehabilitation needs of the offender. A mix of both seems to produce a healthy symbiosis of criminal justice system leverage, access to treatment, and therapeutic tension" (Cook, 1997).

The TASC model has also been adapted and incorporated in recent innovations such as drug courts, which began managing drug-involved offenders in the late 1980s, and have now been implemented in more than 300 jurisdictions. Judges, prosecutors and defense attorneys,

treatment professionals, case managers, and pretrial or probation departments together apply continuous oversight of participants as they undergo substance abuse treatment as part of or in lieu of a criminal sentence. Key components include

- Integration of alcohol and other drug treatment services with justice system case processing
- Prosecution's and defense counsel's promotion of public safety while protecting participants' due process rights, using a nonadversarial approach
- Eligible participants identified early and promptly placed in the program
- Access to a continuum of alcohol, drug, and other related treatment and rehabilitation services
- Frequent alcohol and other drug testing
- Coordinated strategy governing responses to participants' compliance
- Ongoing judicial interaction with each participant
- Measurement through monitoring and evaluation the achievement of program goals and gauge effectiveness; continuing interdisciplinary education promotes effective planning, implementation and operations
- Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness

See TIP 23, *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* (CSAT,1996a) for more on drug courts.

While TASC programs have been designed with the interaction of treatment and criminal justice systems in mind, case managers in non-TASC settings must be careful not to encourage or support goals or objectives that place the offender in conflict with expectations of the

criminal justice system. The roles of the criminal justice official (usually a probation officer) and the case manager should be defined in advance in agreements forged at the highest levels of both the court and the agency providing services. Typically, the case manager negotiates with the parole or probation officer for sanctions that make clinical sense. Such a relationship affords the case manager the opportunity to educate a representative of the justice system about the value of treatment and case management. An upcoming TIP, *Transition from Incarceration to Community-Based Treatment*, addresses treatment for recently released offenders. It will be available in 1998.

Clients With Physical Disabilities

Chemical dependency is a coexisting problem for many people with physical disabilities (Moore and Polsgrove, 1991). Some 15 to 30 percent of all people with disabilities have a substance abuse problem, more than twice the rate in the general population. Among disabilities, rates of substance abuse are highest among people with traumatic brain injury, spinal cord injury, mental illness, and learning disabilities (Rehabilitation Research and Training Center on Drugs and Disability, 1997). The case manager delivering services to this population must know and understand those conditions as well as blindness, deafness, and chronic disease. Other suggested areas of knowledge are

- The etiology and course of various physical disabilities
- Effective treatment options, both group and individual
- The difference between appropriate disability accommodations and enabling “handicapped” behavior
- How disability acceptance and anger affect substance abuse treatment

Because many social service professionals still assume that people with disabilities are too helpless or too removed from the world to gain access to drugs, the case manager’s role may lie chiefly in education—both about physical disabilities and about substance abuse treatment. Clients with disabilities may not recognize their need for substance abuse treatment or may expect to be denied treatment. Once in treatment, they may be misunderstood, or singled out for mobility or communication problems (Rehabilitation Research and Training Center on Drugs and Disability, 1996). The Americans with Disabilities Act (ADA) provides support for treatment programs oriented to this population by mandating that facilities be physically accessible to people with disabilities and that treatment professionals have an understanding of disability issues.

Assessment includes many issues unique to physically disabled persons. The case manager should explore the relationship between the client’s disability, substance abuse, and recovery potential. For example, clients who had a significant substance abuse problem before becoming disabled need different treatment approaches than those who started using to cope with a new disability. An individual with a disability that predates his substance abuse may be obsessively focused on his “disability” and not be aware of the functional limitations imposed by the chemical dependency. Others may have acquired a disability as a direct result of substance abuse, but without “sober” time for understanding the disability they may not be aware of their functional limitations and how their current functioning levels make it difficult to learn or perform certain tasks. Mentors who have disabilities or physical rehabilitation professionals can assist newly disabled individuals in understanding their disability.

Treatment programs may need to be expanded to accommodate clients’ disabilities. The case manager may also need to educate

other service providers about the needs of people with disabilities. To reach those with physical disabilities, 12-Step groups must be willing to use hearing enhancement equipment (e.g., hearing loops) in meetings and to hold meetings in accessible places. The case manager should become familiar with special equipment in order to help organizations purchase or borrow appropriate resources as required under the ADA.

The person in a wheelchair who must take medication for chronic pain from an injury may prompt resistance from recovery-oriented self-help groups. Similarly, some vocational programs within a treatment setting require clients to be sober for some time before they can be placed in a training setting. As a result, vocational rehabilitation services, while appropriate, are not available to individuals receiving pharmacotherapy for opiate addiction within those programs that do not consider such people drug-free. A case manager from either the disability field or the substance abuse field should educate members of other disciplines on how to structure treatment appropriately. The Center for Substance Abuse Treatment is producing a TIP on persons with disabilities who have substance abuse problems, which will be available in late 1998.

Gay, Lesbian, Transgendered, and Bisexual Clients

Gay, lesbian, transgendered, and bisexual cultures are often associated with substance use in general and alcohol use in particular. Findings suggest that both gay men and lesbians are more likely to be involved in the use of alcohol, marijuana, and cocaine than heterosexual members of all age cohorts (McKirnan and Peterson, 1989; Skinner, 1994), with the differences particularly pronounced

among younger people. Gay and lesbian clients may also find their sexual partners in areas prevalent with drugs, increasing the risk of contracting the AIDS virus. The prevalence of use, coupled with homophobia, makes the recognition and treatment of substance abuse problems more difficult.

Given the emotionally charged atmosphere that often surrounds sexuality, case managers must be especially aware of their own feelings and beliefs. The link between personal beliefs and interviewing skills is especially important in the assessment of these clients, who may be reluctant to discuss health problems or issues related to sexual practices. The case manager must know the context of the client's life and ideally, the specialized language used to describe sexual practices in the client's community. The interviewer should gather precise information regarding the nature of the individual's sexual practices and number of sexual partners, unless a client is particularly vulnerable, in crisis, or might otherwise see the inquiry as intrusive or inappropriate.

To help gay or lesbian clients gain access to services, the case manager must know more than just an agency's formal stance toward them. Some agencies that are officially accepting are in fact hostile to homosexual clients, or simply are not familiar enough with their special needs to serve them effectively. A case manager should know which 12-Step meetings, clinics, and other resources are available, knowledgeable, and accommodating to the gay and lesbian communities. As with any client, treatment planning includes helping the gay client identify and develop social opportunities that do not involve drugs and alcohol. Advocacy for gay clients includes helping clients seek treatment for injuries and infections sustained through sexual activity and seeing that clients' needs are taken seriously.

Case Management in Rural Areas

The delivery of case management services in rural areas presents unique challenges. Social services may be lacking or so geographically dispersed that effective access and coordination is difficult. In addition, case managers working in rural areas must frequently deal with a culture in which “everyone knows everyone else,” from both the client’s and the service provider’s standpoint.

Given the scarcity of resources, agencies, and specialty services, the professional in this setting is more likely to be a generalist. Case management is more likely to provide both service and service coordination. The substance abuse case manager must be a tireless source of information and education about substance abuse problems, not just for the client, but for the community as well. Perhaps the most difficult function of the case manager in a rural

setting is advocacy. In a close-knit environment, advocating for a client may mean challenging the decisions of other service providers. On the other hand, the professional’s close relationships with those providers may benefit the client.

Case management in a rural setting can take one of several forms. Telecommunication and video-conferencing practice models have been used to allow clients relatively easy access to providers and to facilitate providers’ communication and recordkeeping (Alemi et al., 1992). Where the client lives far away from the program, services may be provided in an intensive manner, for example, daylong sessions with a particular client. A lack of formal services can be mitigated by the use of informal helping networks such as Alcoholics Anonymous. However, in using informal networks, the case manager will have to deal with the unique challenges to confidentiality occasioned by the rural environment.