VCBH Ventura County Behavioral Health Department

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"Best Science, Best Service, Best Outcomes"

A Division of Ventura County Health Care Agency

July 21, 2005

TO: Pierre Durand, HCA Director
John Johnston, CEO

FR: Linda Shulman, Director

RE: Behavioral Health Department Response to Proposition 36 Grand Jury Report

The Department believes that the findings and efforts of the Grand Jury in FY 03-04 were taken very seriously – and that in this past year, many of the issues identified by that Grand Jury have been discussed, reviewed and in many instances acted upon. The creation of the Oversight Committee, and the final product of the revised Work Plan for 05-06 are all direct results of these efforts. In FY 05-06 the newly implemented Work plan addresses many of the concerns, both of the Grand Jury and our partners. It is unfortunate that the timing of implementation of these new protocols and procedures did not correlate to the timing of the review by the Grand Jury. The HCA Fiscal Department is also preparing a response to address the financial concerns raised in the report.

Oversight Committee: Findings 32 - 53

The 05-06 Work plan and the signature of all members of the Oversight Committee on the Board Letter represents the creation of a document similar to an MOU as it was an agreement amongst all partners for the implementation of Prop 36. Minutes of the Oversight Committee and the Board Letter presenting this new protocol will reveal the hesitation on the part of the Public Defender and the District Attorney's office to specifically sign an MOU, as their legal responsibilities could be impacted by such a document. Therefore, it was agreed upon to present the 05-06 Work plan as a committee and indicate the agreement amongst the parties by doing so.

(F 39) The Grand Jury refers to a recommendation to create by-laws, and voting procedures to be approved and documented, as well as recording meeting minutes. All Oversight Committee meetings had minutes – which will reflect the discussions that occurred in regards to determining voting procedures and the various agencies perspectives on Consensus agreement vs. majority agreement. It was determined by the Oversight Committee that the Operations Committee should operate on consensus and move items that could not be agreed upon to Oversight Committee for resolution. This process was developed early in the year and the Department believes addressed these concerns.

(F 49) The Grand Jury report states : "The April 2005 Meeting was scheduled within days of the Grand Jury asking the Director of BHD how many Oversight Committee meetings have taken place during the year."

The Director of BHD was first interviewed by the Grand Jury on March 30th. The 05-06 Work plan was due to State ADP on May 1st. Therefore, the Department needed to finalize the work plan with the Oversight Committee in April – to ensure timely submission of the plan in May. The appearance of scheduling a meeting due to Grand Jury inquiry is coincidental at best.

(F 52) Brief History of the Operations Committee

The Implementation Committee was a carry-over from the Drug Court Model. The key players were already in place. Implementation Committee evolved into the Operations Committee. A representative from the CEO's office was the original chairperson of the Implementation Committee and meeting minutes were published during this time. When he stepped down in October, 2001, the Committee voted a representative from the Public Defender's office as the new chairperson. When the second chairperson stepped down in August 2002, the Committee nominated and unanimously voted in a representative from BHD/ADP. In 2004, discussions of rotating the chair position were held. In September 2004, a representative from Probation was nominated and declined. No other members were willing to assume the position at this time, and therefore, the representative of BHD/ADP remained chair. In June 2005, another Probation representative was nominated and was unanimously voted in as the chair of the Operations Committee.

Completion Standard – Mischaracterized Statistics and Sliding Benchmarks: Findings 54 – 63.

(F - 60 – 62) The Grand Jury references the need for statistical data – and in F 62 – states there is no indication that requests for statistics and metrics have ever been addressed or that any Ventura County Prop 36 funds have ever been allocated for the purpose of quantifying treatment results.

As Attachment I to this report will show, the department has spent a total of $289,568 in development of a data system for Proposition 36. This represents a total of 3,537 hours of time billed to the department by ISD for work on developing our information system and interface with the Criminal Justice Information System (VCIJIS). The Proposition 36 Case Management System (CMS) captures all appointment scheduling in the calendar section, client demographics, assessment information (ASI scores and ASAM form), drug and medical history, treatment and ancillary referrals, treatment attendance, drug testing dates and results, progress notes, non-compliance, status, and discharge information. In addition, forms are printed out with all necessary information, and several reports are run from the system to verify billing and to check case manager case loads.

The interface between VCIJIS and CMS is able to produce a report summarizing how many clients have been referred to Prop. 36 in a specific time frame, how many violations of probation occurred, number of clients arrested after they are sentenced to Prop. 36, and how many completed probation. It also shows what clients have law enforcement activity within the last 10 days, 30 days, 180 days and over 180 days. Case managers are able to see the details of this information on each individual client. We are currently in the process of developing other reporting capabilities, and being able to electronically transfer Minute Order case information directly into the BHD/ADP system instead of hand keying the information in.

Prop 36 Services Pipeline: Findings 64-87

(F-67) Orientation

Orientation is part of the assessment process. This is the time when new clients first entering Prop. 36 complete all the necessary paperwork including releases of information, HIPAA, consents for treatment and drug testing, HIV policy, client's rights, duty to warn, etc. Clients are also informed about what to expect in treatment, accountability, guidelines they need to follow and consequences if they do not. Orientation groups of 7-10 were held prior to 10/11/04. Immediately following orientation, clients were then individually seen for an assessment. The entire process took approximately 2 hours. As part of the redesign in last FY, the Assessment changed this protocol and in October, three staff were selected to perform assessments (averaging approximately 4 per day per staff) and the remaining staff took over case management functions. Group orientations were disbanded at this time and the assessors took over doing individual orientations with the assessment. **(also see F-137 below)** This restructure allowed for more rapid availability of assessment appointments and greater flexibility in scheduling assessment based on clients needs. **(See F 150-153 below.)**

(F-70) Placement Criteria

Placement of clients into treatment is based on the results of the assessment, including the American Society of Addiction Medicine (ASAM PPC-2R) Patient Placement Criteria for the Treatment of Substance-Related Disorders.

ASAM Placement Criteria is a clinical guide used in matching clients to the appropriate levels of treatment based on medical necessity and biopsychosocial severity. ASAM Placement Criteria enhances the use of multi-dimensional assessments in making objective placement decisions for various levels of care based on six assessment dimensions.

ASAM Placement Criteria are objective, measurable and quantifiable. The underlying goal of the criteria is to place clients with specific symptoms and behaviors in the most appropriate level of care based on a careful assessment. The preferred level of treatment is the least intensive level that meets the treatment objectives, while providing safety and security for the client. Depending on the individual needs of the client, clients can be moved to a more or less intensive level of care. ASAM guidelines are flexible, assessment-based, and clinically driven, which is a transition away from fixed program-driven treatment. According to ASAM Criteria, length of stay should be based on the individual needs of the client and not a fixed length of stay for all, or treating every client in an inpatient program.

(F-79) Residential Placement

Placement of clients into residential treatment is based on the results of the assessment, including the American Society of Addiction Medicine (ASAM PPC-2R) Patient Placement Criteria for the Treatment of Substance-Related Disorders (refer to F-70 above).

During the 2004-2005 year, only one residential provider had a wait list for Prop. 36 clients, and this was only for two months out the year. Currently 2 providers provide residential treatment for men, 2 providers provide residential treatment for women, and 2 providers provide residential to women with children.

(F -82) Treatment begins when referred to treatment provider. There is no substance abuse treatment at the CAS. Please refer to Response to Centralized Assessment Center and Appendix I

– for a more detailed description of the role of case management and function of the staff at the Centralized Assessment Center.

Drug Treatment without Probation: Findings 95 – 122.

(F – 104) It was determined in the Oversight Committee that the new funding would be provided to the District Attorney. BHD had originally proposed that the additional money be provided to Probation, to assist in having them take additional formal probation clients – as we had indicated in our response to the Grand Jury in 04. While Firewall and reporting problems were legitimate issues in previous years they are no longer at play. In fact, with the "report all" protocol put in place through the Oversight Committee, the Assessment Staff, in the first two weeks of July submitted 381 reporting forms to the District Attorney's office under the new reporting protocols. If this rate were to continue that would mean that approx 760 reporting forms would be submitted monthly. In June, 2005 – under the old reporting protocols 239 non compliance reports were submitted. The new protocols clearly have a higher level of information sharing and reporting of activities of the clients. At this time, these additional reportings have not resulted in additional dispositions taken by the District Attorney's office.

Central Assessment Services: Findings 123 - 146

Overall – it appears that there may be a misunderstanding in the function and job responsibility of the Assessment Center Staff. Addendum 1 to this report is a brief description of the assessment and case management responsibilities in the field of substance abuse. Additionally the following is a table of the total services provided by the Assessment Center Staff in FY 04-05:

SERVICE	TOTAL HOURS	%
Pre-Admission	82.25	.6%
Assessment	2122.25	14.8%
Transfer Out	359	2.5%
Re-assessment (face to face)	1571	11.0%
Re-assessment (phone)	88	.6%
Individual Counseling	103.5	.7%
SMART	90.75	.6%
Discharge	191	1.3%
Case Management	6428.75	44.9%
Case Conference – Assessment Center	614	4.3%
Case Conference - Court	1416.5	9.9%
Professional Consultation	1220.5	8.5%
Drug Testing	25.25	.2%
Transportation	13	.1%
Total	**14,325.75**	**100.0%**

With a total of 10 staff (9 Alcohol and Drug Treatment Specialists and 1 Licensed Clinician)– this 14,325 hours of service provided in FY 04-05 – represents an average of 1,435 billable hours of service for each employee. This represents a 75% productivity level for each employee which is a

high level of performance and demonstrates the work and dedication of the Assessment Center Staff.

(F-136) Overstated Workload

Workload is not overstated. When the Grand Jury toured the assessment center and asked how many clients were seen in a day, they were verbally told 12 initial assessments, plus individual appointments were scheduled per day, along with walk-ins. Review of the schedule they received shows an average of 12 appointments scheduled per day with an 18% no show rate (or approximately 10 assessments performed each day.)

(F-137) Calendar – Group orientations

Orientation is part of the assessment process. The computer schedule shows initial assessments as "group orientation" since this was the way the computer system was designed. Group orientations stopped in October 2004 **(See F 67 above)**. The Grand Jury was given schedules for May 23-June 24, 2005 (24 working days). During this time 163 (57%) of the 286 appointments were for initial assessments, and the remaining (43%) 123 appointments were for re-assessments and exit assessments. The assessment center averages 10 assessments per day (6 new assessments and 4 re-assessments or exit assessments).

Assessment Timeliness: Findings 147 - 162

(F 150-151 and 153) – Days between Sentencing and Assessment

The Grand Jury Reports that there appears to be no documented improvement in the time between sentencing and assessment.

The new assessment procedure implemented in October of 04 – and referenced in the September report to the Board did indeed improve the time between sentencing and assessment. In July – August, the average time between sentencing and Assessment was approximately 30 days, with the average time of scheduling an assessment once contacting the assessment center being 19 days. In October – December, of the same year, with the new procedure in place, the average time between sentencing and Assessment was 12 days – with the time between contact with the Assessment Center and the assessment averaging 3 days. Additionally, in these months 32% of clients were seen with 24 hours of contacting the Assessment Center for scheduling their appointment.

The Minute Orders given to clients in court states that client's have 5 days to contact the assessment center to set up an appointment. It does not say they have to be assessed within 5 days. Clients are allowed to reschedule their initial assessment appointment once. In between sentencing and assessment, clients may be re-arrested on new charges and are often in jail. Clients who do not contact the assessment center within 5 days of sentencing are non-complied and referred back to court.

The department has agreed that effort needs to be made in regards to increasing assessment show rates and has been working over the past year to move the assessment process to the Courthouse. This project is being worked on diligently by both the Court Administration and the Department and we expect to provide Proposition 36 Assessment at the Courthouse in the near future.

(F 160) – The Grand Jury Report indicates that once the assessment office is opened in the Hall of Justice, BHD/ADP plans to provide staff to greet new clients as well as schedule their assessment appointments at the CAS. This is not true. The current plan is have all Prop 36 Assessments performed at the Court Assessment Office. There were some initial discussions that due to space concerns at the Court House there would not be enough room to perform assessments at the courthouse, however, these concerns have been raised with the Courts and we are continuing to develop the program to ensure sufficient capacity to complete the Prop 36 assessments at the newly designed center.

Response: **Recommendation 1 and 2:**

In regards to the recommendation to remove BHD/ADP as Lead Agency of Prop 36, the Department does not concur with this recommendation.

The role of Lead Agency – as defined by the Law is not one of influence over the implementation and operations of the law within the County. The role is:

TITLE 9. Rehabilitative And Developmental Services
Division 4. Department of Alcohol and Drug Programs
Chapter 2.5. Substance Abuse and Crime Prevention Act of 2000 and Substance Abuse Treatment and Testing Accountability Program

§9520. Responsibilities of County Lead Agency.

The county lead agency identified in the county board of supervisors' resolution, minutes, order, motion, or ordinance, as specified in Section 9515(b) shall:

(a) Coordinate the development and ongoing implementation of a county plan for administration of the Act in accordance with Section 9515. Coordination meetings shall be held at least once every three months and shall include representatives of all county agencies and any other entitles responsible for administering the Act, including but not limited to the office of the county alcohol and drug program administrator, the probation department, the parole authority, and the courts, with input from providers of drug treatment services in the community, representative of drug treatment associations in the community, impacted community parties and federally recognized American Indian tribes.

(b) Directly provide and/or contract for the provision of authorized services specified in the Act;

(c) Administer the county trust fund established pursuant to Section 9517;

(d) Coordinate provision of services with all county agencies and any other entities involved in the administration of the Act. Such coordination shall include:

(1) Coordinating and tracking client flow through the local service systems,
(2) Sustaining existing services and expanding capacity as needed, and
(3) Monitoring the provision of services;

(e) Submit data and reports to the Department in accordance with the requirements of Section 9535;

(f) Collect data as necessary for the evaluation of county programs in accordance with the requirements of Sections 11999.9 and 11999.10 of the Health and Safety Code; and

(g) Participate in surveys and data collection activities developed for the purpose of the annual and long-term statewide evaluation conducted pursuant to Sections 11999.9 and 11999.10 of the Health and Safety Code. Data to be collected may include client assessment information about drug and alcohol use; health and mental health needs; criminal behavior and risk of criminal behavior; employment; family and social supports; and services provided. The county shall retain data for five years from the date of collection, beginning July 1, 2001.

The Department has insured that the Annual County Plan has been completed, approved by the Board of Supervisors and submitted to the State. Operations meetings have been held monthly – and have included all required program partners. The FY 05-06 Plan – approved by the Board of Supervisors on May 12, 2005, was a product of collaboration and coordination by the Department. The Department did not have a stronger role or greater influence as the Lead Agency in determining this plan - but rather took on the role of collaborator and brought parties together to discuss and determine changes to the plan. The Operations Committee has not been chaired by BHD/ADP every year (please reference response to F-52). Here again, chair of the committee, only means, coordinate that the meetings occur and prepare the agenda – which every partner has input into developing.

In addition, contacting the State Department of Alcohol and Drugs – prior to any work plan changes – would only work to delay the County receiving the FY 05-06 allocation from the State and could cause damage to the County's relationship with the State. If after reviewing all items, the Board wishes to have the 05-06 County Plan changed, the revised Work Plan can be submitted to State ADP for approval at that time.

Recommendation 3: The Proposition 36 Oversight Committee, while new has had a positive impact on the implementation and performance of all departments and stakeholders in the County. Having the Department Heads of each Agency involved in this difficult Program implementation where they can discuss differences and then move to agreement, has allowed a more thoughtful and meaningful dialogue and the Department believes a much improved 05-06 Work Plan.

Recommendation 4: As the Grand Jury Report recognizes, approximately 2/3 of the clients referred to Prop 36 are on Conditional Release. These clients do not have a Probation officer to report to and the Assessment Center Case Managers are the only community oversight of these clients. As pointed out in several of the Findings above, the Assessment Center provides a key function of case management and assessment and overall oversight of Proposition 36 clients.

Recommendation 5: The Department believes this would be much too high of a workload – both for Probation and the Courts. In the Grand Jury report – Cal Remington is quoted as saying that he would need triple the resources to place all clients on formal probation. This year, Probation estimated that they would need $1 million to fully staff for oversight of the 1/3 client population currently on formal probation. Putting all clients on formal probation would then require that Probation spend $3 million. As the County's allocation is only $2.8 million – this would leave NO money for treatment.

Recommendation 6: It is not within scope of Probation officers to assess clinical needs of clients and determine appropriate treatment referrals. Nor is it within the scope of the Probation department to oversee and supervise contracts with clinical providers. The original Implementation

Committee came from the Drug Court Model that recognized the need for a centralized assessment, referral and tracking center.

Recommendation 7: The Operations Committee can, and has discussed provision of treatment services and this can continue to occur – no matter who serves as the lead agency. Currently BHD/ADP assessment center staff work closely with Probatiôn and treatment providers. BHD/ADP is able to provide technical assistance, utilization review and program oversight to treatment providers. BHD/ADP is able to hold treatment providers accountable, and has raised treatment standards in the county. Not being treatment specialists, Probation would not be able to perform these functions. Probation would not be able to do chart reviews for proper tracking and documentation, monitor required State outcome reporting for completeness and accuracy, resolve client complaints, monitor counselor skills and competencies, inspect facilities, and make sure state placement requirements are being followed. The quality of treatment services would decrease without BHD/ADP as the gatekeeper.

Recommendation 8: Currently, the percentage of clients who come to ADP Outpatient clinics that have Drug Medi-Cal is approximately 38%. This means that approximately 62% of clients who come are self pay. The increased County Cost to moving 10 Alcohol and Drug Counselors to ADP clinics would be at a minimum, approximately $350,000. This does not include any increased costs associated with other Prop 36 Assessment Center staff being relocated or other space and overhead costs associated with such a transfer. The bottom line, is that if the Assessment Center were to be disbanded – the likelihood is that this staff would have to be laid off. Additionally, while the Department clearly sees the need to increase the amount of Drug and Alcohol services to the County – there is no needs assessment that would determine that these additional services are needed in County Clinics.

Additionally, all Prop 36 Treatment Contract Providers have been encouraged to become Drug Medi-Cal Providers. Currently approx 28% of clients in Prop 36 have Drug Medi-Cal. If the current treatment providers were to become providers they could increase their revenue for treatment that they are currently providing by this amount. This would then make additional Prop 36 allocation available for expanded services. To date, the providers have not followed through on this recommendation.

Recommendation 9: BHD/ADP has financial accountability for all funds. The Department is audited by State ADP annually, and has been found to be in complete compliance. Operations Committee does and can have input into the expenditures of Prop 36 funding and more directly, the Oversight Committee did make decisions about additional funds to be provided to the District Attorney's office this year. Additionally, contract providers are active members of the Operations Committee. It would be inappropriate to leave funding decisions to a group that includes the people who have most to gain by these decisions. Providers have quarterly contract meetings with BHD/ADP and during these meetings have had amble opportunity to bring concerns regarding their financial situations in relationship to these contracts. This year, BHD/ADP increased the value of the contractors after being supplied with information during these contract meetings that substantiated the need. Additionally, the Department discussed the need to create sanctions for Prop 36 clients for non payment of client fees at the Oversight Committee – as this was a key element in reduced funding for providers over the past few years.

Recommendation 10: Treatment decisions should be placed into the hands of treatment providers – (this is part of the departments rationale for not agreeing with Recommendation 6 – which would take Treatment decisions out of the hands of treatment providers and place them in the hands of Probation.) The department does not believe that anyone is in pursuit of a perfect protocol – and

protocols that have been discussed at Operations Committee and Oversight Committee – have not had anything to do with treatment – but rather with reporting clients treatment results – drug tests, and adherence to the conditions of their probation back to the courts.

Recommendation 11: BHD/ADP has not been hoarding money. Not all of the implementation funds were spent, recognizing that the program would grow and more funding would be needed in the later years. Being fiscally responsible, BHD/ADP recognized the need to reserve funding to be carried-over. All providers are asked to submit budgets and costs at contract negotiation time. Providers ask for increases, but do not provide the documentation needed to justify increases to their contracts. It's also hard to determine actual program costs and needs when providers keep submitting different numbers or cannot provide a staffing list and hours. There have been compliance issues with providers and checks have been held until these issues are resolved. Providers have billed us for services that they have not performed, and they have been held accountable.

Recommendation 12: BHD believes that it has a strong record of success in collaborating and implementing forensic services in our County. We have a strong relationship with Probation and the Courts in the Juvenile Justice System and in the development of the Adelante Mental Health Court. The Mentally Ill Offender Grant Program with the Sheriff's Department and the Courts was a strong success and we continue to collaborate in our Adult Forensic programs. The department has worked very well with Dependency Drug Court program as well. The successes of the Department as a partner and leader in providing forensic services to the County are evident throughout the Forensic system.

Addendum I

Assessment

As·sess·ment (a ses´ ment) *n.* Those procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems, and needs for the development of the treatment plan.

The assessment process begins with the first contact during screening and is ongoing throughout the entire treatment experience. An accurate diagnosis then leads to the "prescription" of an appropriate treatment. Failure to make a valid assessment before providing therapy is like a medical doctor prescribing medication before asking a patient, "What's wrong?" or "Where does it hurt?" For example, failing to assess suicidality could result in direct harm to the client and possible litigation against the counselor or agency.

The counselor should assess a client in all "major" life areas, i.e., substance abuse history, psychological history and current functioning, educational history, vocational history, financial status, legal history, social history, and physical health history including current medications and treatment history. While gathering information takes a certain amount of skill, the key to performing this core function competently is on the higher level ability of evaluating the client's information. The assessment process is much like detective work. Evaluation challenges the counselor to be not only knowledgeable about alcohol and drug abuse, but also to assess the extent to which a client's alcohol or drug use has interfered with the client's life functioning. The assessment process also requires that a counselor identify and evaluate a client's strengths and weaknesses.[i]

Clinical Assessment of Psychoactive Substance Use

In persons with no preexisting psychopathology, chronic substance use often produces behavioral symptoms that mimic nearly every kind of psychiatric disorder. Whatever the reason, failure to identify individuals who have problems with alcohol and/or other drugs has serious consequences. In the treatment of substance abuse, as in any type of therapy, perhaps no single factor is more important to success of the interview than the psychological atmosphere created by the clinician's attitude and behavior toward the patient. It is the starting point of the therapeutic relationship and offers a unique opportunity to engage and motive the patient to accepting the need for positive change. Especially in the treatment of substance abuse, it is a serious mistake to assume that strong confrontational tactics are required to get at the truth.[ii]

Ongoing Need for Assessment

Assessment with substance abusers (SAs) must of necessity be more thorough and detailed than with other types of patients, because substances of abuse have such pervasive effects on both psyche and soma. In addition, they substantially shorten an individual's life span over time. The major goal of the initial evaluation is for the patient to end up committed to appropriate, workable treatment. Assessment is always a process that continues throughout treatment, but this is particularly true of SAs; as their commitment to abstinence as well as their psychological state must

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[i] Herdman, John. *Global Criteria: The 12 Core Functions of the Substance Abuse Counselor*, 3rd Edition. Holmes Beach, FL: Learing Publications, 2001.
[ii] Washton, Arnold M. *Psychotherapy and Substance Abuse.* NY: Guilford Press, 1995.

be constantly re-evaluated.[iii] Assessments should be revised and monitored as the client moves through recovery.[iv]

At their first meeting, the counselor must take note of the client's facial and body signs that can indicate alcoholism, empathize with the emotional pain that controls the client's life, and sense what lies hidden behind the psychological denial of family breakdown, declining job performance, and the incessant need to drink. This information must be gathered to enable the counselor to make an accurate diagnosis of either problem drinking or alcohol addiction and to coordinate this diagnosis with an appropriate treatment plan.[v]

Comprehensive Case Management for Substance Abuse Treatment

Case management generally can be described as a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals. Case management lends itself to the treatment of substance abuse, particularly for clients with other disorders and conditions who require multiple services over extended periods of time and who face difficulty in gaining access to those services.

Research suggests two reasons why case management is effective as an adjunct to substance abuse treatment. First, retention in treatment is associated with better outcomes, and a principal goal of case management is to keep clients engaged in treatment and moving toward recovery. Second, treatment may be more likely to succeed when a client's other problems are addressed concurrently with substance abuse. Case management focuses on the whole individual and stresses comprehensive assessment, service planning, and service coordination to address multiple aspects of a client's life. Comprehensive substance abuse treatment often requires that clients move to different levels of care or systems; case management facilitates such movement.

Perhaps a more helpful way to understand it is to examine the functions that generally comprise case management: (1) assessment, (2) planning, (3) linkage, (4) monitoring, and (5) advocacy. When implementing to its fullest, case management will enhance the scope of addictions treatment and the recovery continuum. A treatment professional utilizing case management will:

- Provide the client a single point of contact for multiple health and social services systems
- Advocate for the client
- Be flexible, community-based, and client-oriented
- Assist the client with needs generally thought to be outside the realm of substance abuse treatment

To provide optimal services for clients, a treatment professional should possess particular knowledge, skills, and attitudes. CSAT's Addiction Technology Transfer Centers classify referral and service coordination—basic case management functions—as core competencies for substance abuse treatment providers. Case management serves to span client needs and program structure. Substance abuse treatment and case management functions differ in tat treatment involves activities that help substance abusers recognize their problems, acquire the motivation and tools to

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[iii] Kaufman, Edward. *Psychotherapy of Addicted Persons.* NY: Guilford Press, 1994.
[iv] Treatment Improvement Protocol (TIP) 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Substance Abuse Treatment.
[v] Metzger, Lawrence. *From Denial to Recovery: Counseling Problem Drinkers, Alcoholics and Their Families.* NY: Jossey-Bass Inc., 1988.

stay abstinent, and use the acquired tools; case management focuses on helping the substance abuser acquire needed resources.

In the field of substance abuse, three interagency models have been identified. In the *single agency* model, the case manager personally establishes a series of distinct relationships on an as-needed basis with counterparts in other agencies. In the *informal partnership* model, staff members from several agencies work as a collaborative team, often constituted cases by case; *the formal consortium* binds case managers and service providers through formal written agreements.

Whenever agencies or service providers work together, the potential for conflict exists. Areas of tension may be present from the very onset of the collaboration. Sometimes social pressures or the need to maximize resources can force public agencies into joint ventures even if they do not mesh well or have a history of being service competitors. Tensions can also develop in the course of delivering services; for example, interagency collaboration may result in a client having two case managers. When problems do arise, case managers and other agency personnel can use both informal and formal communication to clarify issues, regain perspective, and refocus the interagency case management process.[vi]

Substance Abuse Treatment and Case Management for Treatment-Based Courts

Substance abuse treatment is the comprehensive, individualized response to the biological, psychological, and social causes of addictive disorders. Effective treatment is the therapeutic response to a biopsychosocial disorder, and therefore treatment should never be equated with or used as a form of punishment or sanctioning. Like other health disorders, effective treatment for substance abuse must begin with a careful examination of the causes and symptoms of the condition, and be conducted by a trained substance abuse professional.

Functions of Case Management

- **Planning**, for treatment services and the fulfillment of criminal justice obligations, such as meeting conditions of the treatment plan or punitive sanctions and cooperating with supervision
- **Brokering Treatment** and other services and assuring continuity as the client progresses through treatment and program completion
- **Monitoring and Reporting** progress of the client using a schedule that ensures reporting back to the referring court on a frequent and consistent schedule
- **Supporting** the client in identifying problems, and advocating for the client with legal, treatment, social service and medical and mental health systems

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[vi] Treatment Improvement Protocol (TIP) 27: Comprehensive Case Management for Substance Abuse Treatment. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Substance Abuse Treatment.

- **Monitoring** urinalysis, breath analysis or other chemical testing for relapse to substance abuse

- **Protecting the Confidentiality of Clients' Treatment Records** consistent with Federal and State regulations regarding the right to privacy

Treatment Modalities/Components

Modalities — A range of treatment options should be available to provide treatment most appropriate the clients' assessment needs. Frequency of attendance and testing, as well as the level of treatment, are determinations made by a licensed or certified substance abuse counselor based on assessment data.[vii]

[vii] *Substance Abuse Treatment Planning Guide and Checklist for Treatment-Based Drug Courts.* U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Substance Abuse Treatment.