



**UNIVERSAL
CURRICULUM**
Treatment of Substance Use Disorders

Executive Secretariat of the Inter-American Drug
Abuse Control Commission of the Organization
of American States (ES-CICAD/OAS)

The Universal Treatment Curriculum for
Substance Use Disorders (UTC)

Trainer Manual

UTC 82

Case Care Management

1st Edition, 2023



OAS | CICAD





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Case Care Management Trainer Manual

1st Edition - 2023

Disclaimer

Case Care Management Course

The substance use disorder treatment interventions described or referred to herein do not necessarily reflect the official position of INL or the U.S. Department of State. The guidelines in this document should not be considered substitutes for individualized participant care.

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TRAINER ORIENTATION

Introduction

The problem

Psychoactive substance use and substance use disorders (SUDs) continue to be among the major problems around the world, taking a toll on global health and on social and economic activities. The United Nations Office on Drugs and Crime (UNODC) reports that in 2017, some 271 million people between the ages of 15 and 64 had used illicit substances at least once in the previous year (UNODC, 2019).

Of those who use psychoactive substances, a significant number will develop substance use problems or SUDs. The 2019 UNODC survey notes that around 35.3 million people between ages 15 and 64 suffer from drug use disorders. This number is 15% higher than previous estimates, having included new information about drug consumption from India and Nigeria (UNODC, 2019).

SUDs contribute significantly to global illness, disability, and death. Injecting drug use (IDU) is a significant means of transmission for serious communicable diseases such as hepatitis C and HIV/AIDS. The UNODC, the Joint United Nations Program on HIV/AIDS (UNAIDS), the World Bank and the World Health Organization (WHO) jointly estimate that 11.3 million people inject drugs, which corresponds to a prevalence rate of 0.25% within the population aged 15-64 (UNODC, 2019). It is estimated that an average of 14% of the total number of people who inject drugs are living with HIV. Further, more than half of the people who inject drugs are estimated to be living with hepatitis C.

Drug-related deaths also show the extreme harm that can result from drug use. The Global Burden of Disease Study 2017 estimates that, globally in 2017, there were 585,000 deaths and 42 million years of healthy life lost due to drug use (UNODC, 2019).

Additionally, as noted in the 2019 UNODC report, it is estimated that only one in seven problematic drug users worldwide receives treatment for drug use disorders or dependence each year.

The problem of SUDs is even more prevalent when considering the people cycling through prisons and jails. Behavioral health issues, specifically substance use disorders, are a driver of criminal justice system involvement.

Designing Alternatives to Incarceration for individuals with an SUD facing minor or non-violent drug or drug-related charges can be an effective way to address the underlying clinical needs that often contribute to the likelihood that an individual will engage in criminal behavior. By designing interventions that identify the needs of individuals and linking them with supportive treatment services in their community, policymakers can have an impact on:

- Reducing drug use & adverse public health effects;
- Reducing crime & recidivism;
- Protecting victims from future crime; and
- Increasing social reintegration opportunities for people with substance use disorders that have committed non-violent crime due to their drug consumption.

Language disclaimer

In this manual the terms Substance Use Disorders (SUD) and addiction are both used. Although the authors would prefer the SUD, the use of the word addiction is still widespread in countries worldwide. The manual refers to the NIDA definition which is consistently used in the Universal Curriculum publication. Addiction is defined as a chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences.
(NIDA, 2020)

The Case Care Management Curriculum

This *Case Care Management* (CCM) curriculum has been developed by the Executive Secretariat of the Inter-American Drug Abuse Control Commission (ES-CICAD), Secretariat for Multidimensional Security of the Organization of American States (SMS- OAS), in collaboration with Treatment Alternatives for Safer Communities (TASC) and an international *Case Care Management* advisory group. It has been made possible thanks to the financial support of the Bureau of International Narcotics and Law Enforcement Affairs (INL) of the U.S. Department of State.

More broadly, *Case Care Management* is part of a training series on Alternatives to Incarceration developed with funding from the U.S. Department of State, and the Executive Secretariat of the Inter-American Drug Abuse Control Commission (ES-CICAD) and the Drug Advisory Program of the Colombo Plan. More information about ES-CICAD and the Colombo Plan can be found at http://www.cicad.oas.org/main/default_spa.asp and <http://www.colombo-plan.org>, respectively.

Following the *Alternatives to Incarceration* course, which supported the design and implementation of national-level systems promoting alternative models for individuals with SUDs facing minor or non-violent drug-related criminal charges, the Case Care Management curriculum provides additional knowledge about the implementation of a network of coordinated services for this population.

The ultimate goal of the curriculum is to train policymakers and professionals in the judiciary, health, and social services sectors on the advantages of *Case Care Management* as a specialized tool, able to support the justice system in providing treatment-based alternatives to incarceration at different points for minor or non-violent drug or drug-related offenders with SUDs. Case Care Management trains highly specialized professionals to work with participants in the justice system, guiding them on their path toward recovery and social reintegration, thereby lowering recidivism and enhancing public security.

Goals and objectives of the Case Care Management curriculum

Training goals:

- Illustrate the public safety and public health implications of treatment, recovery, and social integration interventions in the justice system setting;
- Increase participants' understanding on addiction, crime, recovery, and the continuum of care;
- Present a definition of Case Care Management;
- Present the role of Case Care Management in the multisystem approach;
- Illustrate the added value of Case Care Management in the justice system;

- Illustrate the values, critical elements and functions of Case Care Management;
- Present the models of Case Care Management;
- Illustrate how the Case Care Manager interacts with the stakeholders in the multisystem approach;
- Present the profile of a Case Care Manager; and
- Present an overview of how to implement Case Care Management at a country level.

Learning objectives

Participants completing the Case Care Management course will be able to:

- Understand the global challenge of addiction and its relation to public security;
- Describe the complexity and the vicious cycle of addiction and crime;
- Describe how addiction works, the importance of recovery, and the treatment continuum of care;
- Understand the importance of social integration in the continuum of care as a preventive factor in recidivism and addiction;
- Describe the benefit of Case Care Management in the multisystem approach ;
- Describe Case Care Management and how it works in practice;
- Describe the profile of a Case Care Manager and how to hire and train the professionals; and
- Understand how to implement Case Care Management at the country level.

Customizing the Curriculum

This curriculum and its contents are intended to be customized to the country's strengths and needs, and realities of the individuals, families, communities, and cultures that will use it. It has been developed and laid out to make it easier to adapt the basic core curriculum to each specific context:

- Trainers are encouraged to customize other content in ways that will make it more effective for their countries.
- Trainers are encouraged to use these resources as they need them, and as they have the time to use them. The curriculum as a whole can be used as an intensive three-day session about these concepts and practices, or individual modules can be used for shorter training sessions or woven into other training events.
- Trainers are also encouraged to create a welcoming environment that reflects the community in terms of food, dress, etc.

The Trainer

Trainer qualifications

This curriculum is designed to be delivered by very specific individuals who are grounded in both the subject matter and the communities they serve. They should have experience delivering training to high-level officials and must be familiar with the subject matter.

Trainers for this course should have the following knowledge, skills, and experience:

- Knowledge of addiction and recovery;
- Working knowledge of the criminal justice system and how it operates within the country;
- Specialized knowledge in evidence-based treatment for the criminal justice population, as well as the concepts of the criminogenic risk-need-responsivity framework for making intervention decisions;
- Experience using the practices taught in this course;
- Experience and skills in briefing and communicating with high-level officials in their country;
- A collaborative, participatory approach toward training;
- Ability to facilitate participant learning, including the use of many types of exercises, case studies, and group exercises that appeal to many learning styles;
- Willingness and ability to support the ongoing learning process after the training; and
- Ties to the communities participating in the training.

For this course, a minimum of two trainers (or co-trainers) are required. A support person to help with logistics (scheduling, room set-up, copying materials, and so on) is also highly recommended, particularly when training groups of more than 20 participants.

The trainer's connection with participants

No matter how much the trainer knows or how interesting the course is, the success of a training often depends on the quality of the connection between the trainer and the participants. This is often the element that draws participants' attention, stays in their memory after the training, and inspires them to use what they have learned and keep learning more about the subject.

There are many qualities that give trainers the best chance of making strong, positive connections with participants. Here are some examples of these qualities:

- The most effective trainers are genuine. They are true to themselves, instead of acting like someone else (for example, pretending they are someone from the participants' culture, or someone they think would be more of an expert or an authority than they are). Genuine trainers are interesting, but they are not trying so

hard to attract participants' attention that they draw attention away from the message of the training.

- Effective trainers clearly and consistently respect all participants, their communities, and their cultures. For example, they do not chew gum while they are running the training or use words that would be offensive to some participants. Through this giving of respect, they can gain the respect of their participants, increase participants' respect for themselves, and show participants respectful ways of responding to their communities.
- Whether or not they come from the participants' cultures, effective trainers know enough about these cultures to appreciate their strengths and respect their traditions. Nonetheless, effective trainers also stay well aware of the limits of their own understanding of participants and their cultures. They never assume they know more about participants than the participants themselves have learned through their unique life experiences. Effective trainers learn how to balance the need to blend into participants' cultures with the need to be professional. For example, they have neat and careful personal grooming and dress in ways that are professional— neither too casual nor too formal.

Focus on the community process

It is important for trainers to see this training as part of a larger, ongoing effort within their country. Trainers should:

- Increase participant understanding and interest in Case Care Management in view of the implementation of the services at the country level.
- See themselves as “facilitators” who make it possible for participants to discover their own way to shape Case Care Management, rather than as authorities who hand out knowledge to passive students.
- Find a way to let the group process unfold naturally and still stay on schedule, so that participants are able to build relationships with one another, build their own learning skills, and prepare to help their countries more effectively.
- Continue to show respect for participants, fellow trainers, and governmental leaders throughout the training and follow-up processes.
- Sow the seeds of ongoing collaborative relationships and processes throughout the training and the work that follows the training.
- Support those collaborative relationships and processes by providing follow-up contact and technical assistance, so participants can develop their use of Alternatives to Incarceration in their respective countries.
- Successful trainers for this curriculum are familiar with Case Care Management in their own country and/or have working experience with Alternatives to Incarceration programs for individuals with an SUD in conflict with the law.

The In-person Trainer Manual

This Trainer Manual has five parts:

- Part I—Trainer Orientation (this section)

- Part II—Master Agenda
- Part III—Evaluation Forms
- Part IV—Training Modules
- Part V—Appendices

Part I—Trainer Orientation is the section you are reading now.

Part II—Master Agenda contains the Master Agenda that will help in the planning process. The in-person training is designed to be delivered over three consecutive days, as shown in the Master Agenda. However, the modular structure of the curriculum allows for flexibility. If necessary, the training can be offered over three non-consecutive days, although the modules should be delivered in the order in which they are presented in the manual.

The times shown for module activities are guidelines. Actual times will depend on each training group's size and participation level. Based on participants' learning needs, the trainer can take more or less time to deliver a particular topic. In the Master Agenda, the timings of the days have been left blank, so that the trainer can use a schedule that works for the audience and the setting. The trainer should prepare a daily schedule for participants, using actual start and end times.

Part III—Evaluation Forms contains participant evaluation resources.

The manual presents a Daily Evaluation form for participants to complete at the end of each day of training and an Overall Training Evaluation form to be used at the end of the training. The Daily Evaluation helps the trainer identify any changes that should be made during the training. The Overall Training Evaluation provides an overall look at participants' experiences.

Participants need to know that completing the forms is important and that their feedback will improve training content and delivery over time.

Part IV—Training Modules provides instructions for presenting the 10 modules in this Curriculum. Each module in the manual includes:

- A preparation checklist.
- A timeline.
- An overview of goals and objectives.
- Presentation and exercise instructions.
- Exercise materials.
- Copies of Resource Pages from the Participant Manual.
- Copies of the PowerPoint slides.

For each PowerPoint slide, the information that the trainer should provide is written as a script directly underneath the picture of the slide. Script text is indicated with an icon of the

word “Say” or “Ask,” and italicized (e.g., say: *Please turn to Module 2 in your manuals.*). Trainers should feel free to use their own words and add examples rather than simply reading the script. Adding real-life examples enriches the training experience, but this benefit must be balanced with time considerations.

There are also training instructions throughout the modules, offering specific guidance, different approaches, or special considerations. They appear in boxes similar to the following:

Training instructions: Looks like this.

ICON	INDICATES
	The trainer refers to the participant manual
	The trainer introduces an exercise
	The trainer begins or continues a presentation
	The trainer asks a question to the group
	The trainer begins or continues a presentation or asks a question of the group.

Part V—Appendices includes four additional documents:

- Appendix A— Training Exercises Instructions
- Appendix B— Glossary
- Appendix C— Resources
- Appendix D—Special Acknowledgments.

The Participant Manual

Trainers will need to remind participants to bring their manuals with them each day. The Participant Manual contains a participant's orientation, glossary, and resources. For each module, it includes:

- Training goals and learning objectives.
- A suggested timeline.
- PowerPoint (PPT) slides, with space for notes.
- Resource Pages containing additional information or exercise instructions and materials.

The Learning Approach

The adult learner

Although some didactic presentation (lectures) by the trainer is necessary, this training series relies heavily on collaborative exercises and other learner-directed activities.

Adults have much to offer to the learning process, having already gained quite a bit of knowledge through their education, work, and other experiences. The curriculum provides opportunities for the trainer to encourage participants to share their relevant experience and knowledge with others. This process can also prepare participants to form more effective partnerships and collaborative relationships following the training event.

This training series is based on adult learning principles, which advise trainers to:

- Focus on real-world problems.
- Emphasize how the information can be applied.
- Relate the information to the learners' own goals.
- Relate the materials to the learners' experiences.
- Allow debate of and challenge to ideas.
- Listen to and respect the opinions of participants.
- Encourage participants to be resources for the trainer and for one another.
- Treat participants with respect.

The approach

The learning approach for this training series includes:

- Trainer-led presentations and discussions.

- Frequent use of creative learner-directed activities, such as small-group and partner to-partner conversations.
- Small group exercises and presentations.
- Periodic reviews of the material, to increase the amount of information that the participants will remember.
- Exercises to assess how much the participants have learned.
- Action planning to allow small groups to identify short to long-term goals and tangible steps that their group will take to achieve these goals.

Preparation for in-person training

Major training preparation tasks include:

- Logistical planning, including scheduling, selecting the site, and securing or arranging for equipment and supplies at the site.
- Selecting and preparing participants.
- Becoming thoroughly familiar with the curriculum.

The training space

An attractive, well-organized training space can enhance a participant's learning experience. The room must be large enough to accommodate all participants and small groups. Seating small groups at round tables is ideal because it saves much of the time participants would otherwise spend moving into and out of their small groups for exercises. The trainer must be able to rearrange the room and seating for particular presentations and exercises. Additional small tables around the edges of the room can hold supplies, learning materials, and trainer materials.

However, the ideal space is not always possible. If the space is not large enough to accommodate tables, small groups can always push back their chairs and work on the floor—if participants are comfortable doing so. Using more than one room at a site can help provide space for small-group activities. However, do not use more than two rooms, because it is helpful to have a trainer present in each room to monitor the group process at all times and provide help wherever it is needed.

Providing tea, coffee, water, and snacks during refreshment breaks will encourage participants to mingle and talk with one another during these times.

Participants will also need information on where to buy lunch if lunch is not provided.

Equipment and supplies

The PowerPoint presentations require a laptop computer, LCD projector, and screen. A remote control for the projector allows the trainer to move freely around the room. If a remote is not available, a training assistant or the co-trainer who is not presenting can control the slides.

If a PowerPoint projector is not available (or if it breaks down during the training!), the training can continue without it. The Participant Manual includes copies of all slides, and the Trainer Manual shows a copy of each slide, followed by the information needed to explain it.

At least one whiteboard (with markers), several pads of flipchart paper, tape, and colored markers for group exercises are essential to the training.

The Preparation Checklist in each module indicates the specific supplies needed for the module.

Master Supply List for All Modules:

- One copy of the Trainer Manual for each trainer
- One copy of the Participant Manual for each participant
- One copy of the overall training schedule and Master Agenda for each participant
- Colored markers:
 - Washable, unscented, and in multiple colors (one set per table for participant use)
 - Multiple black and blue markers for presentation use (black and blue are most visible on newsprint; light colors can be used for highlighting)
- Tape (one or two rolls of masking tape for hanging flipchart paper)
- Flipchart
- Copy of the evaluation forms as appropriate and if not provided in the training binders

Selecting and preparing participants

Ideally, the training group should be large enough to be divided into at least three small groups with at least six to eight participants in each, but the training materials can be adjusted for smaller training groups.

Having a training group that includes a mixture of representatives from the health and justice systems is essential to the success of the training. The trainer can prepare participants for learning and increase their positive expectations before the training begins by sending participants a pre-training package that contains items such as:

- A welcome letter.
- The Training Master Agenda.
- A short list of questions that will stimulate interest in the material (e.g., relevant questions from the pre-training survey).

Becoming familiar with the curriculum

Trainers should read the curriculum, study it, and make sure that they understand the training goals and learning objectives of each module and are fully prepared to facilitate the exercises. The better a trainer knows the material, the more he or she can focus on the participants. Solid preparation helps a trainer relax and be more engaging.

Co-trainers should strategize their roles and responsibilities ahead of time. Depending on the match of presentation styles and personalities, some trainers choose to deliver entire modules before switching roles; others prefer to switch roles more frequently.

Other decisions to make include:

- When each co-trainer will capture comments from participants on the flipchart or act as the timekeeper.
- What the expectations are for individual and small-group process observations.
- Whether content contributions are accepted and/or expected from the non-presenting co-trainer.

Customizing the curriculum

Each trainer should be prepared to give examples that illustrate the information and skills addressed in the training. Whenever possible, the trainer should describe experiences with particular techniques or processes. The trainers and participants should discuss any adaptations that might be necessary for applying techniques to members of their communities, or of particular ethnic, cultural, or gender groups. Trainers should also ask participants to talk about experiences from their work, to ensure that the training addresses their concerns.

Each trainer must also have a good understanding of the needs of the training group and be prepared to adapt the training to meet these needs. For example, the trainer may need to:

- Simplify the language (including translating or replacing clinical terms and jargon), to make concepts easier to understand.
- Allow more time for participants to understand concepts that may be foreign to their cultural worldviews, and find concrete examples that help bridge the gap.
- Be creative (e.g., use metaphors or traditional storytelling to make a point).

Important!

Although the curriculum can and should be adapted to suit participants' needs (as well as trainers' personalities and training styles), trainers must maintain the integrity of the content. For example:

- The logistics of an exercise may be changed, but the learning objectives should remain the same, and trainers are responsible for ensuring that all of the objectives are met.
- Group discussion is a valuable part of learner-directed training, but trainers need to manage the time well and not let undirected discussion replace information or exercises.
- Trainers should not skip sections because they assume that participants already know certain information. This training is for people from different systems that may not be familiar with issues or terminology of the other; participants need all of the information in the curriculum, or the modules chosen.
- Training timelines for each module allow for interaction and creativity.

However, trainers must remember that adding extra exercises and allowing extended discussion will increase the time needed to complete the module.

Opening Ceremony

Module 1 includes time for an opening ceremony. The trainer may want to invite a representative from the organization sponsoring the training and/or ministers from the government to welcome participants to the training and deliver opening remarks on Case Care Management. Such a welcome can emphasize the importance of the training.

Getting Started: Preparation Checklists for in-person training

1 to 2 months before the first session

- Carefully review the course.
- Review the background reading in Appendix C—Resources.
- Determine who will attend the training.
- Develop an overall schedule for the training, including dates and times for each module.
- Arrange the training space and audiovisual equipment.
- Obtain all the necessary training materials.

- Invite guest speakers.
- Arrange for refreshments, including lunches if they are provided.

1 to 2 weeks before the first session

- Confirm participants' registration.
- Confirm guest speakers.
- Secure enough copies of the Participant Manual.
- Check space and equipment arrangements.
- Load the PPT presentations onto the laptop computer.
- Review the entire training manual.
- Prepare and make a copy of daily schedules for each participant.

1 to 2 days before the first session

- Finalize room and equipment arrangements.
- Verify onsite lunch arrangements if necessary.
- Set up the room.
- Prepare name badges, if necessary.
- Make copies of the first day's Daily Evaluation form.
- Gather all supplies, including the Participant Manual, notebooks for journal entry and copies of evaluation forms.
- Review the "Before every session" checklist (below).

Before every session

- Arrange chairs for each session in a comfortable way.
- Prepare posters for the session, if needed.
- Display key newsprint pages and posters generated during the training to use for review.
- Ensure that the computer, LCD projector, screen, and PowerPoints needed for the session are available.
- Check to see if there is an adequate supply of:
 - Newsprint pads, flip chart stands and crayons or markers.
 - Pins, blue tack, or tape to stick the newsprints on the walls.
 - All other materials needed for the session.

After every session

- Review completed Daily Evaluation forms for suggestions for the next day's delivery.
- Secure creative and/or key newsprint resources (e.g., definitions, creative artwork) developed by participants for use as a final review and in future trainings.
- Add information contributed by participants and/or the co-trainers into the course content.

At the end of the training program:

- Request all participants to hand in their filled out evaluation forms.

MASTER AGENDA FOR IN-PERSON TRAINING

DAY 1

DATE: _____

CONTENT AND TIMING DAY 1	
Activity	Time
Opening Ceremony	30 minutes
Module 1- Training Introduction	60 minutes
Presentation: Course Overview	20 minutes
Partner Exercise: Introduction	30 minutes
Reflective Exercise: Course Expectations	10 minutes
Break	15 minutes
Module 2- Research on Addiction, Crime, Treatment and Recovery	90 minutes
Presentation: The Global Impact of Substance Use	5 minutes
Presentation: Understanding the Science of Addiction	25 minutes
Presentation: Linkages Between Substance Use Disorders and Crime	15 minutes
Presentation: Evidence-Based Options and Outcomes	35 minutes
Presentation: Addiction and Recovery	10 minutes
Lunch	60 minutes
Module 3- Case Care Management Multisystem Approach	120 minutes
Presentation: The Multisystem Approach	10 minutes
Embedded Exercise: Stakeholders	20 minutes
Presentation: Case Care Management and the Justice System	10 minutes
Group Discussion: The Justice System in your Country	20 minutes
Interactive Exercise: The Participant	30 minutes
Presentation: How Case Care Management supports the Stakeholders	20 minutes
Presentation: Reasons to invest in Case Care Management	10 minutes
Break	15 minutes
Module 4- Defining Case Care Management	110 minutes
Presentation: Defining Case Care Management	10 minutes
Interactive Exercise: What does "C" stand for?	15 minutes
Presentation: Case Care Management and the Classic Case Management Models	20 minutes
Presentation: The Values of Case Care Management	15 minutes
Reflective Exercise: Case Care Management Definition	25 minutes
Presentation: The Critical Elements of Case Care Management	15 minutes
Wrap up and Questions	10 minutes
Evaluation Day 1	5 minutes
End of Day 1	

CONTENT AND TIMING DAY 2	
Activity	Time
Module 5- Functions of Case Care Management	60 minutes
Presentation: Functions of Case Care Management	50 minutes
Group Exercise: How to measure Case Care Management Success	10 minutes
Break	15 minutes
Module 6- Models of Case Care Management	95 minutes
Presentation: Models of Case Care Management	15 minutes
Embedded Interactive Exercise on Case Care Management Models	15 minutes
Presentation: International Examples of Case Care Management	60 minutes
Reflective Exercise: Case Care Management Models	5 minutes
Lunch	60 minutes
Module 7- The Case Care Manager interacting in the Multisystem Approach	120 minutes
Presentation: The Case Care Manager and the Justice System	10 minutes
Interactive Exercise: Case Study 1	20 minutes
Presentation: The Case Care Manager and the Participant	10 minutes
Interactive Exercise: Case Study 2 and 3	20 minutes
Presentation: The Case Care Manager and the Health and Social Services	10 minutes
Interactive Exercise: Case Study 4	20 minutes
Presentation: The Case Care Manager and the Communities	10 minutes
Interactive Exercise: Case Study 5	20 minutes
Break	15 minutes
Module 8- The Profile of a Case Care Manager	60 minutes
Presentation: The Profile of a Case Care Manager	15 minutes
Presentation: How to hire a Case Care Manager	15 minutes
Presentation: How to train a Case Care Manager	15 minutes
Reflective Exercise: Case Care Management Profile	15 minutes
Module 9- Case Care Management Implementation Roadmap	60 minutes
Presentation: Step 1 Program Design	10 minutes
Presentation: Step 2 Resource Planning	10 minutes
Group Exercise: Monitor and Evaluation Planning	20 minutes
Presentation: Step 3 Program Creation	10 minutes
Presentation: Step 4 Pilot Implementation	10 minutes
Evaluation Day 2	5 minutes
End of Day 2	

DAY 3

DATE: _____

CONTENT AND TIMING DAY 3	
Activity	Time
Module 10- Case Care Management implementation: developing the system- Part 1	90 minutes
Group Exercise Implementation Plan Part 1	90 minutes
Break	15 minutes
Module 10- Case Care Management implementation: developing the system- Part 2	90 minutes
Group Exercise Implementation Plan Part 2	45 minutes
Reporting Out	45 minutes
Course wrap up and evaluation	30 minutes
Closing ceremony	30 minutes
End of the Training	

EVALUATION FORMS FOR IN-PERSON TRAINING

DAILY EVALUATION:

Day one/Day two/Day three

Date: _____

Trainer 1:

Trainer 2:

Trainer 3: (if applicable)

To be completed at the end of each day of training by each participant

Please indicate your level of agreement with these statements about today's training session	Strongly Agree	Agree	Neutral	Disagree	Strongly disagree
1. I would highly rate today's training					
2. The quality of the information was good					
3. The training was well-organized					
4. The trainers were knowledgeable about the subject					
5. The trainers were well-prepared for the course					
6. The trainers were open to participant comments and questions					
7. I felt free to ask questions					
8. The training topics were relevant to my work					
9. I expect to use the information gained from this training					
10. I would recommend this training to a colleague					
Please complete the following statements:					
One thing I learned today that I plan to use in my work is:					
What I like best about today's training is:					
I wish there had been more information about:					
Today's training could have been better if:					
Other comments:					

OVERALL TRAINING EVALUATION

Date: _____

Trainer 1:

Trainer 2:

Trainer 3: (if applicable)

To be completed at the end of each day of training by each participant

Please indicate your level of agreement with these statements about the training as a whole	Strongly Agree	Agree	Neutral	Disagree	Strongly disagree
1. The training was of a high quality as a whole					
2. The overall quality of the information presented was good					
3. The training was well-organized					
4. The training objectives were clearly stated					
5. The objectives of the training were achieved					
6. The training modules were presented in a logical order					
7. The training activities/exercises allowed for practice in important concepts					
8. The training provided balance among presentations, activities, participant questions, and discussions					
9. I felt free to ask questions					
10. The training topics were relevant to my work					
11. I expect to use the information gained from this training					
12. I would recommend this training to a colleague					
Training Materials					
Please indicate your level of agreement with these statements about the training materials	Strongly Agree	Agree	Neutral	Disagree	Strongly disagree
1. The visual aids were adequate and facilitated the learning process					
2. The manuals were helpful and facilitated understanding of the topic					

Trainers (to be completed for each trainer)

Trainer 1 Name:

Please indicate your level of agreement with these statements about this trainer	Strongly Agree	Agree	Neutral	Disagree	Strongly disagree
1. Trainer 1 was well-prepared					
2. Trainer 1 was knowledgeable about the subject matter					
3. Trainer 1 communicated the material in a meaningful manner					
4. Trainer 1 provided clear answers to participant questions					
5. Trainer 1 promoted engagement and participation					

Trainer 2 Name:

Please indicate your level of agreement with these statements about this trainer	Strongly Agree	Agree	Neutral	Disagree	Strongly disagree
1. Trainer 2 was well-prepared					
2. Trainer 2 was knowledgeable about the subject matter					
3. Trainer 2 communicated the material in a meaningful manner					
4. Trainer 2 provided clear answers to participant questions					
5. Trainer 2 promoted engagement and participation					

Trainer 3 Name:

Please indicate your level of agreement with these statements about this trainer	Strongly Agree	Agree	Neutral	Disagree	Strongly disagree
1. Trainer 3 was well-prepared					
2. Trainer 3 was knowledgeable about the subject matter					
3. Trainer 3 communicated the material in a meaningful manner					
4. Trainer 3 provided clear answers to participant questions					
5. Trainer 3 promoted engagement and participation					

Please complete the following for each module:

Please indicate your level of agreement with these statements about this module	Strongly Agree	Agree	Neutral	Disagree	Strongly disagree
Module 2 <i>Research on Addiction, Crime, Treatment and Recovery</i> is very complete					
Module 3 <i>Case Care Management multisystem approach</i> is very complete					
Module 4 <i>Defining Case Care Management</i> is very complete					
Module 5 <i>Functions of Case Care Management</i> is very complete					

Module 6 <i>Models of Case Care Management</i> is very complete					
Module 7 <i>Case Care Manager interaction in the multisystem approach</i> is very complete					
Module 8 <i>The Profile of a Case Care Manager</i> is very complete					
Module 9 <i>Case Care Management Implementation Roadmap</i> is very complete					
Module 10 <i>Case Care Management Implementation and Report Out</i> is very complete					

What I liked best about this training was:

The most useful module for me was:

The least useful module for me was:

I wish there had been more information on:

This training could have been better if:

I would be interested in having further training on these topics:

Other comments

MODULE 1



INTRODUCTION

Preparation checklist

Content and timeline

Training goals and learning objectives

PowerPoint slides

MODULE 1

Module 1 Preparation Checklist

- Review the “Getting Started” section for general preparation information on page 13 of this manual.
- Preview the module of the day.
- Prepare for the opening ceremony (if applicable).

In addition to the materials listed in the “Getting Started” section, assemble the following:

- A Participant Manual for each participant.
- A copy of the overall training schedule and Master Agenda for each participant.
- Index cards or Post-its (one for each table).
- One glue stick or roll of tape for each table.

Module 1 Content and Duration

Activity	Time
Opening Ceremony	30 minutes
Module 1- Training introduction	60 minutes
Presentation: Course overview	15 minutes
Partner Exercise: Introduction	15 minutes
Reflective Exercise: Course Expectations	15 minutes
Break	15 minutes

Module 1 Goals and Objectives

Training Goals

- Provide an overview of the structure and content of the course.
- Present the overall training objectives.
- Provide an opportunity for participants to introduce themselves and engage with the group.

Learning Objectives

Participants who complete Module 1 will be able to:

- Explain the overall structure and content of the course.
- State the training objectives.
- Get acquainted with the other participants.



Welcome to this training on Case Care Management. My name is _____ and my co-trainers' names are _____.

We'll be working together to facilitate this training.

We want this training to be a collaborative process among all of us. The format is interactive and allows discussion and exercise to memorize the content and connect knowledge to practice and you will be actively involved in creating a learning community.

Before getting started, I would like to address just a few housekeeping issues.

Training instructions: The trainer should review any important housekeeping items, such as where the restrooms are, where smoking is permitted, and where and when refreshment breaks will be.



Just remember that we have a few ground rules:

1. Punctuality
2. Respect
3. Ask questions
4. Engage with other participants
5. Have fun- It is a serious subject, but we can enjoy our time together



MODULE 1

Objectives

Welcome the participants and stimulate engagement

Provide a general overview of the course

Present the key objectives of the training



OAS



1.1

Say

In this chapter, we will have the opportunity to get to know each other. I will also provide an overview of the course and elaborate the key objectives we want to achieve with this training.



Training instructions: Trainer should refer to page 252 of the Participant Manual. The trainer could take this opportunity to mention Annex A as an important reference throughout the training and beyond, to quickly access the exercise, and collect thoughts and notes that will be used during the training.

Say

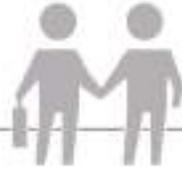
Before we start the course, we will have a partner exercise to get to know each other a little better. Please take two minutes to answer these questions:

- What is your name?*
- Where do you live and work?*
- Why are you interested in Case Care Management and alternatives to incarceration?*

After the two minutes are up, please find a partner that you do not already know and introduce yourself.

Once you have found a partner, you will have five minutes each to introduce yourselves to one another, using the answers you have provided to the questions above. After the five minutes are up, you will be asked to introduce your partner to the rest of the training group.

Training instructions: The trainer should encourage people to mingle and move around to find a partner.



Overall Training Goals

- Illustrate the public safety and public health implications of treatment interventions in the justice system setting
- Introduce Case Care Management in the framework of alternatives to incarceration for people with substance use disorder (SUD) in conflict with the law
- Define Case Care Management
- Support the process of the Case Care Management implementation in your own country



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1.4

Say

We are going to have a look at the overall training goals of this course:

- Illustrate the public safety and public health implications of treatment, recovery, and social integration interventions in the justice continuum.
- Understand how Case Care Management fits into the broader framework of Alternatives to Incarceration for justice-involved individuals with substance use disorders.
- Define Case Care Management.
- Brainstorm about how Case Care Management could be implemented in your own country.



Learning Objectives

Participants that complete the Case Care Management course will be able to:

Understand the global challenge of addiction and its relation to the justice system

Contribute to more effectively addressing addiction in your country

Describe the vicious and complex cycle of addiction and crime

Describe how addiction works with the importance of recovery and the continuum of care.



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After completing the course, you will be also able to:

- ☐ Understand and elaborate on the global challenge of addiction and its links with the justice system.
- ☐ Contribute to more effectively addressing addiction in your country.
- ☐ Describe the complexity and the vicious cycle of addiction and crime.
- ☐ Understand and explain how addiction works, as well as the importance of recovery and the treatment continuum of care.



Understand the importance of social integration in the continuum of care as a preventive factor in recidivism and addiction

Understand the stigma, discrimination and barriers associated with addiction and criminal activities

Describe the benefit of a multisystem approach responding to the fragmentation of services

Describe Case Care Management and how it works in practice

Understand the steps of Case Care Management and how to implement it



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1.6

Say

You will also:

- ☐ Understand the importance of social integration in the continuum of care as a preventive factor in recidivism and addiction.
- ☐ Understand the stigma, discrimination, and barriers associated with addiction and criminal activities.
- ☐ Be able to describe the benefits of a multisystem approach responding to the fragmentation of services.
- ☐ Be able to describe Case Care Management and how it works in practice.
- ☐ Understand the steps of Case Care Management and how to implement it.



Course Overview

- **Module 1** - Introduction
- **Module 2** - Research on Addiction, Crime, Treatment and Recovery
- **Module 3** - Case Care Management Multisystem Approach
- **Module 4** - Defining Case Care Management
- **Module 5** - Functions of Case Care Management



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Let's go over the content of this course. The Case Care Management training is divided into 10 modules, covering the following topics:

Module 1 is the introduction to the course, where we are now.

Module 2 presents state-of-the-art research on addiction, crime, treatment, and recovery.

Module 3 introduces the multisystem approach of Case Care Management and its connection to the main stakeholders, including the justice system.

Module 4 elaborates on the definition of Case Care Management, working toward a better understanding of the term, the Case Care Management core values, and critical elements.

We will be ending Day 1 at the conclusion of Module 4.

On Day 2, we will continue with **Module 5**, which explains how the critical elements work in practice, elaborating on the functions of Case Care Management.



CASECARE MANAGEMENT



CASECARE MANAGEMENT
CURRICULUM FOR PARTICIPANTS

- **Module 6** - Models of Case Care Management
- **Module 7** - Case Care Manager Interacting in the Multisystem Approach
- **Module 8** - The Profile of a Case Care Manager
- **Module 9** - Case Care Management System Implementation Roadmap
- **Module 10** - Case Care Management Implementation Exercise and Report Out



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1.8

Say

Module 6 presents the models of Case Care Management with the basic elements of the models and international examples from the Americas and Europe.

Module 7 elaborates on how the Case Care Manager interacts in the multisystem approach with the relevant stakeholders.

Module 8 features the Profile of a Case Care Manager, illustrating the qualifications for the job as well as how to hire and train for the position.

Module 9 provides an overview of the steps and elements for Case Care Management System Implementation.

We will close Day 2 with a specific overview of Case Care Management and the crucial elements.

Day 3 focuses on interactive exercises and working in a group.

Module 10 is interactive group exercise in which participants will create an Action Plan and executive presentation concerning a Case Care Management program for their respective jurisdictions that can be subsequently submitted for approval and implementation.



Ask What do we mean by the term “effective collaboration?”

Say When speaking about Case Care Management, we should always remember that what we want to create is a mechanism to promote synergies between public safety and public health approaches.

A public safety approach aims at reducing recidivism and further victimization, cutting incarceration costs, fostering social integration, promoting citizen security, more inclusive and safer communities, and reducing stigma and marginalization.

A public health approach promotes and supports treatment and recovery for people with substance use disorders.

A public safety or public health approach by itself is limited, but when they are combined, they can provide more effective opportunities for people with SUDs in the justice system and beyond.



Research shows that there are different types of risk factors which lead to criminal behavior.

The slide presents the following main group:

Personal risk factors

- Disorders that affect impulsivity (e.g. FASD, ADHD, etc)
- Addiction
- Bullying
- Discrimination, isolation, exclusion

Familiar risk factors

- Domestic violent, abuse, neglect
- Parental Dysfunction (addiction, mental illness, criminal behavior)
- Loss of family member (divorce, death, abandonment)

Societal Risk factors

- Low income
- Inadequate housing
- Lack of education/employment opportunities

Source: Adaptation from Calgary, John Howard Society.



Treatment is key

Individuals with SUDs may commit crimes, but they are often associated with minor or non-violent ones used to finance drug purchases

Research on diversion shows that the criminal behavior is likely to stop with effective treatment for SUDs.

Drug use disorders should be considered primarily as a health problem rather than be associated to criminal behavior.

Source: EMCDDA (2007)



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1.11

Say

Although individuals with SUDs may commit crimes, they are often associated with minor or non-violent ones used to finance drug purchases.

Research on diversion to treatment has shown that the recovery process for people with SUDs causes them to rescind from acting upon criminal behavior. Hence, this is why it's imperative to tackle underlying drug issues and focus on forms of recovery in order to reduce crime.

Source:

EMCDDA. (2007). Drug in Focus: Briefing of the European Centre for Drugs and Drug Addiction. https://www.emcdda.europa.eu/system/files/publications/470/Dif16EN_85000.pdf

The coordination between systems can allow drug treatment to be associated with reductions in drug use, the odds of offending, costs to society, and it can even improve public safety, and the well being of both the user and their direct environment (UNODC 2018; Holloway et al. 2006BIB-043; Gossop et al. 2005).

Cullen 2007; Mitchell et al. 2007). However, custodial responses, such as imprisonment, have not been successful in reducing drug-related offenses (Stevens et al. 2003BIB-079; Mitchell et al. 2017BIB-065; Spohn and Holleran 2002BIB-077) or improving psychological functioning (Massoglia 2008BIB-058). Further research indicates that recidivism rates are higher within justice-involved individuals who served prison sentences in comparison to offenders who received a non-custodial sentence provided in the community, especially within a sample of drug-using offenders (Andrews and Anderson 2006BIB-002; Woldgabreal et al. 2014BIB-093; Spohn and Holleran 2002BIB-077). More studies by Spohn and Holleran (2002BIB-077) indicated that since there is a possibility that prison settings might be criminogenic by nature, it is more likely that the inmates' social bonds will be weakened. As a result, justice-involved individuals sentenced to prison time may be less prepared to return to the community, making it more difficult to reintegrate into society after their sentence is completed. This statement is supported by Camp and Gae's (2005BIB-021) observation on inmate culture and prison regimes who are often associated with criminogenic results. On the other hand, non-custodial sentences, like the supervision of offenders within communities, may prevent people from experiencing debilitating circumstances by letting them maintain contact with their society (Woldgabreal et al. 2014BIB-093), (Colman & Blomme, 2020).



Say

We want to gradually empower people with SUD. The individuals are no longer standing alone and socially marginalized by becoming part of the community, in which social integration is not just desirable but achievable, and is the result of an individualized process starting with treatment and leading to desistance in criminal behavior and problematic substance use.

Individuals with SUDs can be more engaged members of society if given the chance to access treatment and services that increase stability, functionality and social integration. Case Care Management provides a linkage to a coordinated network of stakeholders and services promoting opportunities for participants in Alternatives to Incarceration program and to justice-involved individuals thought-out the justice continuum.

Course Expectations



Before we move on, I'd like to take some time to consider your expectations for this training, given what you know so far. Please take five minutes to think about what you would like to take away from these three days, then write down your thoughts, doubts, ideas, and expectations on the Post-it notes you have on your table.

Training instructions: The trainer should direct participants to page 253 of the Participant Manual to write down their notes.

Say

The trainer will allocate five minutes for participants to write down their thoughts and then collect the Post-its. The lead facilitator could go through the ideas provided on the Post-its and group them into categories, noting the main and recurring ideas. Ideally, if there is space on the wall of the training room, the trainer can have the Post-it notes grouped on the wall for the participants to read during the break. At the end of Day 3, a section of the wrap up time should be dedicated to reviewing the expectations and doubts expressed during this reflective exercise, and asking for comments from the participants.

MODULE 2



Research on Addiction, Crime, Treatment and Recovery

Preparation checklist

Content and timeline

Training goals and learning objectives

PowerPoint slides

Resource pages

MODULE 2

Module 2 Preparation Checklist

- Review the “Getting Started” section for general preparation information on page 13 of this manual.
- Preview Module 2.
- In addition to the materials listed in Getting Started, assemble the following:
 - A stack of letter-sized (or A4-sized) paper for each table.
 - Pads of Post-it notes for each table.

Module 2 Content and Duration

Activity	Time
Module 2- Research on Addiction, Crime, Treatment and Recovery	90 minutes
Presentation: The Global Impact of Substance Use	5 minutes
Presentation: Understanding the Science of Addiction	25 minutes
Presentation: Linkages Between Substance Use Disorders and Crime	15 minutes
Presentation: Evidence- Based Treatment Options and Outcomes	35 minutes
Presentation: Addiction and Recovery	10 minutes
Lunch	60 minutes

Module 2 Goals and Objectives

Training Goals

To provide updated research on the following topics and their linkages:

- The Global impact of substance use.
- The science of addiction.
- Linkages between substance use disorders and crime.
- Evidence-based treatment options and outcomes.
- Addiction and recovery.

Learning Objectives

Participants who complete Module 2 will be able to:

- Understand and explain the global impact of substance use.
- Understand the science of addiction.
- Explain the linkages between addiction and crime.
- Understand the importance of treatment and the continuum of care.
- Explain the mechanism of recovery and how it changes over time.



MODULE 2

RESEARCH ON ADDICTION, CRIME, TREATMENT AND RECOVERY



2.1

Training instructions: This module is very informative and quite long. It should ideally be presented by two trainers. The trainers presenting this module should have sound expertise on the science of addiction and a deep knowledge on evidence-based treatment opportunities. They should be familiar with the links between drug and crime, and understand recovery and how it changes over time.

Trainers should plan and rehearse before the actual training and agree on the set of slides that each one will present. The manual provides a suggestion on how to divide the task based on the piloting experience, but trainers might modify this according to their needs and preferences.

Trainer 1- with sound scientific knowledge of addiction could cover the following sections:

- The global impact of Substance Use from slide 2.1 to 2.6
- Understanding the Science of Addiction from slide 2.7 to 2.23
- Evidence-Based Treatment Options from slide 2.35 to 2.47
- Addiction and Recovery from slide 2.58
- Joint presentation from slide 2.60-2.62

Trainer 2 – with sound expertise on the treatment and recovery process:

- Linkages between SUDs and Crime from slide 2.24 to 2.34
- Evidence-Based Treatment Options from slide 2.48 to 2.49
- Treatment Outcomes from slide 2.50 to slide 2.57
- Joint presentation from slide 2.60-2.62

Say

Trainer 1: Dear Participants, welcome to Module 2 presenting what science tells us on addiction, crime, treatment, and recovery. I am assisted by my colleague (Name of the Trainer 2), and together we will explore the fundamentals of substance use disorders, the linkages between drug use and crime and what can be done to alleviate the burdens of substance use disorders.



MODULE 2

Learning Objectives

Explore the global impact of substance use and its impact on individuals, families, and communities

Understand the science of addiction

Recognize links between addiction and crime

Identify the range of evidence-based treatment options for substance use disorders

Understand costs related to addiction and incarceration, and cost savings related to treatment

Become familiar with the principles of recovery



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2.2

Say

Trainer 1: After completing this module, I would expect that you will:

- ❑ Become familiar with the bigger picture of substance use disorders and their global impact.
- ❑ Understand the science of addiction and recovery.
- ❑ Recognize the linkages between drugs and crime.
- ❑ Understand the available evidence-based treatment options and their effectiveness.
- ❑ Have an overview of the costs related to addiction and incarceration/intervention in the criminal justice system.
- ❑ Understand recovery and how it works over time.

THE GLOBAL IMPACT OF SUBSTANCE USE

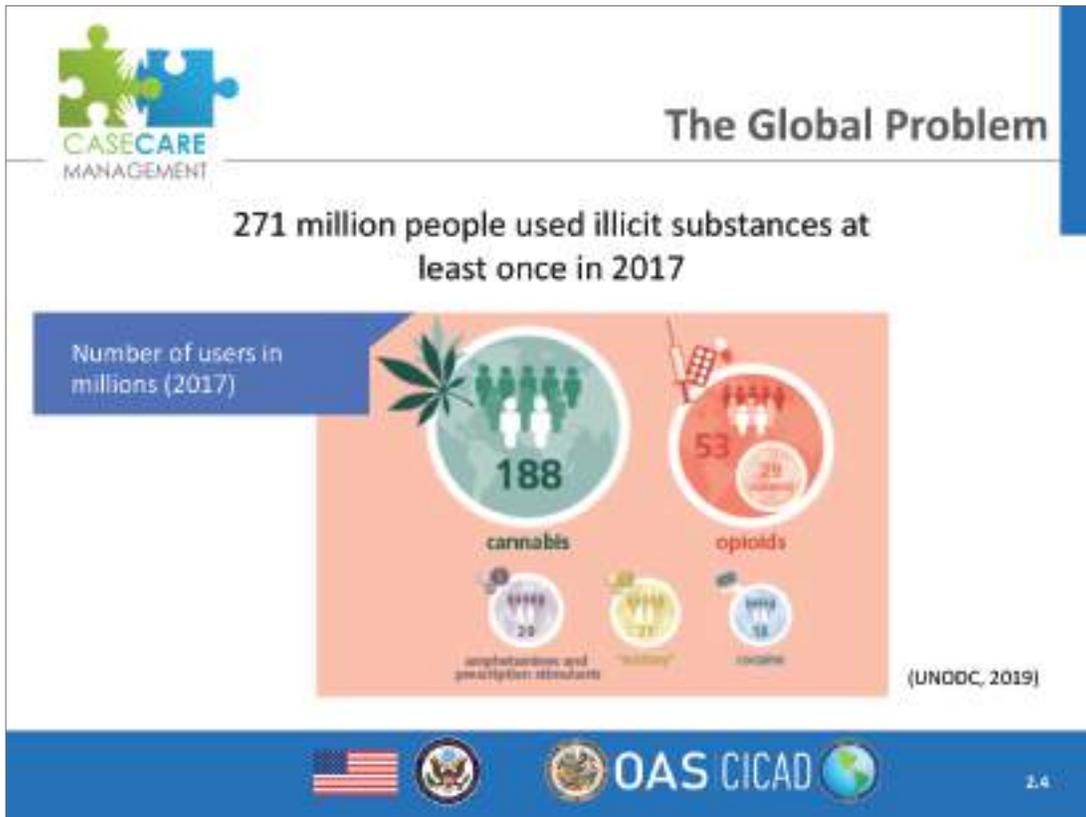


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2.3

Say

Trainer 1: Let's have a look at the extension of the drug problem worldwide.



Say

Trainer 1: If we are looking at the United Nations World Drug Report, an annual report about the drug and crime situation worldwide, there are almost three million people around the world who have some degree of relationship with substances. In other words, they have used psychoactive substances at least once. The most commonly used drug around the world is cannabis, followed by opioids, drugs like heroin and amphetamine-type substances and stimulants.

Training instructions: The trainer should inform participants that the United Nations World Drug report is published every year and issued around June 26, which is the UN International Day Against Drug Abuse and Illicit Trafficking. The UN Office on Drugs and Crime’s World Drug report contains the latest data on drug demand and supply trends, and provides insights into the UN’s work on prevention, criminal justice intervention, treatment, recovery, supply reduction initiatives, and current challenges in countering drugs and crime globally. Trainers and participants should be encouraged to have a look at the report and review some of the latest data and information.

“Differences between men and women in the extent of drug use may play a critical role in changes in the projected number of people who use drugs in developing countries, including in Africa” (UNODC, 2021).

An estimated 271 million people worldwide aged 15–64 had used drugs at least once in the previous year (range: 201 million to 341 million). This corresponds to 5.5 per cent of the global population aged 15–64 (range: 4.1 to 6.9 per cent), representing one in every 18 people (UNODC, 2019).

UNODC publishes the World Drug Report (WDR) every year. The UTC curricula are regularly updated every 3 years.

The most recent WDR states: Over the past year, around 275 million people have used drugs, up by 22 per cent from 2010 (UNODC, 2021).

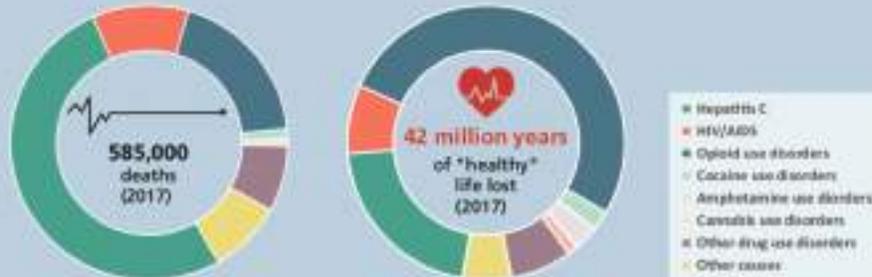
Source:
 United Nations Office on Drugs and Crime. (2021). World Drug Report 2021. <https://wdr.unodc.org/wdr2021/>
 United Nations Office on Drugs and Crime. (2019). World Drug Report 2019. Available at <https://wdr.unodc.org/wdr2019/>
 United Nations Office on Drugs and Crime. (2019). World Drug Report 2019. <https://wdr.unodc.org/wdr2019/>



585,000 deaths and 42 million years of “Healthy Lives” have been lost as a result of drug use in 2017.

Global Burden of Disease Study 2017

Hepatitis C and opioid use disorders are responsible for most of the deaths and disability attributed to the use of drugs



Sources: Institute for Health Metrics and Evaluation, “Global Burden of Disease Study 2017”, Global Health Data Exchange.



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2.5

Say

Trainer 1: It is also important to know that Substance Use Disorders (SUDs) are the cause of almost 600 thousand deaths and 42 million years of lost productivity and healthy life amongst other losses. We are talking about an enormous number of people suffering from some level of distress. Not all of these people are addicted or have a severe disorder but are people that have a relation with psychoactive substances and the losses that we are mentioning severely affect productivity and human lives. Despite this worrisome data, there is some hope. We should also remember that the vast majority of people do not use drugs, and not all of those who use drugs will develop substance use disorders will develop a substance use disorder.

Drug use killed almost half a million people in 2019, while drug use disorders resulted in 18 million years of healthy life lost, mostly due to opioids. (Word Drug Report 2019).

Source: United Nations Office on Drugs and Crime. (2019). World Drug Report 2019. Available at <https://wdr.unodc.org/wdr2019/>

According to the study, in 2019, an estimated 494,000 deaths and 30.9 million years of “healthy” life lost as a result of premature death and disability were attributable to the use of drugs. Most of the burden of disease was among males, who contributed to 71 percent of deaths and 66 percent of DALYs in 2019 (UNODC, 2021).

Source: United Nations Office on Drugs and Crime. (2021). World Drug Report 2021.



Global Consequences of Substance Use Disorders

- According to the United Nations, 35 million people suffer from SUDs
- Higher rates of hepatitis and tuberculosis
- Higher costs of healthcare
- Lost productivity
- Deaths and suicide by overdose
- Injuries and deaths from accidents (e.g., automobile)
- Elevated risk for crime and violence
- High costs related to incarceration
- Poor relationships with families and communities



26

Say

Trainer 1: Among the almost 300 million people across the world who have used psychoactive substances at least once in the past year, 35 millions of them have a Substance Use Disorder (SUD). People with SUDs have significantly greater rates of multiple diseases, for example: HIV, hepatitis, and tuberculosis. These people need health care services because of the health problems related to SUDs and financial aid due to unemployment. They also carry the risk of death by overdose, especially from opioid use and misuse. People with SUDs are also more likely to run into the criminal justice system and are more likely to end up in a controlled environment such as a prison, which leads to an increase of costs related to their incarceration. We also know that people with SUDs develop significant problems in their interactions with their peers, families, and children.

These huge numbers might seem a bit abstract for many of you, but nobody is immune against SUDs. This may happen to you, to your friends, your family, people that are important to you. This can happen to anyone. For this reason, it is important to understand SUDs and what can be done to minimize the burden they impose on society.

Training instructions: Trainer could ask participants how they see their own country's problem in context to this global data.

Source: United Nations Office on Drugs and Crime. (2019). World Drug Report 2019. Available at <https://wdr.unodc.org/wdr2019/>

UNDERSTANDING THE SCIENCE OF ADDICTION



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2.7

Say

Trainer 1: Let's develop a better understanding of what we know from the science. In the last 20 years with the development of new technologies, particularly brain imaging devices, findings from genetic studies and multiples scientific methods that were not available 25 years ago, we have learn a lot and our understanding of the nature of SUDs and recovery has changed dramatically.



Defining Drug Addiction and Substance Use Disorders

In the last decades, thanks to the development of brain research, our understanding of addiction as a brain illness has evolved, there is the more specific term of “substance use disorder.” This term is also less stigmatizing to use than “addiction.”

Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Source NIDA 2020



OAS



2.8

Say

Trainer 1: In the last decades, thanks to the development of brain research, our understanding of addiction as a brain illness has evolved, there is the more specific term of “substance use disorder.” This term is also less stigmatizing to use than “addiction.”

Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria



Signs and Severity of SUDs

- Excessive amounts used
- Excessive time spent using/obtaining

- Craving or urges to use
- Unsuccessful attempts to cut down

- Tolerance
- Withdrawal

- Hazardous use despite physical danger
- Health problems
- Missed obligations
- Interference with activities
- Personal problems

DSM-5 presents the "Substance Use Disorder" terminology

11 diagnostic criteria over a 12-month period:

- Mild: 2-3 symptoms
- Moderate: 4-5 symptoms
- Severe: 6 or more symptoms
- Only 2 criteria are physiological (yellow box)
- The majority of the criteria are behavioral

Adaptation from DSM-5 and URC curriculum




OAS CICAD

2.9

Say

Trainer 1: Substance use disorders span a wide variety of problems arising from substance use, and cover 11 different criteria as follows:

Note that 9 of the 11 signs or symptoms are behavioral and only two are physiological.

- Taking the substance in larger amounts or for longer than the individual meant to
- Wanting to cut down or stop using the substance, but not managing to
- Spending a lot of time getting, using, or recovering from use of the substance
- Cravings and urges to use the substance
- Not managing to do what one should at work, home or school, because of substance use
- Continuing to use, even when it causes problems in relationships
- Giving up important social, occupational or recreational activities because of substance use
- Using substances again and again, even when it puts the individual in danger
- Continuing to use, even when the individual knows they have a physical or psychological problem that could have been caused or made worse by the substance use
- Needing more of the substance to get the effect the individual seeks (tolerance)
- Development of withdrawal symptoms, which can be relieved by taking more of the substance
- Clinicians can specify how severe the substance use disorder is, depending on how many symptoms are identified. Two or three symptoms indicate a mild substance use disorder, four or five symptoms indicate a moderate substance use disorder, and six or more symptoms indicate a severe substance use disorder.

Source: Volkow N.D., Frieden T.R., Hyde P.S., Cha S.S. (2014) Medication-assisted therapies — tackling the opioid-overdose epidemic. *N Engl J Med* 2014;370:2063-6.

Why do People Use Drugs?

Two major reasons

- 1 They like what it does to their brains (positive reinforcement)
- 2 To cope with, or avoid, stressful life events (negative reinforcement)

OAS CICAD

Say

Trainer 1: Let’s ask ourselves a question: Why do people use drugs in general? The history of drug use is as long as the history of human beings. Psychoactive substances have been around for thousands of years, and there is wide historical evidence for it. If we just say that people are irresponsible, or that they are lacking will power, that they are crazy or mad, this would be too simplistic. It still does not answer the question: Why?

There must be a valid reason. And that leads us back to the fact that psychoactive substances and the way they affect our brain and our behavior actually have a very reinforcing property. In other words, people like what the substances do to their brain. This is what we call positive reinforcement. In everyday language we would say, people enjoy it, people have fun, or people get high. This is one reason why human beings use psychoactive substances. There is another reason that is quite important to emphasize. People use drugs not just to have fun. For some, the only way this is the only way to survive their horrible life situations. There are many countries around the world, many environments, particularly with teenagers, where conditions are physically and emotionally unbearable. The only way to survive is to use substances to cope with life events that are very adverse and unpleasant. In these cases, we are not talking about recreational use—this is not about fun, but about survival. They are negative reasons. We need to understand the phenomenon; support recovery. I do not want to justify addiction, I want us to understand what the rationale behind humans using substances and continuing using substances, and how some—but not all—of them will develop SUDs and other serious problems. Schaeffer’s model demonstrates the larger Experimental pattern through to the Compulsive, and the reduction of population.

The following type of use were identified:
 Experimental use – Drug use is motivated by curiosity or desire to experience new feelings or moods. This may occur alone or in the company of one or more friends who are also experimenting. It normally involves single or short-term use.
 Social/recreational use – Drugs are used on specific social occasions by experienced users who know what drug suits them and in what circumstances (e.g. ecstasy use by experienced users at dance parties, or alcohol with a meal).

Circumstantial/situational use – Drugs are used when specific tasks have to be performed and special degrees of alertness, calm, endurance or freedom from pain are sought. (e.g. truck driving shift work or studying for exams).
 Intensive use – This drug use is similar to the previous category, but more intensive. It is often related to an individual’s need to achieve relief or to achieve a high level of performance. It can also involve binge AOD use, where there is excessive use of a substance at one time. The pattern of binge use may be occasional or may relate to specific situations.
 Compulsive/dependent use – Drug use leads to psychological and physiological dependence where the user cannot at will discontinue use without experiencing significant mental or physical distress. Drug use is central to the user’s day-to-day life” (Michell & Flynn, 2018).

Source: Michell, R. Flynn, K. (2018). Association of Alcohol and other Drug Agencies NT Northern Territory Harm Reduction 2018. https://www.aadant.org.au/sites/default/files/uploads/files/northern_territory_harm_reduction_2018_select_committee_submission.pdf.
 2.2 Schaeffer’s Model. (2004). Department of Health. Discussion of the Four Key Health Issues., www.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-front9-wk-toc~drugtreat-pubs-front9-wk-secb~drugtreat-pubs-front9-wk-secb-2~drugtreat-pubs-front9-wk-secb-2-2

In-person Trainer Manual: Case Care Management



Drug Addiction is a Brain Disorder

People **don't** choose to **become addicted.**

Addiction damages the ability to choose not to use drugs.



(Blum & Payne, 1991)



OAS CICAD



2.11

Say

Trainer 1: Why do people experiment? In general, teenagers experiment with everything. People do not start with something with the intent of becoming dependent. In the process of becoming dependent to a substance, our brain loses the power and ability to make proper choices. The process of developing SUDs is by far more complex than just making conscious choices of becoming dependent or not, of continuing to use drugs, versus to stop using drugs.

Training instructions: The trainer can ask questions to the audience like: Who has experience with treatment? Have you ever had a patient that expected to be dependent when he or she started using?

Source:

Blum, K., & Payne, J. E. (1991). Alcohol and the addictive brain: New hope for alcoholics from biogenetic research. United Nation Office on Drugs and Crime (2016). Guidelines on Drug Prevention and Treatment for Girls and Women. Available at http://www.unodc.org/documents/drug-prevention-and-treatment/unodc_2016_drug_prevention_and_treatment_for_girls_and_women_E.pdf page 27

O'Brien, C. (2011). Addiction and dependence in DSM-V. *Addiction*, 106:866-867.

Source: Shahram, H. (2019). Pathways to Addiction: Stages of addiction. <https://www.psychologytoday.com/us/blog/science-choice/201910/pathways-addiction>



Say

Trainer 1: Typically, teenagers start experimenting with substances. We should do everything we can to prevent drug consumption and not encourage this kind of experimentation. Once in contact with substances, some teenagers might like the experience and repeat it overtime, passing from experimentation to active seeking. Most experimenting teenagers will stop without any interventions and will never develop a problem. There are a variety of reasons for that: genetic, biological, environmental. Those that continue using are likely to develop a problematic consumption and face serious problems later on. Some of them will get preoccupied by drugs to such an extent that they will cease other previously enjoyable activities such as playing sports and playing or listening to music. They will begin abandoning all activities that they used to enjoy and will forget that there are other activities that can be enjoyable experiences. Substance use will become their single source of positive reinforcement and source of rewards. We will see why and how this happens. They will develop dependence. And in this case, dependency is a set of biological changes in the brain as a result of exposure to drugs, and the behavioral changes will be clear and people will get into all sort of problematic behaviors. They will get stuck and likely develop serious problems.

Source: Shahram, H. (2019). Pathways to Addiction: Stages of addiction. <https://www.psychologytoday.com/us/blog/science-choice/201910/pathways-addiction>



Vulnerability to SUDs

Genetic vulnerabilities due to family history of SUDs

Age at first use

Social conditions (e.g., poverty, physical illness, stress, history of trauma, helplessness)

Negative peer influences

Mental disorders (particularly if untreated)

Type of drug use

Systemic discrimination on the basis of race, gender and minority status, e.g.



OAS CICAD



2.13

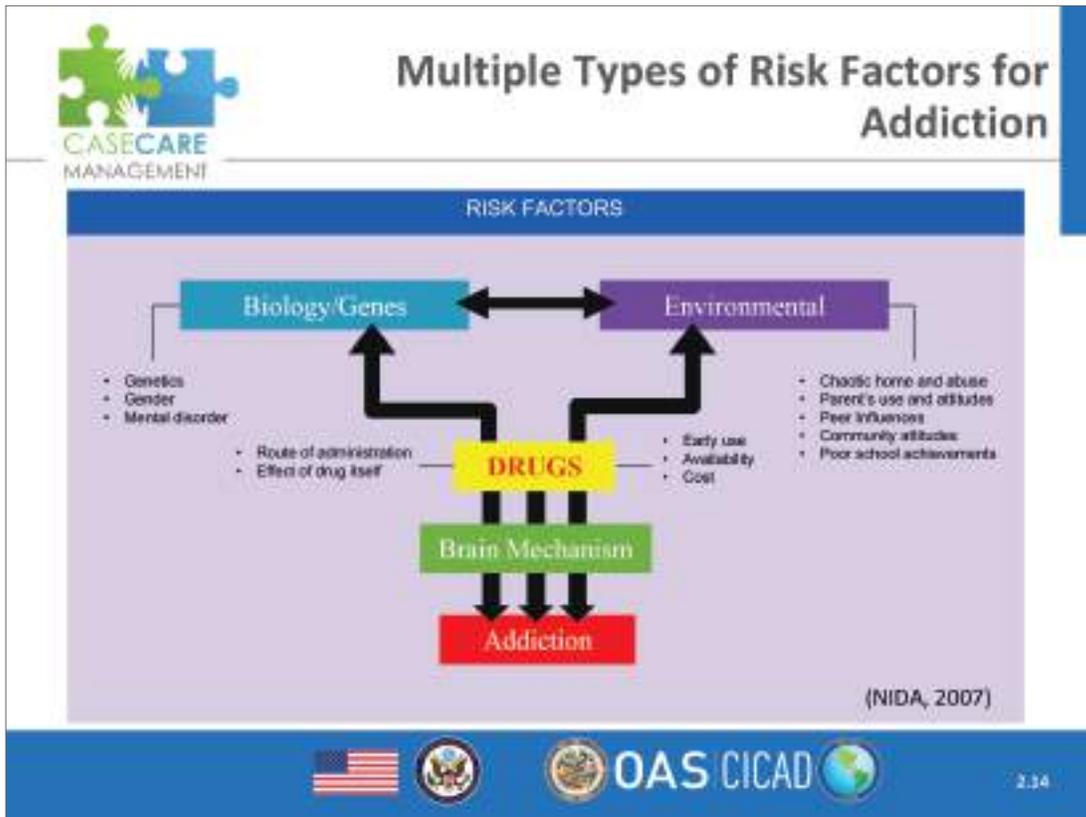
Say

Trainer 1: Why are some people are more vulnerable than others? If drugs were the cause of the problem, then everybody using the substance would become dependent. Many people like a glass of wine at dinner, but it does not mean they will get dependent. Many teenagers experiment with substances and the majority of them will not develop any sort of dependence. The question is why. How are people that develop a problem different from those that do not develop the problem? To answer this question, we need to emphasize that there are a number of risk factors, which can often appear in combination. There is no single factor that increases or decreases the risk. We can have a bad combination of factors, or there is a critical mass of the risk factors. Perhaps half of the explanation is genetic vulnerability. People with SUDs are genetically different from people who have the experience of using without ever developing a problem. We also know that the age of first use has a significant impact on the likelihood that this individual, in the presence of other factors including genetics, will develop problems. There is also an environmental, non-biological factor, like poverty. Also, physical, emotional, social, sexual abuse or a combination of them, significant stress or traumatic experiences especially in early childhood. These are factors that, if combined with other factors, will increase the likelihood to develop SUDs. In environments where consumption is the social norm, people will be subjected to negative peer influence and pressure, because the only way to belong to the group is to continue using.

Some of the mental health or psychological conditions might increase the chances for SUDs particularly if the mental health disorder was not attended nor treated.

In addition, we also know that, because psychoactive substances are classified in thousand categories, some of them contribute to the development of SUDs more quickly. The type of substance used, while not the key factor, has some importance in the development of SUDs.

Additional information on protective and resilient risk factor are available at the NIDA website: <https://nida.nih.gov/publications/preventing-drug-use-among-children-adolescents/chapter-1-risk-factors-protective-factors/what-are-risk-factors>



Say

Trainer 1: When people develop SUDs, very commonly they are accused of a lack of will-power, irresponsibility, a lack of religious devotion, or being “crazy.” New scientific evidence confirms that this is something far more complex. It is a combination of three major areas of risk: 1. Biological factors, particularly genetics 2. Environmental factors. 3. Individual psychological factors.

When we have the combination of these three factors, we have the situation where we see a significant increase in the risk of this individual to start developing problems, as well as the way that the drugs react with the brain.



Genetics

- Genetic vulnerability explains approximately 50% of substance use disorders
- Substance use disorders are NOT genetically determined, but ARE genetically influenced
- Comparable to diabetes, hypertension, asthma, and many other diseases
- Family history increases the risk of substance use disorders
- There is no single “alcoholic” or “drug” gene



OAS CICAD



2.15

Say

Trainer 1: We should not think that there is a single gene for alcoholism, or single gene of cannabis or amphetamine dependence. There is a number of genetic combinations. None of them is specifically responsible for drug disorders, but a combination of them may make people genetically more vulnerable to SUDs.

In biological and behavioral medicine, there are two types of genetic conditions. The first is a genetically determined condition—if I am unlucky enough to get a combination of pathological genes from both my parents, I am more likely to develop a certain disease. This has nothing to do with my lifestyle, education, nutrition, or exercise environment, it is simply my genetic vulnerability that led me to developing this problem. Examples of this are cystic fibrosis (a lung disease), Huntington disease, or a neurological condition.

SUDs are NOT genetically determined. However, there is a second group of genetic conditions that we call “genetically influenced” conditions. If someone has a family history of the problem,

because of the genetic vulnerability, this person will be more at risk to develop the same problem. Examples of this are diabetes and hypertension, or some forms of cancer, especially breast cancer, which is highly influenced by genetics.

Having an increasing risk of developing the problem does not necessary mean that the problem will develop.

Paying attention to these vulnerabilities and behaving differently will help you to decrease the likelihood of developing the problem, even though the genetic factors stay the same. Take a person that has a severe family history of alcohol dependence. Should that person decide not to drink, he will never develop alcoholism. This will not however protect you from developing other problems related to other substance use.

People with genetic vulnerability could be helped through treatment. They could change not the vulnerability in itself, but their behavior, by being able to stay in treatment and recovery.



Psychological Vulnerabilities

Temperament

Excessive risk taking

Impulsivity (greatly influenced by genetics)

Tension and stress (low stress tolerance)

Learning disabilities

Attention problems (with or without hyperactivity)

Mood disorders and other mental diagnoses



OAS/CICAD



2-16

Say

Trainer 1: There are a number of psychological factors that can increase risk:

- ☐ Temperament.
- ☐ Excessive risk taking (the key is excessive: risk taking is normal for every teenager).
- ☐ Very highly impulsivity (which is actually significantly influenced by the genetics)
- ☐ Low stress tolerance (can be a significant factor for all sort of problems, including substance use).
- ☐ Attention problems, with or without hyperactivities.
- ☐ Mood disorders and other mental diagnoses.

These are psychological factors likely to make people more vulnerable. None of these specifically causes SUDs by itself, but can do so when combined with genetics and the third type of factor: social-environmental factors.



Social-Environmental Factors

- Community disorganization
- Peer pressure and social learning
- Dysfunctional socialization
- Academic failure
- Drug taking is socially acceptable
- Availability of drugs
- Poverty
- Trauma




2.17

Say

Trainer 1: These factors are not biological.

- ❑ Community disorganization: In a disorganized environment, people are trying to survive using multiple coping mechanisms, including drug use.
- ❑ Peer pressure and social learning: Drug use may be more likely where people are under stress, or have problematic social learning.
- ❑ Dysfunctional socialization: People that have difficulties socializing in a functional way may be more prone to drug use.
- ❑ Academic failure is a significant risk factor for SUDs. For many years, we used to believe that when children started having difficulties and their grades went down it was because they started using drugs. What we have learned over the last couple of decades is that it is, in fact, the opposite. Experiencing academic difficulty is one of the most typical reasons for the onset of substance use. From a practical perspective, if your children or your friends' children are having some difficulties in school, do not overreact. Academic problems are one of the reasons for kids to start using substances. Please do not overreact.
- ❑ Another environmental reason is the availability and acceptability of drugs. The more available a substance is, the more people will use it. If we make substances less available through taxation,

border/customs controls, or other forms of supply reduction, they will be less accessible and less available and fewer people will use them.

- ❑ Extreme poverty is another typical risk factor for substance use initiation. Once someone has a substance use disorder, it can be extremely difficult to achieve financial success or maintain a stable economic status. Three main factors can explain this relationship between addiction and poverty: Individuals with SUD use some portion of their earnings on drugs. While the cost of substances differs, when added over time, even the smallest expense can affect a person's financial well-being, especially as tolerance levels increase. SUD can cause the individuals to miss work, perform poorly and fail drug tests. These all threaten job security and employment status. Substance use increases the risk of costly medical emergencies and long-term conditions. Depending on the extremity of the problem, some medical visits can leave a person in financial debt, threatening economic stability.

Source: Ramsey, H. (n.d.). Drug Addiction and its Relationship with Poverty. <https://borgenproject.org/drugaddiction/>

- ❑ Being victim and or having experienced trauma is another factor that increase vulnerability to SUD. Additional resources on trauma informed care are available at the SAMHSA website: <https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>



Familial Factors

- Parents and sibling use drugs
- Poor and inconsistent family practices
- Family conflicts
- Abuse/violence
- Generational criminal justice system involvement




7.18



Trainer 1: There are also familiar factors:

- ☐ Substance use among parents and siblings.
- ☐ Different family practices and attachment problems during childhood affect our development as humans. In disorganized families, or families with inconsistent practices, children are more stressed. Some extreme situations include abusive relationships, or dysfunctional attachment. In these cases, children may start using substances and are more likely to develop future problems.
- ☐ Violence also plays a role. Please note: it is not just being subjected to violence that might increase the risk of developing SUDs. Even witnessing violence will increase the chances of developing developmental problems. Additionally, pay attention to what kind of computer games kids are playing. There can be quite a lot of violence in games, with shooting, explosions, and blood. Even witnessing this type of simulated violence can increase risk.

Research on intergenerational drug use, current user, parents, and grandparents suggests that there are predictable factors such as genetics and parenting styles with diverse degrees of discipline that influence vulnerability to substances in offspring.

Source: Pears, K., Capaldi, D., Owen L. (2007). Substance use risk across three generations: the roles of parent discipline practices and inhibitory control. *Psychol Addict Behav.* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1988842/>

Findings suggest that older sibling substance use has a direct effect on younger sibling use, but relationship dynamics and reinforcement played a significant role as well. Specifically, collusion and conflict in the sibling relationship both had indirect effects through younger siblings' deviant peer affiliation. Findings validate the powerful socializing role of both siblings and peers, and elucidate the complex mechanisms through which socialization occurs.

The influence of sibling drug when it comes to adolescent users could be found here:

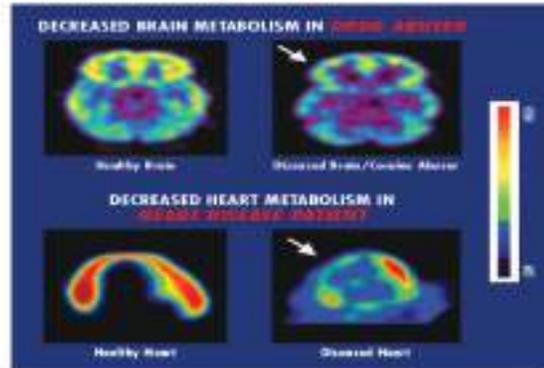
Source: Low, S., Shortt, J. W., & Snyder, J. (2012). Sibling influences on adolescent substance use: the role of modeling, collusion, and conflict. *Development and psychopathology*, 24(1), 287–300. <https://doi.org/10.1017/S0954579411000836>

Source: National Institute of Child Health and Human Development (2002) Children Exposed to Violence: Current Status, Gaps, and Research Priorities. NICHD Workshop on Children Exposed to Violence, July 24-26, 2002. Available at https://www.nichd.nih.gov/sites/default/files/publications/pubs/documents/children_violence.pdf

Addiction changes the brain

- Causes strong urges
- Hard to think clearly
- Hard to resist urges
- Relief only under the influence of drugs

Addiction IS a brain disease.



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2.19

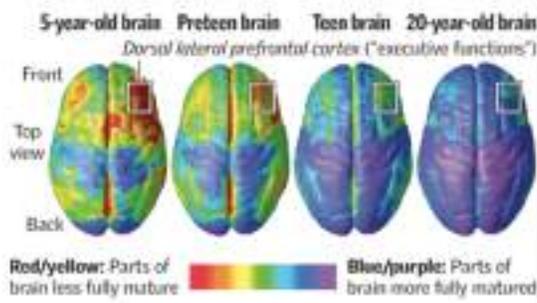
Say

Trainer 1: We said that addiction and SUDs are fundamentally brain diseases. Let's elaborate a bit more on what we mean.

Let's discuss the teen brain since the typical age of onset worldwide is between the ages of 12 to 16.



Drugs and the Teen Brain



Teenagers are particularly at risk of developing addiction because:

- The brain's frontal cortex is not fully developed
- Teens rely more on the limbic system to make decisions

(NIDA, 2020)



2.20

Say

Trainer 1: Another important component to look at is the typical projection of SUDs: the typical age of onset worldwide is between the ages of 12 to 16. This is the time when people start experimenting with drugs. We are talking about a disorder with a pediatric onset. During this time, an adolescent's brain is not fully functional yet. The decision-making behind the experimentation is significantly impaired because the brain is not fully functional until the age of 24-25.

Because the brain's prefrontal cortex (the part in charge of critical thinking) is not yet fully developed in teens, they rely more on the limbic system (which is tied to rewards and emotions) to make decisions.

The key brain part that is still developing is the prefrontal cortex. It's the area you use in critical thinking, such as when you weigh pros and cons before making a decision.

Because the prefrontal cortex is not yet fully developed, teens automatically rely more on the limbic system to make decisions. This system's network of brain structures is linked to emotions and experiencing rewards rather than critical thinking.

Because their prefrontal cortex is in development, teens are more likely to make decisions based on what provides instant gratification, such as a feeling of happiness.

Fundamentally, substance use disorders are a disorder with a pediatric on-set and they continue later in life.

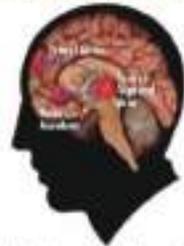
Source: Scholastic NIDA. (2020). Drugs and the Teen Brain, Teacher's guide. Available at <http://headsup.scholastic.com/teachers/drugsandtheteenbrain>



How Do Drugs Work in the Brain?

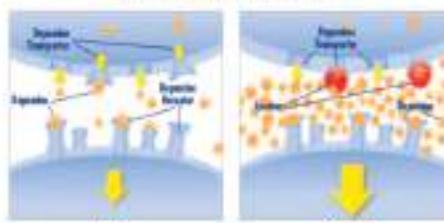
ALL DRUGS OF ABUSE TARGET THE BRAIN'S PLEASURE CENTER

Brain reward (dopamine) pathways



These brain circuits are important for natural rewards such as food, music, and art.

All drugs of abuse increase dopamine



Typically, dopamine increases in response to natural rewards such as food. When cocaine is taken, dopamine increases are exaggerated, and communication is altered.

(Adapted from Volkow, 2018)

All psychoactive substances affect the brain's reward system by flooding the circuits with dopamine.



OAS CICAD



2.11



Interactive Exercise: The Hand-Brain example

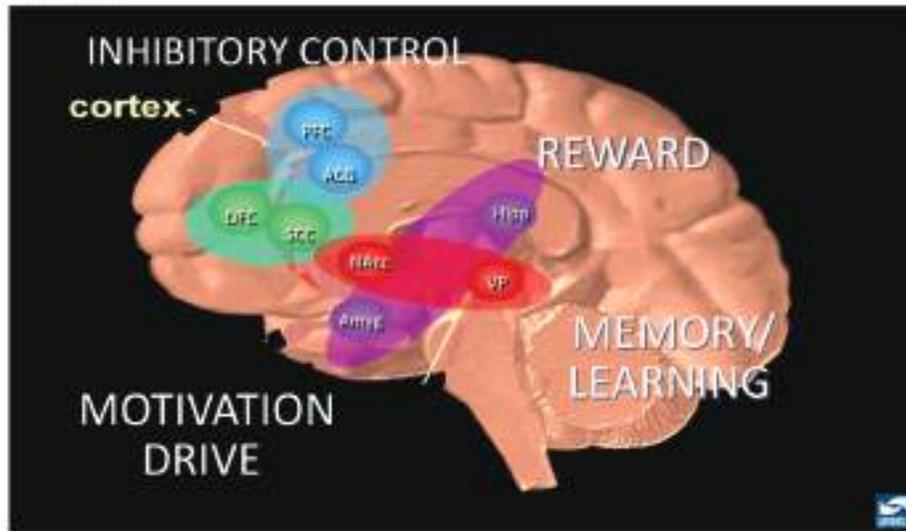
Let's do an exercise. Please raise your hand. Place it at the level of your eyes. Now tuck your thumb in and close your fingers around it. Imagine that this is your brain. The outside part of your hand is the back side of the brain. Your fingers are the brain cortex, your nose is there. This is the thinking part. If you open the cortex, opening up your fingers, right in the middle where your thumb is there is a part of the brain, the scientific name is the limbic system. The limbic system is our emotional brain. It is the part of the brain that is responsible for our ability to experience reward, pleasure, regulate our sleep, and control our impulsivity. This is the part of the brain that is primarily affected when we talk about emotions. It regulates our mood. Why is this important? All of the psychoactive substances, belonging to different chemicals and physical classes still have something in common: they are all able to penetrate the brain directly to affect this emotional limbic part of the brain, changing the way it functions.

Say

Trainer 1: All psychoactive substances affect directly the limbic system by changing the amount of certain chemicals in our brain between the neurons. These are different chemicals, their common characteristic is that they are capable of transforming a signal from one cell to another, and because of that property, we call them neurotransmitters. All together there are 100, 120 neurotransmitters, but there are four or five that are extremely important for our understanding of the development of SUDs, and the most important chemical neurotransmitter in our brain is dopamine.

Source:

Volkow, N. (2018, July). Drugs, Brains, and Behavior: The Science of Addiction. Available at <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preface>



Say

Trainer 1: Dopamine is responsible for our ability to write, and our fine motor moves. I am sure you have heard about people with Parkinson’s disease. The reason for their tremors is due to a dopamine problem.

The dopamine function in the brain explains the reason for us to experience pleasure from things that we like, for example food, shelter, water, sex, going to the movies, reading books, interacting with others. We experience pleasure because of the normal functioning of the dopamine system.

If the system does not function well, it will be very difficult for you to experience psychological rewards from your activities. It would even be difficult for you to store your memories. Pleasurable experiences are stored in your memory more easily.

Dopamine is very important in our ability to do many things, primarily in our emotional regulation, impulsivity regulation, and the ability to experience pleasure and reward from activities.

Psychoactive substances causes changes to the brains of people starting to develop SUDs. The functions will be changed with exposure to substances. The brain will forget all other pleasurable activities because of the malfunction in the brain psychology. The ONLY source of pleasure and reward will be the drugs. There is an expression “Highjack the brain”. The drugs highjack the brain by changing the way the brain function.

If you ask, “Is recovery possible?” The answer is yes. Our brain is likely to recover and to restore the functions. In some cases, back to normal levels. It would take time, and this is why there are some residual symptoms in people with SUDs even if they already stopped using and are in recovery. Some of the symptoms will continue for months or years, but people do get better.

Source:
Volkow, N. (2018, July). Drugs, Brains, and Behavior: The Science of Addiction. Retrieved from <https://www.drug-abuse.gov/publications/drugs-brains-behavior-science-addiction/preface>.



Addiction is a Relapsing Disorder

Substance use disorders are considered relapsing by nature.

40-60% of people
relapse in the first year
after detoxification.

(The Treatment Center, 2018)



OAS CICAD



2.23

Say

Trainer 1: As we have said already, an SUD is a chronic condition and causes relapses in the majority of those who suffer from it. People tend to get better, and then get worse, and then get better again. There is a fluctuation in their condition. Approximately 50% of patients with SUDs relapse during the first year of treatment. This number is consistent with the number of patients with diabetes or hypertension that suffer recurrences of those conditions within in the first year of treatment. It takes time for us to adjust our behavior, our lifestyle, our habits, or even our thinking. It takes time for people to get into recovery; it is unlikely to happen overnight. It is a process, but it is possible. People do get better.

Training instructions: Module 2 is very dense in terms of information and requires participants' attention. Trainers might assess the level of engagement of the participants and decide to take a short break at this point, if needed.

Source: (The Treatment Center, 2018)

LINKAGES BETWEEN SUDS AND CRIME



OAS/CICAD



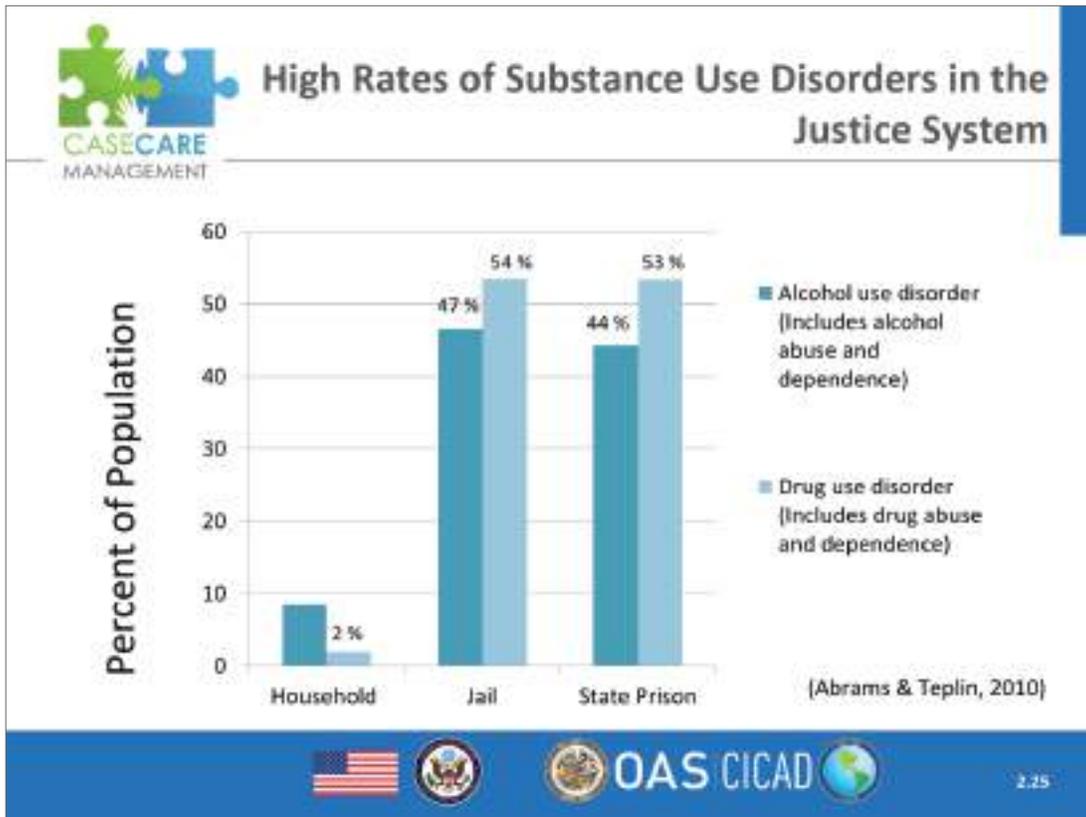
2.24

Training instructions:

It is suggested that Trainer 2 teach this part of the module.

Say

Trainer 2: Let's review the connections between SUDs and crime to identify the different types of interactions.



Say

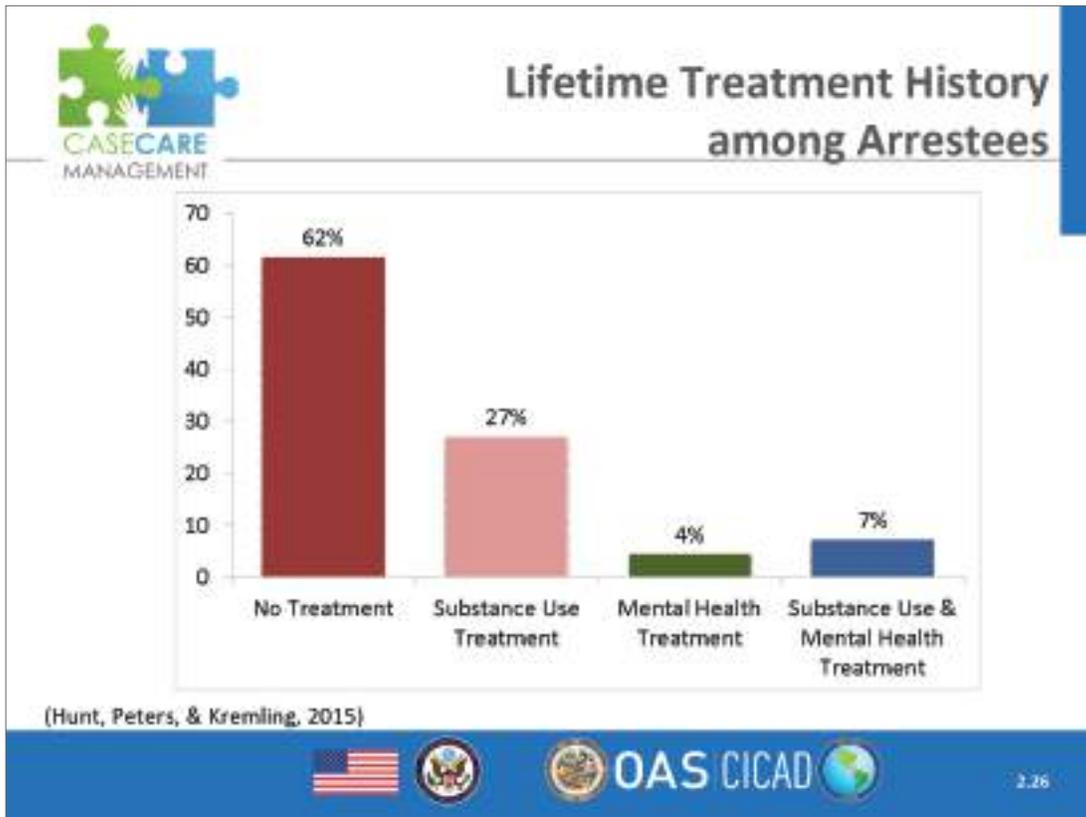
Trainer 2: To begin, let's look at the rates of SUDs in the criminal justice system. You will see in the chart the rates of SUDs in U.S. jails and prisons in comparison to the general population. If you look both at the middle bars and the bars to the far right, you will see that half of the people in prison or jail have an alcohol or drug use disorder. Many have a "polysubstance" use problem involving both alcohol and other drugs. In comparison to the general population on the left side bar, we have rates of SUDs in the justice system that are up to 25 times higher than the general population. We also know that there is a significant gap in treatment in correctional settings for people who have these disorders, and at least in some part of the world less than 10% of the population in detention centers or prison actually receives the treatment and services that they need (UNODC, 2019).

A history of drug use is common among European prisoners, with levels disproportionately high compared to the general population.

- Health problems, especially communicable diseases and psychiatric co-morbidity, are especially prevalent among prisoners using drugs.
- The mortality risk in the first weeks after release from prison is extremely high.
- Relevant differences are reported between European countries in drug use and drug-related problems among prisoners.
- In European countries, valid and comparable data on drug use and related consequences among prisoners are still scarce and harmonization work is needed (Giraudon, Montanari, Pasinetti, Royuela, Vicente, Wiessing, n.d.)

Source: Giraudon, I., Montanari, L., Pasinetti, M., Royuela, L., Vicente, J., Wiessing, L. (n.d.). Drug use and related consequences among prison populations in European countries. https://www.euro.who.int/__data/assets/pdf_file/0019/249202/Prisons-and-Health,-13-Drug-use-and-related-consequences-among-prison.pdf.

Source: Teplin, L. A., Abram, K. M., McClelland, G. M., Mericle, A. A., Dulcan, M. K., & Washburn, J. J. (2010). Psychiatric disorders of youth in detention. In *Perspectives on Juvenile Offenders* (pp. 157-192). Nova Science Publishers, Inc.



Trainer 2: If we look at this graph, you will see that individuals in the justice system generally have not received treatment for either mental disorders or SUDs. Over 60% have not received any type of treatment in the past. We are dealing with a population that is new to treatment and we need to orient them and provide reassurances that treatment can be an effective part of the solution to their problems related to SUDs. You can see in the chart that just over a quarter of individuals in the justice system have received some form of treatment for SUDs in the past, and far fewer have received mental health treatment or treatment for both mental disorders and SUDs.

Kaiser Family Foundation (KFF) in the U.S. gathered information from *Individuals Reporting Needing but Not Receiving Treatment for Illicit Drug Use in the Past Year* in 2019.

Information is depicted based on: Data View/ Distributions/ Locations.

- Individuals were classified as needing illicit drug treatment if they met the criteria for an illicit drug

use disorder as defined in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or received treatment for illicit drug use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center). Needing But Not Receiving Illicit Drug Treatment refers to respondents who are classified as needing illicit drug treatment, but who did not receive illicit drug treatment at a specialty facility (KFF, 2019).

Mental Health Conditions and Substance Use: Comparing U.S. Needs and Treatment Capacity with Those in Other High-Income Countries. “This data brief examines the mental health burden in the United States compared with 10 other high-income countries that participate in the Commonwealth Fund’s annual international health policy survey. They also look at the relationship between mental health burden and social determinants of health, differences in seeking care, access and affordability of care, mental health and substance use disorder outcomes, and health system capacity” (Aboulafia, 2020).

Sources: Aboulafia, G. (2020). Mental Health Conditions and Substance Use: Comparing U.S. Needs and Treatment Capacity with Those in Other High-Income Countries. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2020/may/mental-health-conditions-substance-use-comparing-us-other-countries>.

KFF. (2019). Individuals Reporting Needing but Not Receiving Treatment for Illicit Drug Use. <https://www.kff.org/other/state-indicator/individuals-reporting-needing-but-not-receiving-treatment-for-illicit-drug-use-in-the-past-year/>.

Hunt, E., Peters, R.H., & Kremling, J. (2015). Behavioral health treatment history among persons in the justice system: Findings from the Arrestee Drug Abuse Monitoring II Program, *Psychiatric Rehabilitation Journal*, 38(1):7-15.



Targeting Drug Treatment in the Justice System

Most persons in the justice system have used drugs and alcohol

Not all of these persons need intensive drug treatment

Important to prioritize who should receive scarce treatment resources

The Risk-Need-Responsivity (RNR) model helps prioritize treatment



OAS



2.27

Say

Trainer 2: Most people in the justice system have used drugs and alcohol; however, we know that not all of these individuals need intensive treatment. It would be a mistake to provide treatment to people who do not need it. One of our challenges is how to allocate our scarce drug treatment resources to individuals who most need to be placed in treatment to address their criminal behaviors and other related problems.

One of the models that helps us give scarce treatment resources to people who need it most is called the Risk-Need-Responsivity Model.



Risk-Needs-Responsivity (RNR) Model

RISK - Focus resources for drug treatment on moderate to high risk offenders (risk for arrest)

NEEDS - Provide services that address risk factors (needs) for arrest (including drug treatment)

RESPONSIVITY - Provide services in key areas to enhance engagement in drug treatment



OAS CICAD



2.28

Say

Trainer 2: We want to use our most intensive treatment resources for people who demonstrate a moderate to high risk of recidivism/re-arrest. This is because we can generate the biggest reductions in recidivism/re-arrest if we allocate these resources to a higher-risk population. When we provide treatment for this higher-risk population, we want to address different factors that independently predict the risk for future arrest. We'll look at this set of risk factors in a minute. If we focus on reducing the impact of these criminal risk factors, we stand a much better chance of reducing future arrests. We also stand a better chance of reducing the "revolving door" phenomenon where people enter and leave the criminal justice system repeatedly, particularly among those with SUDs. Finally, we want to provide treatment services in a way that helps people engage in drug treatment and overcome certain barriers. We will look at each component of this model as we move forward.



Prioritizing Treatment Based on Level of Criminal Risk

Improved outcomes if treatment focuses on moderate to high risk offenders (risk for arrest)

Achieve **greatest reductions in criminal behavior** if persons with higher criminal risk are treated

- Maximizes cost savings
- Low risk individuals often don't need intensive treatment



OAS CICAD



2.29

Say

Trainer 2: Our first goal is to prioritize treatment for people at a higher risk for recidivism. This is because individuals with lower risk of recidivism often do not need intensive treatment. They can be placed in drug education, community supervision, court monitoring, or other types of programs. If you provide intensive treatment to a low-risk population, you can actually produce a counterproductive result and elevate the risk of recidivism.

In summary, we can have the greatest reductions in criminal recidivism if we focus our treatment programs on those with a moderate to high risk for recidivism. This also maximizes the economic impact of treatment, as we can keep more people out of jails and prisons in our countries.



Prioritizing Treatment Based on Substance Use Severity

The **severity** of substance use problems should determine the intensity of treatment

Offenders with low severity substance use problems **may not require intensive treatment**

Mixing persons with high and low levels of substance use treatment needs is **contraindicated**

Treatment **competes with other prosocial activities** for low needs offenders



OAS



2.30

Say

Trainer 2: We also want to prioritize treatment for individuals who have a higher severity of SUDs. The higher the severity of SUDs, the greater the intensity and duration of treatment that is needed.

As with low-risk individuals, persons with less-severe SUDs may not require drug treatment at all—or could be placed in less intensive treatment programs, community supervision programs, drug education programs, or other less intensive services.

Finally, we know that it may be counterproductive to mix high-risk and low-risk populations in the same program, or mix individuals with severe SUDs with less-severe cases. We also want to use different programmatic approaches for persons with SUDs of varying severity.

A final point is that for people with less-severe SUDs, intensive drug treatment actually competes with other important activities that can prevent involvement in future criminal behavior, such as church, time with family, and work.

Training instructions: Trainers might want to take this opportunity to discuss prison overcrowding if it is relevant for the country.

Overcrowding remains a challenge in many countries, as it overlooks the severity and separation of substance use disorders amongst inmates within the prison population. In order to ease this recurring issue, countries must focus on justice-involved individuals' classification and accommodation based on the severity of their SUDs.



Trainer 2: When we look at this chart, we can picture the different range of options for both conditions. There are two axes here, one that shows the range of severity of SUDs (from less to more severe), and the other that shows the range of risk of recidivism (from low to high). We want to reserve our scarce treatment resources for those in quadrant IV, the upper right corner, who have both severe SUDs and high risk of criminal recidivism, a population for whom we need to provide both intensive drug treatment and intensive monitoring and supervision. In the lower left quadrant, we can see that people with less-severe SUDs and low risk of recidivism do not need intensive treatment services, or intensive community supervision or monitoring. We then have quadrants II and III. In quadrant II, individuals would need intensive treatment, but less intensive community supervision. In quadrant III, individuals would require more intensive monitoring, but present less intensive treatment needs. Examples of intensive treatment are the residential or inpatient treatment, while outpatient treatment could be considered a less intensive treatment option. The intensity of monitoring could be assessed based on the frequency of the sessions and duration.



Top Criminal Risk Factors for Arrest

1. Criminal history
2. Criminal attitudes and beliefs
3. Antisocial peers
4. Antisocial personality pattern
5. Substance abuse
6. Family and/or marital problems
7. Lack of education
8. Poor employment history
9. Lack of prosocial leisure activities
10. Homelessness



OAS CICAD



2.32

Say

Trainer 2: We want to focus our treatment programs in the justice system on a range of factors that independently contribute to recidivism. When we focus on multiple risk factors in drug treatment, we can have a cumulative effect in reducing criminal recidivism.

Here are the major risk factors for arrest, ranked in order of their importance.

For criminal history, we can't do much to change this factor, but it's still important to consider when determining the risk level of an individual. The remaining items listed here, items 2-9 are risk factors that we call "dynamic," or those that can be changed through interventions in our treatment programs.

These factors include criminal thinking, attitudes, beliefs, criminal peers, and substance abuse among others. To maximize effectiveness of drug treatment in reducing risk of recidivism, it's important to provide specific interventions to address each of these risk factors. Treatment programs that address more of these risk factors have a significantly greater effect in reducing recidivism and avoiding costly incarceration.



Treating Areas of Elevated Risk

Risk Factor

- Antisocial attitudes
- Antisocial peers
- Antisocial personality
- Substance abuse
- Family/marital problems
- Poor education and employment
- Leisure activities

(Andrews & Bonta, 2010)

Treatment Focus

- Criminal thinking groups
- Change peer affiliations
- Anger management
- Intensive drug treatment
- Build positive family and relationship supports
- Educational and vocational training and job placement
- Prosocial leisure activities



OAS CICAD



2.33

Say

Trainer 2: The good news is that treatment interventions exist that may address each of these risk factors. This slide provides an example of several of the treatment interventions that can be provided to address each of these areas.

For example, criminal thinking and attitudes can be addressed through cognitive behavioral interventions.

Through our treatment programs, we can also provide responses to each of the other areas.

If we are not addressing these factors, we are placing individuals at a much higher risk of recidivism after they leave the treatment program. We can't always address each of these risk factors due to limitations in resources, but we need to address as many as possible. For example, in addition to drug treatment, we can provide access to educational and vocational programs.



Trainer 2: Let’s look at how we can match people in the justice system to different types of services, taking into consideration the level of treatment needs and the risk to public safety. The most effective treatment outcomes for persons with substance use disorders are in community settings. However, this isn’t possible for people who are violent or who otherwise pose a threat to public safety. You can see in the graph that we start with the low-cost interventions on the left-hand side and move to the higher cost interventions on the right-hand side. In the middle area we have the most effective interventions for people with high needs for treatment and high risk for recidivism. There are a range of programs in the community to address this population, including drug courts, day treatment centers, and other intensive treatment programs.

The goal is to provide a range of options to address the different levels of risks and needs among our offender population. This is just a sketch of what our options should include in the justice system, to accommodate persons with differing levels of drug treatment needs and criminal risk.

At this point, we are going to transition to a review evidence-based treatment options and outcomes for individuals in the criminal justice system.

Source: Andrews, D. A., & Bonta, J. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law*, 16(1), 39-55. doi:10.1037/a0018362 .

EVIDENCE-BASED TREATMENT OPTIONS AND OUTCOMES



OAS|CICAD



2.35

Say

Trainer 1: After having presented the foundational knowledge on addiction, we are now going to explore what can be done about it. One of the basic and critical approaches is to provide people with good quality and consistent treatment.



Treatment of Substance Use Disorders

A system of professionally directed services with the primary goal of changing an individual's problematic relationship with psychoactive substances.

(U.S. Substance Abuse and Mental Health Services Administration SAMHSA, 2014)



OAS CICAD



2.36

Say

Trainer 1: Let's define what treatment is. It might also make sense to describe what treatment is not. You are looking at the definition by SAMSA: *treatment of substance use disorder is a system of professionally directed services with the primary goal of changing an individual's problematic relationship with psychoactive substances.* Please pay attention; we are not talking curing addiction here. Similar to diabetes, we do not have a "cure," so to speak. But we do have a lot of effective treatments for it, just like we have effective treatments for diabetes or even hypertension. In the definition of treatment, the key issue is to change the problematic relationship with psychoactive substances, meaning to improve the conditions—and not necessarily "cure" the issue.

There are multiple activities that we consider to be "treatment" (or not).

Source: (SAMHSA, 2014)



Essential Aspects of Treatment

Activities of any treatment provider should include:

- ✓ Reducing symptoms
- ✓ Preventing complications
- ✓ Improved functioning
- ✓ Respect of human rights



OAS



2.17

Say

Trainer 1: There are many ways to define a treatment activity (cognitive behavioral therapy, individual counselling, outpatient, residential), but no matter its name, the activities should satisfy all four criteria on the screen:

Reduce the symptoms: In our case, this means reducing the compulsive drug use. We are not talking about eliminating the symptoms, but rather reducing the pressure and the intensity of the stimulus.

Prevent complications: “Complications” refers to all sorts of secondary consequences, from physical diseases like hepatitis and HIV, to social complications like criminal behavior, homelessness, unemployment, and many other things.

Improve functioning at many levels.
Respect human rights.

I am not going to name all the different types of treatment, but as long as an activity can satisfy all four criteria, I would consider it treatment.



Why is Comprehensive Treatment Needed?

Individuals with SUDs experience problems in many areas (e.g., mental health, employment, health, social) that make their disorder difficult to treat.

Treatment and recovery are not the same

For most people, treatment is a long-term process that involves multiple interventions and attempts at recovery.



OAS CICAD



2.38

Say

Trainer 1: Drug addiction itself is actually not the only problem that people suffering from SUDs have. They experience multiple other issues, which could either be a result of the drug abuse or are co-occurring/independent of the SUD and are exacerbated because of the substance use. Therefore, treatment should not be focused on just the SUD. Truly effective treatment should address multiple issues: mental health, employment, emotional leadership, financial leadership, family interaction, social support, health, and housing, among other aspects.

For this reason, it is important to mention that even the most brilliant therapist cannot do it all alone. People trained in different disciplines and from different cultures and environments are needed in effective treatment.

Treatment and recovery are not the same.

Treatment is an event that begins and ends. Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

(SAMSA, 2012).

Source: SAMHSA (2012) Working definition of recovery. <http://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf>.



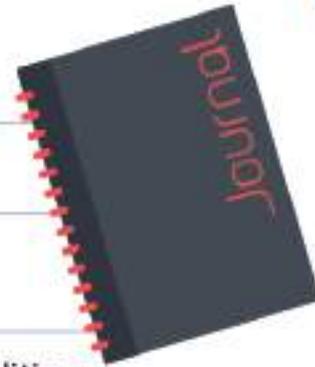
What Do We Know From Science?

There is no universal treatment

There is no ultimate cure, but...

Effective treatment is possible

SUDs are preventable and treatable conditions



OAS CICAD



7.19

Say

Trainer 1: People might ask if one type of treatment is better than another. There is no universal treatment for everybody or a universally effective treatment. There are multiple treatment options, and the choice should be based on the needs and risks that we have already addressed.

When asking whether treatment A is better than treatment B, you need to answer two additional questions:

Ask

Compared to what?
and
For whom?

Generally speaking, there is no evidence that one treatment is better than another.

We also know at this point that we do not have an ultimate “cure” for SUDs, so people with SUDs will always be at a greater risk of drug or alcohol relapse than others who do not. Yet, very effective treatment does exist--people do get better, get into recovery and function really well for the rest of their life. SUDs are a treatable and preventable condition similar to many chronic and relapsing conditions around the world.



What Doesn't Work in Treatment?

- Drug education alone
- Fear-based prevention programs
- Films
- Supervision alone, without treatment
- Self-help alone (e.g. AA), without treatment
- Focus on self-esteem, values clarification, and discipline (e.g., boot camps)
- Mixing participants with different risks/needs profiles
- Intensive treatment for low-risk low-need participants
- Unstructured or ad-hoc treatment
- Large treatment groups (e.g., > 15 persons)



Say

Trainer 1: In the area of SUD treatment, particularly in the criminal justice context, in the last 50-60 years we have tried almost everything you can think of. Unfortunately, many of our attempts have failed. They did not produce a positive outcome. Before talking about what works or might work, I believe it is important to underline what does not work:

- Drug education alone, meaning giving people information on how bad it is to consume drugs. This intervention has been around for a long time and it has been ineffective. And this is quite understandable, because the information alone does not change human behavior.
- Fear based program: Approaches that rely on instilling fear or shaming or scaring people by sharing horrible pictures of what will happen to them if they continue using have proved ineffective.
- Films: Similarly, showing people videos of, for example, how they will look like five years from now if they continue using, is a waste of time.
- Self-help groups alone, such as Alcoholics Anonymous, Narcotics Anonymous, 12-step programs.: The key word here is “stand-alone.” Considering the population with significant dysfunctions in many areas, including justice involvement, the self-help model, if it is implemented as a stand-alone intervention, does not have enough in-

tensity to address all of their needs. However, if you add self-help to other interventions as a recovery management strategy, then it will significantly improve and increase the chances of effectiveness.

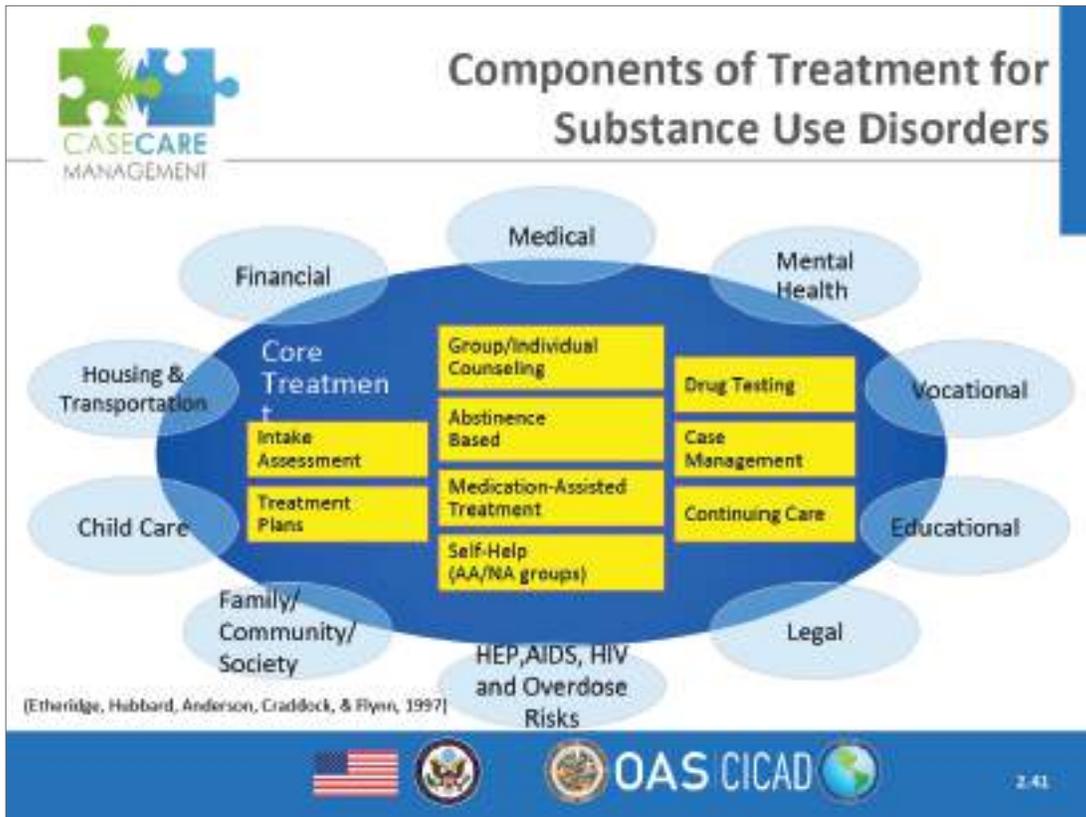
- Programs focusing on self-esteem: These have been around for 20 to 25 years, and are very well-funded. They assume that people commit crimes or use drugs because they have low self-esteem. So, the logic goes, if we increase their self-esteem, they will stop committing crimes and using drugs. The assumption is logical, but the outcome has been zero. Particularly in the justice environment, build self-esteem alone will just make criminals feel good about themselves. That is not what we could consider a positive outcome.
- Treatment interventions that are not manualized: This means that these interventions do not have any logical sequence or steps, or have not yet been found to be effective. For example, group interventions (the typical type of intervention in justice interventions, not individual treatment) that are (A) are too large (say, more than fifteen people), or (B) whose participants are constantly changing, will not work in the context of the criminal justice system or in that of therapeutic communities.



OAS CICAD



2.40



Say

Trainer 1: when we talk about components of treatment, we are talking about what exactly should be in place if we really want to make the treatment work. First, we need to do a very careful intake assessment. The reason for this is that there is no universally effective treatment intervention: people respond differently to different treatment options. We need to assess multiple things—not just the severity of the person’s SUDs, but also their criminogenic needs, criminogenic risks, psychosocial deficiencies and psychosocial dysfunctions. Based on findings of the assessment, we need to develop an individualized treatment plan, together with the participant. This treatment plan is not static, and it will most likely change over time.

In terms of the different types of treatment interventions, there are multiple ways to address both the SUDs and criminogenic thinking/patterns/needs by via either individual or group counselling. Treatment can be abstinence based or involve medication-assisted therapy.

Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders.

Source:
 (SAMHSA, 2015)
<https://store.samhsa.gov/product/Medication-for-the-Treatment-of-Alcohol-Use-Disorder-A-Brief-Guide/SMA15-4907>

Sources:

Klingemann, H. (2020). Successes and failures in treatment of substance abuse: Treatment system perspectives and lessons from the European continent. *Nordic Studies on Alcohol and Drugs*, 37(4), 323–337. <https://doi.org/10.1177/1455072520941977>

Anthony, K. (2021). TEN REASONS WHY YOUR ADDICTION TREATMENT EFFORTS ARE FAILING. <https://www.influencive.com/ten-reasons-why-your-addiction-treatment-efforts-are-failing/>

Some may say that medication-assisted therapy is just substituting one drug with another, but that is misguided. We use medication as a component of treatment, not as a stand-alone intervention. In fact, somebody who is on properly prescribed medication-assisted therapy with no evidence of other substance use might legally be considered abstinent.

The treatment provider plays an important role for the individual in recovery. The professionalism, the understanding of SUDs and the supportive attitude of the treatment provider are an asset for the individual in treatment.

We also use self-help groups, but not as a stand-alone intervention, as noted earlier. Rather, it is a component of the overall treatment continuum that assists people in Maintaining their recovery for as long as possible (e.g.) through emotional support from others, advice and healthy social activities.

We also need to provide drug testing. Again, the reason for drug testing is not to control people, but to monitor their condition. This is similar to what we do with patients with diabetes—we monitor their blood sugar, but not with the intent to catch them eating cookies on the sly. We want to measure the severity of the problem and see there is any improvement. This is exactly the same logic behind drug testing people with SUDs. We want to monitor their recovery.

Considering multiple areas of dysfunction most individuals with SUDs have, we need to have very good quality Case Care Management because we can't do it alone. We need to work with other people in other services. The services must interact with each other. This is the best way to provide people with effective treatment interventions.

As we have already said: SUDs are not acute conditions. Rather, they are chronic. A chronic condition cannot be cured in a 10, 15, or 30-day treatment program; it requires a meaningful continuum of care. This does not mean that the person should stay in treatment forever. It means that when the severity of the SUD is diminishing, when we have control over the symptoms and the compulsive drug use, when we see some improvement in functioning, when we see that the person is more and more adjusted psychosocially and there is less criminal involvement, we would then change the intensity of the services (or change the services completely) based on their needs. But it must be a continuum of care without disruptions.

Source:

Etheridge, R. M., Hubbard, R. L., Anderson, J., Craddock, S. G., & Flynn, P. M. (1997). Treatment structure and program services in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*, 11(4), 244–260.



Who Provides Treatment for Substance Use Disorders?



- Certified Addiction Counsellors
- Social workers
- Physicians/Psychiatrists
- Psychologists
- Nurses
- Case Managers
- Peer driven recovery (trained and supervised)
- Other professionals




OAS CICAD


2.42

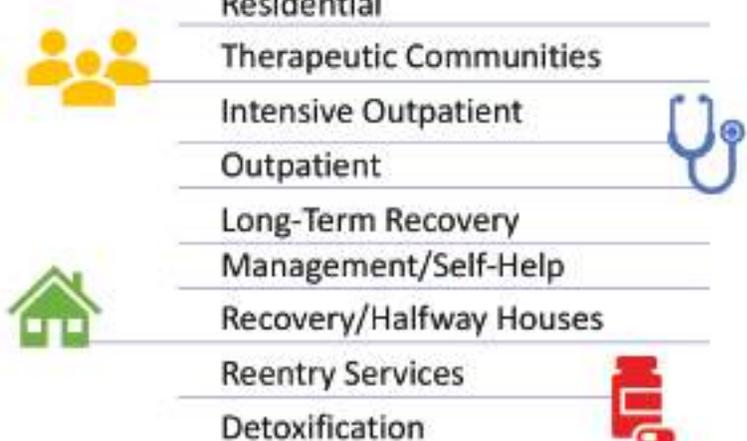


Trainer 1: One question that often arises is: Who provides treatment for people with SUDs? If you remember the definition of treatment, we use the term “professionally delivered.” Treatment must be done by professionals, but that does not necessarily mean psychologists or psychiatrists. It could be done by people who are specifically trained and supervised with respect to providing the services necessary for people with SUDs. This could be certified counselors or social workers—and in the case of medication assisted therapy, in collaboration with physicians, psychiatrists, psychologists, nurses, and/or a Case Manager. Peer-driven and peer-supported treatment could also be implemented. When people who have personal experiences with SUDs and recovery are provided with training and high-quality supervision, they could be very effective in providing treatment interventions in residential settings, like a therapeutic community model, which exclusively uses peer-to-peer treatment interventions. In other contexts, the probation department, probation officers, community-based law enforcement officers, might be needed. These people with proper training are capable of delivering treatment interventions without referring these individuals out. Depending on the needs of the individuals, a range of professionals might be involved, as long as (1) they are trained in addressing both SUDs and criminogenic needs, and (2) they are properly mentored and supervised.



Evidence-Based Treatment Modalities

- Residential
- Therapeutic Communities
- Intensive Outpatient
- Outpatient
- Long-Term Recovery Management/Self-Help
- Recovery/Halfway Houses
- Reentry Services
- Detoxification






OAS CICAD


2.43

Say

Trainer 1: There are quite a few treatment interventions whose effectiveness is supported by science. In terms of the settings, treatment can be done in residential or outpatient facilities. Residential treatment might be an option for people that initially need to detox. Detox by itself is not treatment; in some cases, it is a pre-requisite to enter treatment. Most participants with SUDs do not need detox. Some do, particularly those that have SUDs with life-threatening withdrawal symptoms from dependence on substances like alcohol, benzodiazepines, and barbiturates. Because of the risk such withdrawal can pose, it should not be attempted without medical attention.

When the level of behavioral and psychosocial dysfunction is very high, it might be useful to refer those individuals to residential treatment, which would be last longer and emphasize stabilizing the patient’s physical and mental health stabilization and their psychosocial situation.

If properly implemented, the therapeutic community model can also result in long-term behavioral modification. When not implemented properly, however, the therapeutic communities can devolve into a harsh, face-to-face confrontation. We would not say that this treatment has been properly implemented.

If you do not remove a person from their natural environment and place them in a residential setting, you can place them in an intensive outpatient treatment.

This is particularly true for individuals that are working and have a certain degree of psychosocial stability, yet still carry significant dysfunctions. The person will spend a longer time in treatment but will stay at home, sleep at home, and go to work.

As the severity of the problem decreases, we might want to decrease the intensity of treatment. Recovery is a long process. You might not want to stop treatment abruptly, considering that reaching a certain degree of stabilization does not necessarily mean that treatment should stop. This could result in a quick relapse. We should make sure that there is continuous support for recovery in a life-long type of intervention. This is what we call recovery management.

There are multiple social models that have been found to be quite effective, particularly for individuals involved in the justice system using recovery halfway houses, and for people leaving prison. The worst thing that we could do is send them back home, as this practice shows that people can relapse very quickly. We want to provide transitional care for a couple of months, to help people stabilize outside of the prison setting and regain their mastery of social activities in a social environment.

Source: Additional resources on the Evidence-Based Treatment Modalities could be found at https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO_International_Standards_Treatment_Drug_Use_Disorders_April_2020.pdf (UNODC and WHO, 2020)



Evidence-Based Clinical Approaches

- Cognitive-Behavioral Treatment
- Motivational Enhancement Therapy/Motivational Interviewing
- Individual and Family Counseling
- Recovery-Oriented Systems of Care
- Medication-Assisted Therapies (when appropriate)
- Contingency Management
- Integrated Services for Co-Occurring Disorders



OAS CICAD



2.44

Say

Trainer 1: In terms of clinical approaches, there are several clinical modalities that have been found to be quite effective for the population we are discussing.

Cognitive behavioral therapy (CBT) is one of the most studied and researched treatment interventions. These studies have demonstrated its effectiveness, as well as that of variations of CBT that specifically target criminogenic risks and needs.

Motivational enhanced therapy and Motivational Interviewing (MI) is probably the second most studied type of intervention, and its effectiveness in treating this population has a strong scientific basis.

Individual and family counseling of different types are also available, and respond to different needs.

Medication-based treatment options only exist for people with alcohol disorders, opioid use disorders, and nicotine use disorders. We do not have medications for any other type of SUD. Not every patient with alcohol, opioid use disorders will need medication, but medication is a very

effective option for multiple people with either alcohol or opioid disorders.

Please note, however, that medication alone is not going to solve the problem, but medication that is a component of a more holistic treatment could help many individuals.

Contingency management: This is an approach that reinforces positive behavior, e.g., rewarding people for performing a negative drug test with something of value. We might suggest offering small prizes or vouchers, such as a gift card for a restaurant or movie theater, as cash is not provided. We know from science that every behavior that gets positive reinforcement from the environment it is likely to become repetitive. We also know that any behavior that is getting negative reinforcement from an environment is likely to be extinguished.

We also need to consider that a large proportion of people with SUDs have mental health problems and additional physical health problems. We must be able to develop a system of care capable to address not just SUDs but also our participants' other psychiatric and psychological needs.

Treatment should Target Factors Related to Criminal Behavior

CASECARE MANAGEMENT

- Criminal thinking and antisocial values
- Anger, aggression, and hostility
- SUD
- Education
- Employment
- Family support
- Barriers to receiving services (housing, transportation)

(Knight, 2017)

OAS CICAD

2.45

Say

Trainer 1: Considering that our participants are justice-involved, all our treatment interventions must target facts related to criminal behavior, criminal thinking, criminal sentiment, criminogenic affiliations, impulsivity, aggression, hostility, and anger. Education could be a valuable component of treatment. But education alone does not address criminogenic needs.

In many instances, it would be very helpful to involve the participant’s family in the treatment intervention, but we need to make a very careful assessment of family functioning.

We also need to remove the practical barriers to treatment. Everything we are saying from a scientific perspective is wonderful, but if the person has no transportation to get to treatment, what good does it do? Therefore, in addition to all the treatment implementation, we need to make sure that the person has a place to sleep, has some money, and knows how to get to the treatment program. Many pragmatic aspects need to be considered to make treatment work.

Source: (Knight, 2017)

More information and examples of trauma informed care are provided by SAMHSA, TIP 57, available at: <https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>



Effective Treatment = Cognitive and Behavioral Skills Development

- ✓ Dealing with cravings, relapse “cues”
- ✓ Changing maladaptive thinking
- ✓ Interpersonal problem-solving
- ✓ Practice skills through role play, modeling, and feedback
- ✓ Use incentives and sanctions - behavior modification to achieve treatment goals



OAS CICAD



2.46

Say

Trainer 1: Let’s specifically talk about cognitive behavioral treatment (CBT), which is commonly used for people with SUDs. CBT is not just for the disorder itself. Everything we do to prevent relapse (i.e., long-term recovery management) is fundamentally based in CBT interventions. We assist people in dealing with cravings, which is the most common reason for relapse, and are mindful of the clues that indicate the changes of relapse, so that training professionals know how to address them. We also assist people in changing their maladaptive or potentially problematic thinking errors through CBT, building problem-solving and assertive communication skills.

CBT does not just discuss these issues, but also gives people an opportunity to practice the new behaviors after those behavior are explained to them. When they get into a situation that may trigger craving and relapse, they can practice these new ways to address it and practice how to stay out of trouble.

We also use incentives and sanctions as ways to reinforce desirable behavior, or to extinguish less-than-desirable behavior.



Treatment Should Address Special Needs



- Co-occurring mental disorders

- Gender-specific needs

- History of trauma and victimization

- Homelessness

- Literacy skills




OAS CICAD


2.47



Trainer 1: As we have said several times, in our treatment we are not focused on SUDs alone. We also deal with co-occurring mental disorders. Our treatment should be gender-sensitive and gender-centered, because the problems are qualitatively different between the genders and what works for one gender does not work for another. We must also consider populations with specific needs like the LGBT population, as their treatment intervention will have some specific needs, too.

We need to make sure to address past traumas and traumatic experiences, as unfortunately a very large proportion of people with SUDs—and particularly those who are justice-involved—have a history of significant traumatic experiences. If they are not addressed properly and clinically, they will fuel ongoing substance use.

We need to train our practitioners in how to train and address trauma in both genders. Men are exposed to trauma pretty much with the same frequency as women, but the expression of the trauma will be different between the two genders.

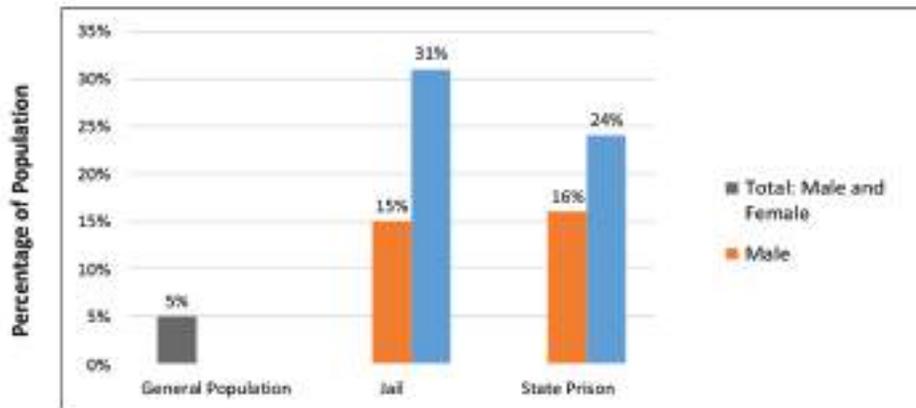
We also need to address conditions of homelessness and education, not just school, but emotional education, financial education, and social literacy (which goes beyond basic literacy).

I will now give the floor to my colleagues, who will continue the session with some specifics about what can be done to develop treatment for people with SUDs in the criminal justice context.



Prevalence of Mental Health Disorders in the Justice System

Major Mental Disorders: Offenders and the General Population



[Ditton, 1999; Kessler et al., 1996; Steadman et al., 2009]



OAS CICAD



2.48

Training instructions: Trainer 2 might start from this slide or Trainer 1 might continue presenting until slide 2.49 (in which case Trainer 2 will start with the new section “Treatment Outcomes” from slide 2.50).

Say

Trainer 2: Let’s look specifically at co-occurring mental and substance use disorders. If we do not detect mental disorders with appropriate screening, we are likely to undermine the effectiveness of involvement in drug treatment. Here you have displayed the rates of mental disorders in the justice system. You can see in the United States, there are very high rates of mental disorders, with a slight difference between the two genders. In comparison to the general population, we find rates of mental disorders four to eight times higher in the justice system, as compared to the general population. Also, about one third of people in the justice system who have mental disorders are not taking prescribed medication at the time of their arrest, and have a greater number of prior incarcerations in comparison to offenders without mental disorders.

Source: Ditton, P.M. (1999). Mental health and treatment of inmates and probationers. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.
Kessler, R.C., Aguilar-Gaxiola, S., Alonso, J., Chatterji, S., Lee, S., Ormel, J., Ustun, T.B., & Wang, P.S. (2009). The global burden of mental disorders: An update from the WHO World Mental Health (WMH) Surveys. *Epidemiologia e Psichiatria Sociale*, 18, 23-33.



Evidence-Based Treatment for Co-Occurring Disorders



- Integrated mental health and substance use treatment
- Behavioral skills training
- Trauma-focused treatment
- Medications (for SUD and other mental health disorders)
- Family interventions
- Supported employment and housing



OAS CICAD



2.49

Say

Trainer 2: What about treatment for populations with co-occurring disorders? There are several different types of evidence-based treatments for people with co-occurring disorders in the justice system. Integrated treatment approaches—in which both disorders are treated at the same time, in the same setting, and with the same staff— have proven to be the most effective. For example, integrated treatment may include use of medications combined with individual counseling for mental disorders, such as depression, anxiety, post-traumatic stress disorder, and psychotic disorders, coupled with drug testing and group counseling for the substance use disorders.

We've talked about the importance of trauma-focused treatment due to the high rates of trauma disorders in this population. Family interventions are also very important, and there is a major need for housing and employment among justice-involved individuals with co-occurring disorders that may not have a history of full-time or even part-time employment.

TREATMENT OUTCOMES



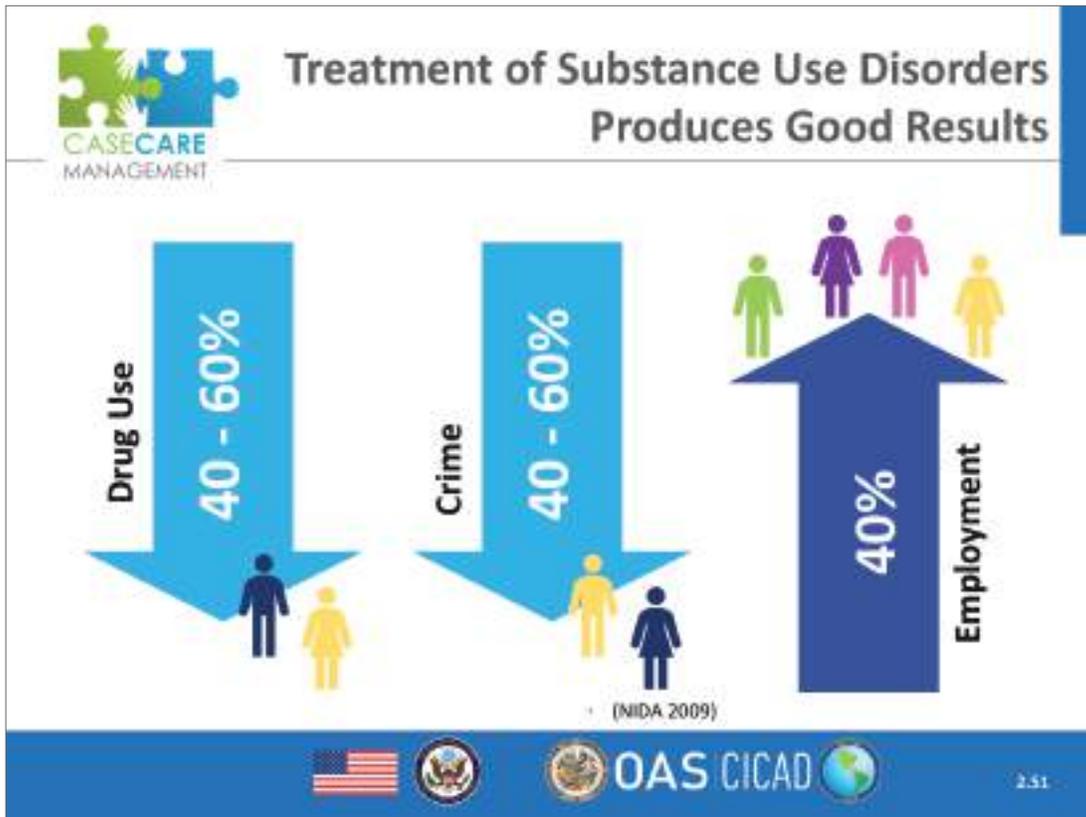
OAS/CICAD



2.50

Say

Trainer 2: What about treatment outcomes in the justice system? Let's look at the different types of outcomes.



Say

Trainer 2: We’ve already discussed the effectiveness of different types of treatment services and programs. Overall, in different settings throughout the justice system, we find significant positive outcomes in areas that we hope would be affected by treatment. For example, treatment leads to reductions in alcohol and drug use of 40 to 60%. Treatment also leads to similarly large reductions in crime and increases in employment among those in the justice system. I would mention that we see these outcomes not only with those that have received treatment while incarcerated, but also for persons receiving drug treatment while under community supervision, or while involved in day treatment programs in the community and/or court-based treatment programs such as drug courts.

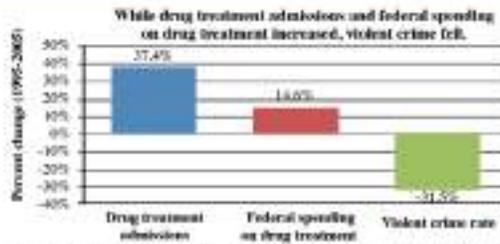
Source: (NIDA, 2009)



Treatment Reduces Crime



Association between investment in treatment and crime reduction



Source: National Admissions to Substance Abuse Treatment Services, 2005; Treatment Episode Data Set (TEDS) Highlight - 2005. Drugs include heroin and other opiates, cocaine, marijuana, methamphetamine/amphetamines. Federal Bureau of Investigation, Uniform Crime Report, Crime in the United States, 1995, 2000, 2005; Office of National Drug Control Policy, 2005; National Budget Control Policy: FY 2005 Budget Summary Table 3: Historical Drug Control Funding by Function 1997-2006.



OAS CICAD



2.32

Say

Trainer 2: Let's look more specifically at the relationship between public spending on drug treatment and crime. As shown in this graph, when we increase funding for treatment, and increase admissions to drug treatment in a particular nation, we see reductions in violent crimes. In this case, we see that increasing the number of treatment admissions by one-third and significantly expanding investment in treatment resources led to a reduction in violent crime of over 30%.

Source:

National Admission to Substance Abuse Treatment Services. (2005) Treatment Episode Data test set (TEDS) Highlight 2005.

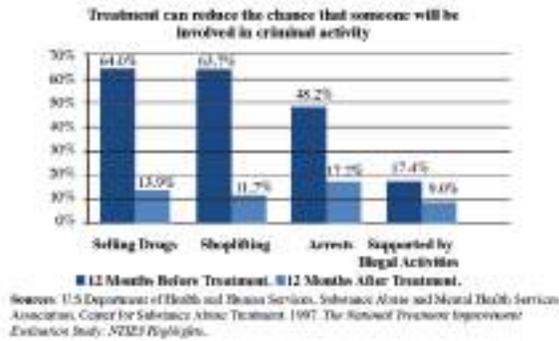
Federal Bureau of Investigation Uniform Crime Report, Crime in the United States, 1995, 2000, 2005
 Office of National Drug Control Policy (2005). National Budget Control Policy: FY 2005 Budget Summary Table 3 Historical Drug Control Funding by Function 1997-2006.



Reductions in Specific Types of Offenses



Treatment effects involvement in criminal behavior



OAS CICAD



2.55

Say

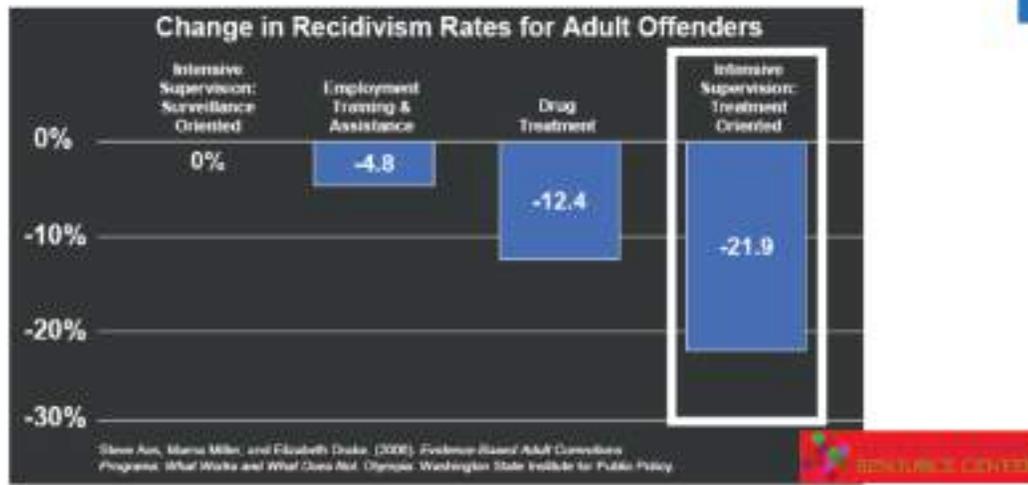
Trainer 2: What about the effects of drug treatment on specific types of crime that are influenced by drug and alcohol use? The different-colored blue bars indicate the likelihood of involvement in criminal activity before and after drug treatment. Look at the significant difference across the different types of offenses, whether it's selling drugs, shoplifting, or other criminal activities. Treatment leads to a five-fold decrease in the risk for committing certain types of crimes.

Source:

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (1997). The National Treatment Improvement Evaluation Study, NTIES Highlights.



Combining Treatment and Supervision Reduces Recidivism



Say

Trainer 2: Overall, we have very convincing research indicating that treatment works, particularly if we use evidence-based approaches. As described on the left-hand side of the chart, if we provide supervision alone, without treatment, there is no impact on criminal recidivism.

When we provide employment training and support, we find small reductions in recidivism. Providing substance use treatment leads to even more impressive reductions. However, we see the best outcomes when evidence-based treatment is combined with supervision in the community, particularly when we target persons who are at high-risk of recidivism and who have high treatment needs, as discussed previously.

Therefore, this combined approach of treatment and supervision is the best way to work with this population in the justice system.

Source:

Aos, S., Miller, M., & Drake, E., (2008). Evidence-based adult correction programs: What works and what does not. Olympia: Washington, Institute for Public Policy.



Treatment Saves Money

Cost to society of drug use in U.S.
= **\$442 billion/year**



Treatment is less expensive than incarceration:

- Outpatient offender treatment = **\$7,000/year**
- Incarceration = **\$40,000/year**



Every **\$1** invested in treatment produces up to **\$7** in savings





OAS CICAD 

2.35

Say

Trainer 2: What about cost savings related to substance use treatment? Here's an example of how much money can be saved by providing substance use treatment. To start with, costs related to alcohol and drug use in each of our nations are enormous. Some of the biggest costs are those related to incarceration, either in short-term detention facilities or in prisons. There are also costs related to injuries to victims, law enforcement, court processing, and lost tax revenue for persons who are incarcerated. For people who don't present a public safety risk, there are significant cost savings from providing treatment in the community instead of incarceration. For example, in the United States, the costs of outpatient treatment are about \$7,000 to \$10,000, in comparison to \$35,000 to \$50,000 to incarcerate a person for one year.

Therefore, the important message is that if we can keep people safely in the community and involved in drug treatment, we can achieve major savings in comparison to incarceration.

In fact, studies have shown that every dollar spent on substance use treatment leads to savings of up to seven dollars. Again, this is due largely to keeping people out of the prison system and avoiding costs of building new facilities to incarcerate people with drug problems.

Source: Ettner, S. L., Huang, D., Evans, E., Ash, D. R., Hardy, M., Jourabchi, M., & Hser, Y. I. (2006). Benefit-cost in the California treatment outcome project: Does substance abuse treatment "pay for itself"? *Health Services Research, 41*(1), 192-213.



Effectiveness of Case Care Management



Enhances linkage to drug treatment, retention in treatment, and satisfaction with treatment

Reduced use of residential treatment

Increased use of community-based services

More effective than standard care/treatment across different outcomes

Large impact for persons with co-occurring disorders

Matches individuals to appropriate level of SUD care and provides advocacy

(Dumaine, 2003; Hesse et al., 2011; Rapp et al., 2014; Vanderplasschen et al., 2007, 2019)



OAS CICAD



2-16

Say

Trainer 2: Now, let's talk specifically about the effectiveness of Case Care Management. What have research studies demonstrated about the impact of Case Care Management across different settings and populations? First, research tells us that Case Care Management increases engagement in substance use treatment. For example, people engage in treatment more quickly and stay in treatment longer than they would otherwise. Another key finding is that Case Care Management reduces the need for residential substance use treatment, which can be very expensive. Instead, we see a greater ability to place people in outpatient community-based services, which are less expensive.

If you compare Case Care Management with the standard type of services received in the community, we find that Case Care Management produces significantly better results, across several different types of outcomes. Case Care Management is particularly effective for people with special needs, such as those who have co-occurring mental and substance use disorders.

Source:

Dumaine, M.L. (2003). Meta-analysis of interventions with co-occurring disorders of severe mental illness and substance abuse: Implications for social work practice. *Research on Social Work Practice, 13*(2), 142-165.

Hesse, M., Vanderplasschen, W., Rapp, R., & Fridell, M. (2011). Case management for persons with substance use disorders. *Cochrane Database of Systematic Reviews, 4* (CD006265). doi:10.1002/14651858.CD006265.pub2

Vanderplasschen, W., Wolf, J., Rapp, R. C., & Broekaert, E. (2007). Effectiveness of different models of case management for substance-abusing populations. *Journal of Psychoactive Drugs, 39*(1), 81-95. doi:10.1080/02791072.2007.10399867

Vanderplasschen, W., Rapp, R., Maeyer, J., & Noortgate, W. V. (2019). A meta-analysis of the efficacy of case management for substance use disorders: A recovery perspective. *Frontiers in Psychiatry, 10*, 1-18. <https://doi.org/10.3389/fpsy.2019.00186>.

Broekaert, E., Mats, F., Morten, H., Rapp, R., Vanderplasschen, W. (2014). Case management for persons with substance use disorders. *Cochrane Database of Systematic Reviews*. <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006265.pub3/full>

Stokes, J., Panagioti, M., Alam, R., Checkland, K., Cheraghi-Sohi, S., & Bower, P. (2015). Effectiveness of Case Management for 'At Risk' Patients in Primary Care: A Systematic Review and Meta-Analysis. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4505905/>

Hudon, C., Chouinard, M., Lambert M. (2016). Effectiveness of case management interventions for frequent users of healthcare services: a scoping review <https://bmjopen.bmj.com/content/bmjopen/6/9/e012353.full.pdf>



Effectiveness of Case Care Management in the Justice System

- Case Care Management significantly reduces substance use and crime among persons under community supervision
- Both medium and high levels of case management lead to significant reductions in substance abuse and crime
- Case Care Management enhances linkage to treatment for substance use disorders and other ancillary services

(Hesse et al., 2011; Prendergast, 2009; Urban Institute, 2011)



OAS CICAD



2.57

Say

Trainer 2: What about Case Care Management in the justice system? Research indicates similar outcomes to those that we just discussed. Among persons who are under supervision in the community and receiving either medium or high-intensity Case Care Management services, we find significant reductions in both criminal behavior and substance use. For example, case management provided by community supervision officers in drug court programs has been found to reduce crime and substance use at both six and eighteen-month follow-up periods.

Just as we saw in the previous slide, within the justice system, we also find increased involvement in treatment for SUDs and other types of services related to addressing trauma, vocational training, and employment. Overall, we find that Case Care Management has a large and positive impact in the justice system, particularly when provided in combination with evidence-based substance use treatment.

Training instruction: shift back to Trainer 1.

Source:

Hesse, M., Vanderplasschen, W., Rapp, R., & Fridell, M. (2011). Case management for persons with substance use disorders. *Cochrane Database of Systematic Reviews*, 4 (CD006265). doi:10.1002/14651858.CD006265.pub2

Prendergast, M. L. (2009). Interventions to promote successful re-entry among drug-abusing parolees. *Addiction Science and Clinical Practice*, 5, 4-13. doi:10.1151/ascp09514

Rossman, S. B., Roman, J. K., Zweig, J.M., Rempel, M., & Lindquist, C. H. (Eds.) (2011). *The multi-site adult drug court evaluation: The impact of drug courts*. Washington, D.C: The Urban Institute.

ADDICTION AND RECOVERY



OAS|CICAD



358

Say

Trainer 1: As we have mentioned several times already, SUDs are treatable conditions, people get better, people do recover, and the recovery rates are quite similar to patients with chronic and relapsing conditions in general medicine (like diabetes).



Addiction and Recovery

Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. Even people with severe and chronic substance use disorders can, with help, overcome their illness and regain health and social function

Recovery is a personalized path and an individual journey, with some common features

Relapse is part of the recovery path



Source: NIDA 2021



OAS CICAD



2.59

Say

Trainer 1: One important aspect of SUDs we should recall is that just as the development of an SUD is a process, recovery is a process as well. It does not happen overnight. People go through the process of recovery in different ways, and there are multiple ways to support individuals recovering from SUDs. Similar to treatment, recovery is individualized. People recover differently, through different means and using different support systems in different types of interventions.

It is important to mention that sometimes people do relapse. SUDs are a chronic and relapsing condition by definition. Relapse can happen—it is not desirable, but realistically can happen. Some people might get to treatment and recover for life. For other people that may not be realistic, but that still does not mean that they have not recovered. Relapse can be a part of the recovery process, and we should accept and appreciate that.

Example of Hypertension: Johnny is a patient with very high blood pressure, and it is a life-threatening condition. He goes to treatment and is fine. Then for some reason treatment stops. The chances are that very quickly Jonny will have high blood pressure again, because it is a chronic and relapsing condition. People will encourage Jonny to go back to treatment, because he was doing fine and following what the expert says so he will get better again. In this case, the relapse is considered as evidence of treatment effectiveness.

Let's use the same example in addiction treatment, for example, somebody in addiction treatment with severe SUDs. Most participants in this situation will get stable and their conditions will improve significantly while they are in treatment. When for some reason the treatment stops, chances are that there will be some difficulties and potential relapse.

Decision-makers might say that this shows that treatment does not work. Johnny was in treatment three months ago and then relapsed.

This is, however, incorrect. Relapse in drug and alcohol is often considered as evidence of treatment ineffectiveness.

Let's make sure we have a clear understanding that when it comes to people with chronic and relapsing conditions, just because the condition has a tendency to re-occur, it does not mean that the person is bad. It means that we need to increase the intensity of treatment and recovery support to avoid relapse in the future and to get to the stabilization, which is still very much possible.

Thus, the most effective treatment programs, including those connected to the criminal justice system, should allow for relapse. We should increase intensity of treatment and drug testing, but we should not automatically terminate somebody from a treatment program based on a single relapse. The program in the justice system setting should provide second and subsequent changes for people to accommodate the normal process of relapse, and to ensure that people are not discharged from program for one instance of relapse.



Training instructions: Encourage the trainers to lead an interactive discussion about reasonable expectations of recovery.



Trainer 1: What are the reasonable expectations for when we see a person becoming more psychosocially stable?

In the first weeks or months of treatment, the person is likely to achieve some level of stabilization. But how sustainable is this? What would be your expectations for this person, based on the time they have spent in treatment?

Trainer 2: It is a very important issue and a good question. People come into treatment with different levels of addiction. Some have been addicted for a short period of time, while others have a chronic history of alcohol and drug use that requires a much longer period of treatment. Treatment occurs in stages, so for the first few weeks and months, we have a different approach. We do not expect abstinence to occur immediately. Rather, we are accommodating potential relapses and we are primarily focused on engagement in treatment and their motivation to change.

We expect people in such a situation to be ambivalent about treatment, and not necessarily try to learn new things or believe that treatment will be effective. Our job in the first few months is to provide optimism, hope, and incentives for them to stay involved in treatment, as well as expose them to other peer mentors who have had success in treatment.

Those tools will allow them to work on skills for several months until they develop internal motivation for treatment.

Trainer 1: It sounds like we should now set the so-called proximal goals and distal goals of a treatment plan.

Proximal goals are the things that the participant is capable of doing right now. For instance, attending group or individual treatment sessions is

something that the participant or patient is capable of doing in the first weeks in recovery. And this will be the goal I will reinforce with significant intensity. Full abstinence is an example of a distant goal. It is something that the participant may or may not be fully ready to accomplish, something that we are working toward because of the nature and the severity of the problem. Chances are that it will not be achievable in the first couple of months.

Trainer 2: Some people will be able to achieve and maintain abstinence in the first few months. We are setting a series of goals that are achievable. This is also where we apply incentives and sanctions. The types of activities we focus on are based on the level and needs of individuals as they begin treatment.

Trainer 1:

It is important to mention that full abstinence is not always the ultimate goal of treatment. Decreasing the intensity of use, while not the ideal result, could nevertheless be considered a manageable and realistic result in certain circumstances.

Medication-assisted therapy, with the properly prescribed medications and no evidence of any other illegal substance use, could be considered abstinence.

In these cases, full abstinence is something that would be ideal, but is not always possible.

In the first year of treatment, the initial stabilization of the participant is a critically important time to make sure that recovery is sustainable and that psychosocial stabilization has taken place. By this, we mean that the person is not engaged in criminal activity, and has stable housing and/or found a job. Our expectations may then change as time passes.

Ask

What would you expect in the first three years in recovery?

Trainer 2: You will have gradually better outcomes across the different dimensions of recovery. At this stage of treatment, you would expect participants not to commit crimes, to be employed, and be engaged in other pro-social activities such as family activities, attending religious services, and/or any hobbies that they might have. People will hopefully be abstinent at that point. This is also an opportunity to consider less intensive treatment interventions.

Trainer 1: Ask the audience about how many people have tried to lose weight or to exercise. Probably the majority of the people in the audience will relate to this experience. Then, ask how many of them have done it consistently and sustainably? And that is the difficult part. It is not difficult to start a diet or to lose a bit of weight. But most people do not continue. They then gain the weight back and stop exercising.

This is a process of change that is quite similar to the process of change that people with SUDs are going through.

Recovery is not that difficult to start. Maintaining it and supporting the person in the long term is far more difficult.

Trainer 2: To wrap up this slide, recovery is a long-term process, and we need to provide ongoing opportunities for people in the justice system to stay involved in treatment for each of the multiple problems we have talked about: SUDs, mental health issues, and other problems that may occur over time. Many of these problems are linked to criminal recidivism, so we need to have opportunities for people to stay involved in treatment within the justice system.

Source: Dennis, M.L., Foss, MA., Scott, CK. (2007). An eight-year perspective on the relationship between the duration of abstinence and other aspects of recovery. *Eval Rev.* 2007 Dec;31(6):585-612.



Recovery Capital

“...the sum of personal and social resources at one’s disposal for addressing drug dependence and, chiefly, bolstering one’s capacity and opportunities for recovery.”

(Cloud & Granfield, 2001)



OAS CICAD



2.61

Say

Trainer 2: Recovery capital is a term that it is used to describe the range or type of support that people need over the long term, to make sure that they stay sober, become employed, and get the support that they need across a range of different areas. This term recognizes that providing this support and engaging with people long-term is a complicated process.

Source: Cloud, W. and Granfield, R. (2001). Social context and “natural recovery”: the role of social capital in the resolution of drug-associated problems. *Journal of Substance Use and Misuse*, Volume 36, 2001, Issue 11.



Trainer 2: This slide gives an example of some of the social resources that could be provided for people with chronic addiction problems. This is aspirational, something we hope to give each individual in the justice system over time or to help them recover over a period of years.

Trainer 1: This is a good summary of everything we have said so far. Addressing the relation between the individual and the substance is by far not the one and most important element of treatment.

We are talking about a very comprehensive system of long-term care capable of addressing multiple dysfunctions connected to the substance use itself. This could be family dysfunctions, mental health issues, psychological issues, low stress tolerance, unemployment, emotional illiteracy, and traumatic experience in the past. People have difficulties, and at the same time there is not a patient or participant in the world that does not have some strengths, interests, and positive experiences from their past. I think we need to deploy, assess, and capitalize on those strengths, in order to increase the amount of recovery capital that person has. And this is one of the key components of any kind of interaction with individuals, and particularly of interaction in the context of comprehensive Case Care Management.

When we work with a participant, we don't just want to find out what their pathologies are. Case Care Management should identify the strengths and the skills of each person. If a person is cooking and selling amphetamines, this person may be talented with chemistry and math. These would be the aspects I would capitalize on, as funny as it sounds. These are some strengths that can be channeled into more pro-social, more functional skills.

We have talked about multiple aspects of treatment that must be primarily based on strengths, but also must address multiple difficulties and deficiencies.

Trainer 2: Just to wrap up, recovery capital does not only exist within treatment. Case Care Management builds upon the gains made in treatment to help our offender population reintegrate into the community. Case Care Management is really a bridge from treatment to a positive integration in the community using all of these elements that you can see on the slide. Case Care Management provides a unique benefit for people in the justice system to move beyond where they come from, and to successfully reintegrate into the community.

Training instruction: Trainers should encourage participants to read the source material and come up with their own conclusions using this information, as well as to continue learning and educating themselves about SUDs.

Additional information on models of recovery capital could be found at:

“The ‘ice cream cone’: Characterizing recovery capital through layers of community engagement. SIM = Social Identity Mapping; ARC = Assessment of Recovery Capital; ABCD = Asset Based Community Behavior” (Best, 2016).

Source: United Nations Office on Drugs and Crime, (2008). Drug Dependence Treatment: Sustained Recovery Management. Available at https://www.unodc.org/docs/treatment/111SUSTAINED_RECOVERY_MANAGEMENT.pdf

Best, D., Irving, J., Collinson, B., Andersson, Catrin., Edwards, M. (2016). Recovery Networks and Community Connections: Identifying Connection Needs and Community Linkage Opportunities in Early Recovery Populations. *Alcoholism Treatment Quarterly*. 35. 1-14. 10.1080/07347324.2016.1256718.

MODULE 3



Case Care Management Multisystem Approach

Preparation checklist

Content and timeline

Training goals and learning objectives

PowerPoint slides

MODULE 3

Module 3 Preparation Checklist

- Review the “Getting Started” section for general preparation information on page 13 of this manual.
- Preview Module 3.
- Prepare for the interactive exercise: assemble the following:
 - A stack of letter-sized (or A4-sized) paper for each table.
 - Pads of Post-it notes for each table.
 - Place colored markers and a stack of colored paper on each table.

Module 3 Content and Duration

Activity	Time
Module 3- Case Care Management Multisystem approach	120 minutes
Presentation: The Multisystem Approach	10 minutes
Embedded Exercise: Stakeholders	20 minutes
Presentation: Case Care Management and the Justice System	10 minutes
Group Discussion: The Justice System in your Country	20 minutes
Interactive Exercise: The Participant	30 minutes
Presentation: How Case Care Management Supports the Stakeholders	20 minutes
Presentation: Reasons to Invest in Case Care Management	10 minutes
Break	15 minutes

Module 3 Goals and Objectives

Training Goals

- Present the Case Care Management Multisystem Approach.
- Provide an overview of how Case Care Management supports the work of main stakeholders.
- Introduce the reasons for investing in Case Care Management.

Learning Objectives

Participants who complete Module 3 will be able to:

- Understand the multisystem approach and explain the role of Case Care Management.
- Describe key reasons for investing in Case Care Management.



CASE CARE MANAGEMENT MULTISYSTEM APPROACH



Training instruction: This module requires two trainers. The first and main trainer will lead the presentation. The second trainer will act as co-facilitator primarily assisting his/her colleague in the interactive exercise and in the part of the module that requires active participation from the audience.

Say

Trainer 1: After listening to the state-of-the-art research on addiction, crime, what ties them together, and opportunities for treatment and recovery, we are now moving to the description of the Case Care Management multisystem approach. This module explains why Case Care Management needs to be connected to a multisystem approach and what this approach entails.

During this module, I will be assisted by my colleague (Name of the second trainer) who will act as a co-facilitator. This course includes interactive exercises and questions where my colleague will help me write down your input on the flip chart.



MODULE 3

Objectives

Present the Case Care Management multisystem approach

Provide an overview of how Case Care Management supports the work of the main stakeholders

Introduce the reasons for investing in Case Care Management

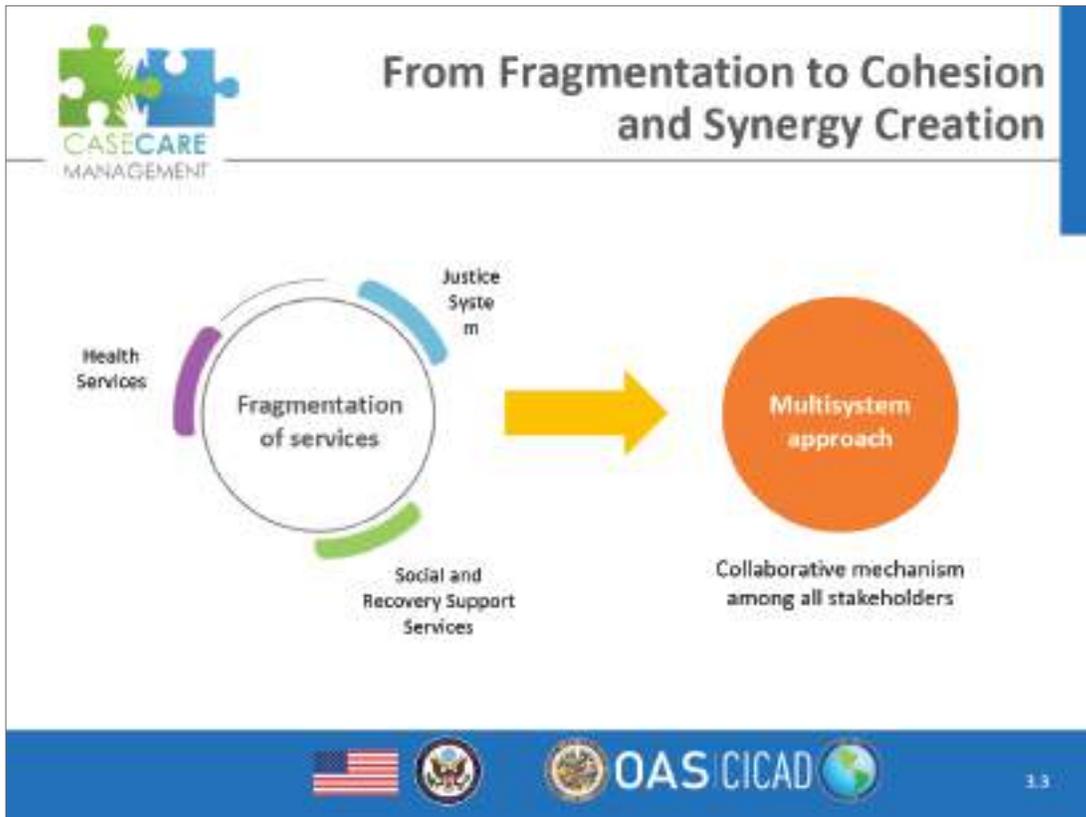


3.2

Say

In this module we go through the Case Care Management multisystem framework and will work together to identify the key stakeholders in your country that have a role in Case Care Management.

In addition, Module 3 introduces some new elements, such as the framework and the design of Case Care Management that will be further illustrated and analyzed at a later stage in the training. Let's get started.



What does a system without Case Care Management look like?



It is likely to be a fragmented system of uncoordinated services. The purpose of Case Care Management is to act as a facilitator, and to create synergies and a connection within and among the different systems.

Case Care Management means different things to different people, but essentially, it serves as a linkage.

Judges, probation officers, and treatment providers are working with the best interest of the participant in mind but could use help in finding partners. The Case Care Manager oversees and helps them connect the dots. While serving as the Case Care Manager, this professional acts as a coordinator for all stakeholders. A Case Care Manager makes all of the different services come together.

Social and Recovery Support Services.



Say Case Care Management’s multisystem approach is based on a multi-sector system that includes different stakeholders.

Ask What do you think about this image? We can see that we have the justice system, the health system, and social services. Looking at it, who do you have in mind? Who are the actual stakeholders, the people with decision-making power that you wish to see reflected in the chart?

Training instruction: The trainer should prepare for the exercise in advance and read the description of Annex A - Training Exercise Instructions (Participant Manual, page 253). The trainer describes the picture with the main stakeholders in the system. Be aware that the participant is not yet depicted. Here we present the justice system, health services, and social services. The trainer asks participants questions about the different actors: When they think of the justice system, whom do they have in mind? Give some examples. The co-facilitator writes the participants’ ideas on the flip chart, starting with the justice system, moving to health services, and then to social services. Participants are encouraged to write down ideas on their exercise page in the annex of their manual or notebook. The results of this exercise will be used later on in Module 10 of the training.



Training instruction: After the stakeholder exercise, the trainer could do a recap of who the main actors are and see if there is a correlation between the results of the exercise and where he would like to lead the discussion.

Say

The interactive exercise on the stakeholder helped us in understanding the complexity of the multi system approach. Case Care Management works with:

- The Justice System
- The Participant
- Health Services
- Social Services
- Communities

Say

In comparison with the previous slide, and thanks to our interactive exercise, we have noticed that the panorama of stakeholders is quite complex, and that there are additional crucial elements to consider such as the participant and the communities. We will talk about the participant in a minute, but let's focus first on the communities.

Ask

What do we mean by the term "communities?" What comes to mind?

Say

By "communities," we not only refer to families, civil society, religious leaders or spiritual leaders, support groups, but also to businesses and employers, civil society, and citizens at large. All of these can be included and take action in terms of sustaining the long-term recovery and social integration of our participants.

CASE CARE MANAGEMENT AND THE JUSTICE SYSTEM



OAS | ICAD



3.6

Say

Let's start with discussing the first stakeholder in greater detail: the Justice System. Case Care Management can play a substantial role in facilitating the work of the criminal justice system and promoting alternatives to incarceration along the criminal justice continuum.



Case Care Management is based on Therapeutic Justice

Therapeutic Justice is a model and method which:

- Integrates a public health approach to substance use disorders in the justice system
- Provides an opportunity for treatment interventions along with the justice continuum from arrest to community release

(Wexler, 2011)



37

Say

Case Care Management is inspired by the concept of therapeutic justice, promoting a public health approach to working with justice-involved people with SUDs:

- Untreated people with SUDs tend to cycle in and out of the justice system.
- Case Care Management connects them to treatment and services that can help break this cycle.

Therapeutic justice aims at providing opportunities for treatment and service interventions at multiple points along the justice continuum, suggesting a linkage to evidence-based treatment as a viable path leading to recovery, promoting social integration, and safeguarding public security. Case Care Management also facilitates and increases communication among the key stakeholders (health, treatment, justice system).

Untreated substance abusing offenders are more likely than treated offenders to relapse to drug abuse and return to criminal behavior. This can lead to re-arrest and re-incarceration, jeopardizing public health and public safety and taxing criminal justice system resources” (NIDA).

Source: NIDA. (2021) Introduction. Principles of Drug Abuse Treatment for Criminal Justice Populations - A Research-Based Guide. <https://nida.nih.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations-research-based-guide/introduction>



The justice system can connect many people to treatment and services within their communities.

There are many opportunities for Case Care Management to engage with justice authorities along the justice continuum, both pre-conviction and post-conviction.



How are people normally referred to treatment in your country?
By whom?

Training instruction: The trainer could start a discussion by encouraging audience engagement and asking for contributions from participants, asking questions about the intersection points mentioned in the chart and what responses in their respective countries are like. This exercise helps in understanding what programs Case Care Management could be integrated into, what the priority areas in the justice continuum are, and what the country might want to study and eventually invest in.



Synergies in the Justice Continuum



OAS CICAD



2.9

Training instructions: The trainer might ask (or should know) if drug possession or consumption is considered a crime in the country (or countries) in question. This information on national law is crucial in order to understand the following steps.

The trainers should also familiarize themselves with the country's legal framework (common law, civil law, customary, religious, mixed) and the impact that the legal system might have on Alternatives to Incarceration opportunities.

Say

Let's have a look at some possibilities.

Pre-adjudication:

Pre-arrest/Deflection is pre-arrest diversion and involves the law enforcement authority and/or the police. It is a relatively new term. There are no charges filed and the person is referred to treatment. Is this used in your country? Are there police officers in the room? Do you (or can you) refer people to treatment?

Diversion happens post-arrest when charges are pending, and law enforcement refers the participant to treatment. The charges are eventually dropped upon successful treatment completion or reconsidered in the case of the participant dropping out of the program.

Post-adjudication:

Sentencing alternatives happen post-adjudication. The judiciary places the defendant into treatment instead of a jail or prison sentence (TASC/Drug Court Model, though the drug court model also works pre-adjudication).

Community Supervision: When a Probation/Parole officer refers participants to treatment to minimize recidivism and promote social reintegration.

Jail/Prison Correction: Treatment is provided by licensed and trained counselors in prison therapeutic community programs. Pre-release treatment programs might also be available.

Post-conviction:

Reentry: Probation, parole, and law-enforcement authorities refer individuals to services the community upon release to continue treatment interventions while still under judicial supervision. Treatment services should report to the relevant judicial authority.

Training instructions: The trainer should keep in mind the following questions and assess the contributions made by the participants, trying to identify possible answer to the following questions:

- Are the participants willing to explore other opportunities such as Pre- and or Post-Sentencing Alternatives?
- Remissions?
- Restorative Justice?



Intervention Opportunities

	PROS 	CONS 
Pre-arrest	Avoid charges and/or arrest, able to remain with family and employment	The participant must be self motivated
Proceedings	Opportunity to avoid conviction; court leverage could help treatment retention factor; able to stay with family and employment	Judge drives decision regarding treatment
Sentencing	Opportunity to enter treatment and social reintegration programs	Arrest; removal from families and employment; prison; increased risk of recidivism
Re-entry	Opportunity to enter treatment and integration in the community	Adverse consequences of incarceration




OAS CICAD

3.10



Being arrested and convicted has consequences on people's lives. What are these collateral and unintended consequences?

Getting a job? Getting a loan? For example, to buy a car? These actions are difficult when your criminal history is not clean....

Even three days of detention could dramatically increase the possibility of recidivism.

There are ways to avoid conviction such as timely engagement with the participant in treatment. Case Care Management helps in this process.

Let's have a look at the pros of Case Care Management at each intervention point:

- Participants who are referred to treatment might be able to stay with family and keep their job.
- Case Care Management works on motivation and supporting treatment retention, facilitating program completion and medium to long-term social reintegration.
- Even post-sentencing, Case Care Management can connect the participant to treatment services and support the participant's re-entry into society with an active role in the community.



Case Care Management supporting the Justice System

Case Care Management performs a standardized process with clinical informed approach and clinical expertise

Case Care Management offers regular communication

Case Care Management promotes a collaborative approach and addresses barriers

Case Care Management promotes timely intervention and address barrier to recovery



OAS



311

Say

There are multiple ways that Case Care Management can support the justice system by offering:

- **A standardized process:** Case Care Management performs standardized clinical assessments to determine eligibility, the level of treatment needed, and what other services the participant requires, as well as assists the judicial authority in making decisions based on the assessment and recommendation provided.
- **Constant communication:** Case Care Management communicates with the participant, connects with health and social services, and keeps the judicial authority informed on progress toward program completion.
- **A collaborative approach:** Case Care Management will support the judicial authority in creating a collaborative approach, providing technical assistance, and helping officials understand how recovery from SUDs works and the concept of therapeutic adjustment. Participants should not be punished if they are not responding to treatment. Options of different treatment modalities can be explored and adjustments in the plan can be made. Synergies and cooperation between the judicial authority and Case Care Management are established.
- **Timely intervention:** The participants' contact with the justice system is limited, and there is no need for long detention because their needs can be timely met.

The Justice System in Your Country



Training instructions: Trainers should prepare in advance and refer to Annex A- Training Exercise Instructions.

The objective of this exercise is to stimulate discussion among participants to identify possible Case Care Management programs. Participants might assume that Case Care Management should address post-conviction or re-entry programs, but based on the explanations provided in the module they could be able to consider other feasible options.

The trainer creates groups and asks them to discuss the possible points of intersection in the justice continuum where they believe Case Care Management could be of help. Depending on how the tables are arranged, the trainer might group the participants differently. In order to allow for more effective exchange, mixed groups are recommended, with representatives from probation, correction facilities, and civil society grouped together.

Participants should record the information they gather in the table provided on page 255 of the participant manual.

The groups will be asked to report back, and the co-facilitator will write down contributions on the flipchart.

The total time estimated for the exercise is 20 minutes.

The results of this exercise will be elaborated and expanded upon in Module 10.

Say

We are going to do a group exercise analyzing the key elements of the justice system in your country and identifying possible intersection points for the Case Care Management program. Please refer to page 255 of your participant manual. You have space there to write down your ideas. At the end of the exercise, you will choose a representative to report back to the entire group.



Who is the participant?

Interactive exercise



OAS CICAD



3.13

Training instructions: This exercise requires previous preparation. The trainers should read the exercise description provided in this manual and have already prepared the necessary material for the presentation.

Say

After seeing how CCM interacts with the justice system, we need to address two of the most important questions in this course:

- Who is the participant?
- How can we have a clear vision of CCM if we do not understand the participant?

We will complete two interactive activities that will help us familiarize ourselves with the profile of the participant.

Case Study and interactive activity 1

Training instructions: Preparation for the exercise needs to be done in advance. The trainer should have four cards, one for each role (ideally but not necessarily of different colors): participant, probation officer, treatment provider, and judicial authority. Each card has instructions written on how to act, and bullet points with suggested questions to be asked in the interactive exercise.

Participant Card

The participant should look confused and overwhelmed, and will try to ask questions such as:

- *What should I do?*
- *Where should I start?*
- *What is the next step?*
- *What does it mean?*

Probation Officer Card

The probation officer should say in a professional but detached way:

I am expecting you:

- *To go to treatment;*
- *To come to the appointment on time;*
- *To participate actively in each session;*
- *To show the judge that you are complying with his/her decision.*
- *What about your housing situation?*
- *We need to schedule the home visit.*

Treatment Provider Card

The treatment provider should say in a professional but attentive way:

Let's review your performance:

- *How are you following the treatment plan?*
- *Are you attending treatment regularly?*
- *Remember that coming to treatment must be your first priority.*
- *Do you have other pressing needs?*
- *What about your family situation?*
- *We should speak with the probation officer.*
- *When is your next appointment to court?*

Judicial Authority Card

The judicial authority should say in a paternalistic way:

I want to know how you are doing:

- *What about treatment?*
- *What about your housing?*
- *Have you found a job yet?*
- *Any job interview so far?*
- *What about your family?*

Exercise Instructions: the trainer asks for four volunteers from the group to act as the participant, probation officer, treatment provider, and the judge from the DTC. The trainer gives the probation officer, treatment provider, and judge each a card with the main expectations they have from the participant. The trainer allows two minutes for them to read the cards and prepare for the exercise. The trainer instruct them to speak at the same time to the participant to create the impression of confusion and to stimulate reflexive thinking on the actual profile of the participant that Case Care Management hopes to serve.

At the end of the exercise, participants will have an overview of some of the challenges that the participants face. Both trainer and co-trainer will help summarize the key aspects and debrief the group.

Upon completion of the exercise, the trainer should thank all the participants who acted in the role-play, and ask the group to join the trainer in a round of applause.



The second activity is based on a case study. Let's read the text from page 255 of your Participant Manual:

Johnny

Johnny is a 24-year old male who has been incarcerated for robbery. Johnny has been using drugs since he was 18. He and his partner Mary have a young daughter named Jill. After being in prison for six months, Johnny is not in a re-entry program and does not attend treatment regularly. He is currently preparing for an interview for a job in retail. He is nervous because he needs the job to support his family. He knows that the interviewer might have prejudices related to his criminal records and substance use history.

Ask

How do you think Johnny should address the issue if asked about it? How would you react if you were the job interviewer?

Training instructions: The trainer will stimulate discussion within the group.

Exercise instructions: The trainer will ask two volunteers to role-play the scene: Johnny and the interviewer.

After the role-play, the trainer will debrief with the group.

Training instructions: Remember to thank all the participants who acted in the role-play and ask the group to join you in a round of applause.



Say

Based on the results of the interactive exercise, let's go through the elements that emerged from the discussion and that help us in better understanding the profile of our participants and the challenges they face:

Legal charges and conviction: If they are facing charges, sometimes they are not aware of the consequences of those charges, when they need to appear to court, what for, and what is expected from them.

Health issues: If they have medical needs, chronic conditions, health problems related to a substance use disorder, or co-occurring illnesses/mental problems.

Poverty: Different degrees of poverty and lack of opportunities or access to resources.

Poor or interrupted education: The challenges they face in getting formal employment or a legal source of income, which often leads to lack of employment.

In the majority of cases, they might also face some sort of stigma (due to being an ex-convict, their race or ethnicity, or their drug consumption). They may also feel alone and confused about what comes next, as well as unable to prioritize actions and create a plan.

Grouping all of these challenges into three main categories, the participants often have:

- Health and treatment needs.
- Financial needs.
- A need for counselling to identify and overcome barriers (both those they are aware of and those that they are not aware of).



Actions to Reduce the Stigma

1. Educate yourself
2. Be aware of your attitudes and behavior
3. Choose your words carefully
4. Educate others
5. Focus on the positive
6. Support people
7. Include everyone



(Source CAMH)



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3.15

Say

Stigma is a reality that we should be aware of. The way in which we think and act can be affected by conscious or unconscious prejudice. There are effective ways to reduce stigmatizing participants that should be used in Case Care Management and elsewhere. Let's have a look at some of the key actions:

1. Know the facts. Educate yourself about mental illness including substance use disorders.
2. Be aware of your attitudes and behavior. Examine your own judgmental thinking, reinforced by upbringing and society.
3. Choose your words carefully. The way we speak can affect the attitudes of others.
4. Educate others. Pass on facts and positive attitudes; challenge myths and stereotypes.
5. Focus on the positive and on one's strengths. Mental illness, including addictions, are only part of anyone's larger picture as a human being.
6. Support people. Treat everyone with dignity and respect; offer support and encouragement.
7. Include everyone. In many places, it may be against the law to deny jobs or services to anyone solely based on these health issues.

Source: CAMH <https://www.camh.ca/en/driving-change/addressing-stigma>



Language matters: People first

Language of Stigma	Correct Language
User/Abuser	Person with a substance use disorder
Addict	Person with addiction
Intravenous drug user (IDU)	Person who injects drugs
Junkie	Person with addiction
Clean/Dirty	Avoid adjectives
Offender	Person in conflict with the law



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3.16

Say

The language we use matters. In the chart, you will see concrete examples of stigmatizing language and the suggested correct language to be used instead. You will notice that the focus is always on the person behind the problem, and we encourage you to always think and put people first.

Teaching Instructions: The trainer may ask the participants to: (1) Identify the stigmatizing languages they have used or commonly used in their environment to describe persons with drug use problems. (2). To find an appropriate word (non-stigmatizing) to replace it.



Case Care Management can be a beneficial partner for the **justice system**, for health and social services, and for the participant.

The main role in the justice system is to support the judicial authority, follow a standardized process, run a standardized assessment, and come back with a plan. Regular reporting including progress of treatment and service plan and representing the participant are also key actions.

Case Care Management is a trusted partner for **health and social services**: Case Care Management creates linkages and assists in monitoring participant progress and in reporting to the authorities in the interest of the participant.

For the **participant**: Case Care Management is the main supporter of the participant. Case Care Management engages with the participant, motivates, assesses strengths, and assists in the creation of an individualized plan and in the achievement of personal and program goals.

Participant

- Primary point of contact
- Rapport
- Engagement

3.18



The Case Care Manager is the **main point of contact** for the participant and is the person that will assist the participant during the duration of the program.

Case Care Managers establish a **rapport** with the participant that is based on transparency and mutual respect. The Case Care Manager is familiar with the clinical nature of addiction and knows how to assist the participant in that respect.

Case Care Management works with the participant and assists the participant in **progressively taking more ownership in the process**. They educate the participants in relevant matters such as the justice system, access to healthcare, and treatment options.

Case Care Management helps the participants in identifying and prioritizing their needs and in meeting their expectations and program goals.



Say

Case Care Management creates a collaborative mechanism with health and treatment providers and provides referrals and linkages. During treatment program implementation, Case Care Management assists treatment providers during crisis prevention and management. It offers ongoing monitoring and shares the burden of reporting to the justice authority.

Case Care Management collaborates with social services to address participants' needs and secure timely referral/linkages with services. Case Care Management also assists in the transition period, from one service to the next, or upon completion and ensures communication protocols are in place so that the service providers know what to expect. Similarly, with respect to collaborating with health and treatment services, Case Care Management shares or takes over the reporting responsibilities to the judicial authority when required.



The slide features the CASECARE MANAGEMENT logo in the top left, which consists of two interlocking puzzle pieces (one green, one blue) above the text 'CASECARE MANAGEMENT'. The main title 'Case Care Management working with Communities' is in the top right. Below the title, there are four blue icons representing diverse people: a person with a headband, a person with a hat and mustache, a bearded man, and a woman with glasses. To the right of these icons are four orange horizontal bars containing the text: 'Education', 'Engagement', 'Family support', and 'Work placement'. Below the icons is the word 'COMMUNITIES' in large blue letters. The bottom of the slide has a blue footer with the US flag, the OAS/CICAD logo, and the number '3.20'.

Say

The Case Care Managers work with communities to create opportunities to promote education on addiction and overcoming stigma and misconceptions, thereby **mobilizing support for recovery and social reintegration.**

The Case Care Manager **reaches out to civil society, spiritual leaders, and support groups to create a supportive network for the participant.**

At the same time, the Case Care Manager encourages **family cohesion and positive models of supportive families.**

The Case Care Manager can also reach out to local **businesses and facilitate participant reentry in the workforce** through internships, apprenticeships, and temporary jobs.



In this slide, we are discussing some of the key elements in the Case Care Management framework that are crucial to understand.

Case Care Management /Alternatives to Incarceration framework: It is important to know the Alternatives to Incarceration initiatives that exist in your jurisdiction and determine which program or programs would be ideal to integrate with Case Care Management.

Speaking of **key stakeholders**, please keep the results of the exercise we did earlier in this module, because they will be used again during the training and especially in Module 10.

There is also the question of **leadership**, that is, determining where Case Care Management should be deployed, and who the lead agency should be in that deployment. Establishing a steering committee should also be discussed. In the steering committee, you might want to have the actors who can work across agencies and overcome obstacles at an institutional level. These individuals will facilitate the creation of the Case Care Management function, and in time oversee the Case Care Management program.

We will also have opportunities to look into the **Case Care Management models**, exploring the building blocks and the nuances that can be considered while creating a model that will work best in your country.

Attention and consideration should be given to defining **roles and responsibilities** of each actor in Case Care Management so that there is clarity on what their job entails and on **program expectations**. It is also important to ensure overall transparency and clarity regarding program eligibility, participant obligations, and the consequences of non-compliance, termination, and successful program completion.



Reasons to invest in Case Care Management



At the systems level:

- To increase cooperation among stakeholders and prevent fragmentations
- To ensure smooth movement within or between system
- To facilitate engagement in the full treatment continuum of care and reintegration into the communities




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3.22



There are a number of reasons to invest in Case Care Management at different levels.

At the System-wide level, Case Care Management could help to:

- Increase cooperation among stakeholders, foster cohesion, and achieve better results while still optimizing resources.
- Prevent fragmentation.
- Increase coherence within or between systems.
- Contribute to retention of participants in treatment and integrating them into society.
- Provide support cross the entire continuum of care, specifically in the transition from one level of care to the next, and upon completion.



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MANAGEMENT**



At the participant level:

In the short term:

- Support, identify and prioritize participant strengths, needs and service options
- Create an individualized plan with the participant
- Facilitate timely access to treatment and needed services
- Follow up services and suggest changes to service plans/treatment plans as needed based on individual participant issues



3.23

Say

At the participant level, Case Care Management can have impacts in the short-term, as well as in the medium to long-term.

In the short-term, Case Care Management could help to:

- Ensure evidence-based screenings and assessment to guide care.
- Support participants in identifying their needs and options for treatment.
- Facilitate timely access to treatment and needed services.

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MANAGEMENT**

you can do it!

At the participant level:

In the medium/long term:

- Support participant's progress
- Enhance participant engagement and motivation
- Support participant in their recovery path
- Support social integration of participant

USA OAS CICAD

3-24



In the medium to long-term, Case Care Management could help to:

- Monitor the participant's progress.
- Ensure appropriate SUD treatment and other services.
- Enhance participant engagement and motivation in treatment.
- Support participants in building their recovery capital, maintaining a life in recovery, and achieving and maintaining autonomy.
- Work toward successful social reintegration (e.g., a stable job, income, housing, and becoming a productive member of society).



Summary: Case Care Management in the Justice System

In Summary, Case Care Management in the Justice System provides:

- Personalized attention to participants and a single point of contact.
- Coordination with services identified according to participants' strengths and needs.
- Follow up and provide continuous support overtime in the recovery and social integration.



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3-25

Say

Concluding this module 3, we would like to summarize the contribution of Case Care Management in the Justice System.

Case Care Management provides:

- Personalized attention to participants and a single point of contact.
- Coordination with services identified according to participants' strengths and needs.
- Follow up and provide continuous support overtime in the recovery and social integration.

MODULE 4



Defining Case Care Management

Preparation checklist

Content and timeline

Training goals and learning objectives

PowerPoint slides

Resource pages

MODULE 4

Module 4 Preparation Checklist

- Review the “Getting Started” section for general preparation information on page 13 of this manual.
- Preview Module 4.
- Prepare for the interactive exercise: assemble the following:
 - A stack of letter-sized (or A4-sized) paper for each table.
 - Pads of Post-it notes for each table.
 - Place colored markers and a stack of colored paper on each table.
- Bring copies of the Daily evaluation form - Day 1.

Module 4 Content and Duration

Activity	Time
Module 4- Defining Case Care Management	110 minutes
Presentation: Defining Case Care Management	10 minutes
Interactive Exercise: What does C stand for?	15 minutes
Presentation: Case Care Management and the Classic Case Management Models	20 minutes
Presentation: The Values of Case Care Management	15 minutes
Reflective Exercise: Case Care Management Definition	25 minutes
Presentation: The Critical Elements of Case Care Management	15 minutes
Wrap Up and Questions	10 minutes
Evaluation Day 1 and End of Day 1	5 minutes

Module 4 Goals and Objectives

Training Goals

- Work toward the definition of Case Care Management as a linkage.
- Present the Case Care Management core values.
- Present the Case Care Management critical elements.

Learning Objectives

Participants who complete Module 4 will be able to:

- Provide a definition of Case Care Management.
- Understand and describe the Case Care Management core values.
- Understand and describe the critical elements of Case Care Management.



DEFINING CASE CARE MANAGEMENT



Say

In this module, we will work together toward defining Case Care Management.



MODULE 4

Objectives

Work on a definition of Case Care Management

Provide an overview of the Case Care Management value system

Provide an overview of the critical elements of Case Care Management



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4.2

Say

After completing this session, you will be able to express your own definition of Case Care Management based on the elements we will be discussing and on group exercises.

You will also be able to describe the values and critical elements of Case Care Management.



Defining Case Care Management

- Specialized Case Management including elements of clinical care within the justice system, creating a service plan with the participant and facilitating linkages to treatment and re-entry services according to participants' needs.
- A range of services provided to assist and support participants in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services (NASMHPD)
- Case Care Management is based on a set of values, elements and functions including linkages and training for the patients, using community resources and monitoring service deliveries.



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4.3

Say

Case Care Management is a form of Specialized Case Management and builds upon the long and rich history of Case Management. Over the last 35 years, the term Case Management has been widely used to describe a method of service delivery and a set of roles assumed by a service provider. Case Management is also referred to as clinical case management, service coordination, or comprehensive psychosocial enhancement. The Case Care Management we are presenting is a new concept of clinical care within the justice system providing linkages to treatment and integration services according to participants' needs.

Over the last several decades, both clinical practice and empirical observation support findings that there is an increasing number of participants with substance use disorders (SUDs) entering the justice system for non-violent offenses. Case Care Management works with the participant, justice system, health system, and communities to assess strengths and needs, create a treatment and service plan, engage with the participant, make connections, and generating opportunities with the overall aim of increasing desistance and supporting social integration of individuals with SUDs.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). (2000) Comprehensive Case Management for Substance Abuse Treatment, Treatment Improved Protocols TIPS 27. Center for Substance Abuse Treatment, available at <https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215>

Another description of Case Management comes from the National Association of State Mental Health Program Directors (NASMHPD), which defines Case Management as “a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other

services essential to meeting basic human services.” This also includes providing “linkages and training for the participant served in the use of basic community resources, and monitoring of overall service delivery.”

Source: National Association of State Mental Health Program Directors Research Institute, Inc. (1996). Proposed new HCPCS procedure codes for mental health services [definitions]. Alexandria, VA: Author, 3. Available at <https://www.nasmhpd.org/node/1394>

As we will see in this module, Case Care Management is based on a set of values, elements, and functions.

The EMCDDA conducts research on prison and drugs in Europe. According to their findings in Europe, there are multiple nations with an increase in the number of participants with substance use disorders entering the justice system for non-violent offenses.

Source: EMCDDA. (2021). Prison and drugs in Europe. <https://www.emcdda.europa.eu/system/files/publications/13904/TDXD21001ENN.pdf>

“Some data on Substance Use During Imprisonment in Low- and Middle-Income Countries demonstrate that since the year 2000, prison populations increased by 60% in Oceania, by 80% in Central America, and by 145% in South America” (Mundt, Baranyi, Gabrysch, Fazel, 2018).

Source: Mundt, A., Baranyi, G., Gabrysch, C., Fazel, S. (2018). Substance Use During Imprisonment in Low- and Middle-Income Countries, *Epidemiologic Reviews*, Volume 40, Issue 1, Pages 70–81, <https://doi.org/10.1093/epirev/mxx016>

Research on Case Management and Recidivism based on the Oregon experience in the U.S. demonstrated that :

- “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.
- The need for intensive offender monitoring should decrease over time—shifting from a highly structured intervention with extensive external controls on relapse or re-offense 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.
- 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”.
- 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” (Travis, 1999)”.

Source: Travis, J. (1999). Case Management in the Criminal Justice System. National Institute of Justice. <https://www.ojp.gov/pdffiles1/173409.pdf>.



Training instructions: The trainer should refer to page 256 of the Participant Manual. The objective of the exercise is to warm up participants and engage their thinking. A co-trainer is needed to facilitate the discussion and write down the answers from the participant on the flip chart.

Say

You may have noticed that we refer to this course as Case Care Management and not as simply Case Management.

Ask

What do you think the C in Care stands for?



Say

The C in Care has multiple meanings, and we will go through them.

The C stands for **Health Care** because Case Care Management is connecting participants to health and treatment services as appropriate. Having the care aspect along with case helps clarify that it is not referring to normal case management. It makes clear for the justice authorities that Care is a key component and not a simple addition.

C stands for **Taking Care** of the participant. Case Care Management is working around the participants' needs, providing not just services, but listening to them in a non-judgmental way and supporting them in getting their lives back on track. This includes figuring out the participants' needs and opportunities.

C stands for **Challenges**: It refers to the challenges that the participant meets, the doubts, the economic difficulties, and the stigma, just to mention a few.

C stands for **Communities**: The communities are the place where we want the participant to be reintegrated. We want the participant to be a productive member of society and communities are an essential part of achieving this goal. They help support and sustain the participant, provide job opportunities, peer-to-peer support groups, spiritual assistance, and offer a positive model of leisure time.

C stands for **Coherence**: Case Care Management needs to provide a standardized process while securing a personalized intervention. How can you achieve that? By working on the core values. We will speak later about these core values that permeate Case Care Management.

C stands for **Critical Elements**, which are the steps of Case Care Management.

I would like to bring your attention to the most important C, which stands for the Participant.



Case Care Management and Classic Case Management Models

- Brokerage/generalist model
- Strength-based model
- Clinical rehabilitation model
- Assertive community treatment model



OAS CICAD



46

Say

Case Care Management builds upon classic models of Case Management, and elaborates them in a form of Specialized Case Management, creating a unique blend of values and function.

We will now see which elements have been fundamental, and which challenges have assisted us in finding better answers and solutions.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). (2000) Comprehensive Case Management for Substance Abuse Treatment, Treatment Improved Protocols TIPS 27. Center for Substance Abuse Treatment, available at <https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215>



The **Brokerage/generalist model** tries to identify participants' needs and helps participants access identified resources.

This model allows for a **quick-response approach** that provides immediate results to participants by linking them with programs or services that will provide ongoing support.

The brokerage/generalist model is, however, sometimes considered inferior because of the limited nature of the participant–**Case Manager relationship** and the **absence of advocacy**.

Case Care Management incorporates the following elements from the Brokerage/Generalist Model: The **participant remains at the center** of the process and much consideration and attention is provided to meet the participant's needs.

Throughout the assessment, planning, and referral involved in Case Care Management, the participant's needs are identified and responded to **in a timely manner**.

Based on the challenges of the Brokerage/Generalist Model, **Case Care Management** also adds the following to its model:

Participant advocacy is one of the Case Care Management elements and functions.

Case Care Management establishes a **genuine rapport with the participant** based on the utmost **respect**. This relationship continues **over time**, making the Case Care Manager the primary point of contact for the participant.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). (2000) Comprehensive Case Management for Substance Abuse Treatment, Treatment Improved Protocols TIPS 27. Center for Substance Abuse Treatment, available at <https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215>

Training instructions: Trainers could use their professional skills and their relational skills to draw these out and to talk through what the priorities are, and why those priorities were selected.



Say

The **Strengths-Based Model** was originally developed to help people with **persistent mental illness** move from institutionalized care to independent living.

The model provides participants with support for **taking direct control** over their search for resources, such as housing and employment.

It examines **participants' strengths** and determines the assets that they can use to obtain resources. The model emphasizes the participant-case manager relationship.

Case Care Management incorporates the following elements from the Strengths-Based Model: Case Care Management supports the participant in achieving an **independent life as a productive member of society**, staying away from problematic substance use, and being resilient with respect to criminal behavior.

In the planning step, Case Care Management assesses and builds upon participant strengths to create a **personalized and flexible treatment and service plan** to support the participant in achieving their personal and program goals.

Case Care Management creates a **strong participant-case manager rapport that lasts over time**.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). (2000). Comprehensive Case Management for Substance Abuse Treatment, Treatment Improved Protocols TIPS 27. Center for Substance Abuse Treatment, available at <https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215>

Training instructions: Trainers could add examples of the importance of the therapeutic alliance taken from their own experience to help relate with the participants.

Training instructions: Trainers could mention that reference page 4.2 is providing further information and a comprehensive overview of the models described.



Say

The Clinical/Rehabilitation approaches to Case Management are those in which **clinical (therapy) and resource acquisition (case management) activities are merged together and addressed by the same person.**

The Clinical/Rehabilitation approach has been widely used in the treatment of people with diagnoses of **both substance abuse and psychiatric problems.**

An advantage of this model is that the participant only has one **point of contact that manages everything.**

Caseloads should be light because providing multiple services is time-consuming. **This model is often used by default, because many SUD treatment programs do not hire people exclusively to provide case management services. In these cases, caseloads often remain high, which can cause counselor burnout.**

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). (2000). Comprehensive Case Management for Substance Abuse Treatment, Treatment Improved Protocols TIPS 27. Center for Substance Abuse Treatment, available at <https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215>

Training instructions: Trainers could link this model to desistance and recovery (D&R) models by talking about how in strengths models you use existing strengths to address unmet needs and in doing so you build empowerment.



The Assertive Community Treatment (ACT) Model involves contact with participants in their homes and natural settings.

It focuses on the **problems of daily living.**

Assertive advocacy is important.

Caseloads must be light.

The Case Manager and participant have frequent contact.

A team approach is followed with shared caseloads.

Case Managers generally **make a long-term commitment to their participants**, although there are now some time-limited adaptations of ACT.

ACT can be utilized for participants who face considerable barriers to accessing or engaging in treatment.

The ACT model has been used in the United States with people on parole that have a history of injecting drugs. Case Managers provided direct counseling services and worked with participants to help them develop skills to function successfully in the community. Case Management staff also provided family consultations and crisis intervention services. In addition, they operated group sessions to provide skills training in areas such as employment and relapse prevention.

ACT is a **high staff-intensive and time-intensive model.**

Based on the strengths of the Assertive Community Treatment Model:

Case Care Management **creates a genuine rapport with the participant** over time and engages with the participant in multiple settings, including their homes and communities.

Throughout the assessment, planning and referral steps of Case Care Management, the participant's immediate needs are identified and responded to in a timely manner, and referral services are secured as appropriate and discussed with the participant.

Case Care Management **engages with the participant and advocates for the participant** with multiple stakeholders such as the justice authority, service providers, and employers, just to mention a few.

Case Care Management **helps the participant understand and navigate the justice and health system in order to overcome barriers in accessing information and services.**

Case Care Management also **engages with the participant's family** and/or supportive network in the community, which are considered crucial elements for successful participant social reintegration.

Based on the challenges of the Assertive Community Treatment model:

According to specific country culture, Case Care Management might suggest the creation of a **two-person professional team to meet with the participant.**

Case Care Management recommends evaluating the maximum caseload to be handled according to the resources available and the institutional capacity.

Case Care Management **invests in initial and continuous training for Case Care Managers and suggests accessing supportive supervision to build up resilience.**

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). (2000) Comprehensive Case Management for Substance Abuse Treatment, Treatment Improved Protocols TIPS 27. Center for Substance Abuse Treatment, available at <https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215>

The Values of Case Care Management

CASECARE MANAGEMENT

Participant-centered and driven	Care-infused	Culturally grounded in humility
Crosscutting Advocacy Between and Among Various Systems	Single Point of Contact and Team Support	Community-based
Pragmatic	Realistic	Flexible

OAS/CICAD

Say

Case Care Management is defined by a set of core values:

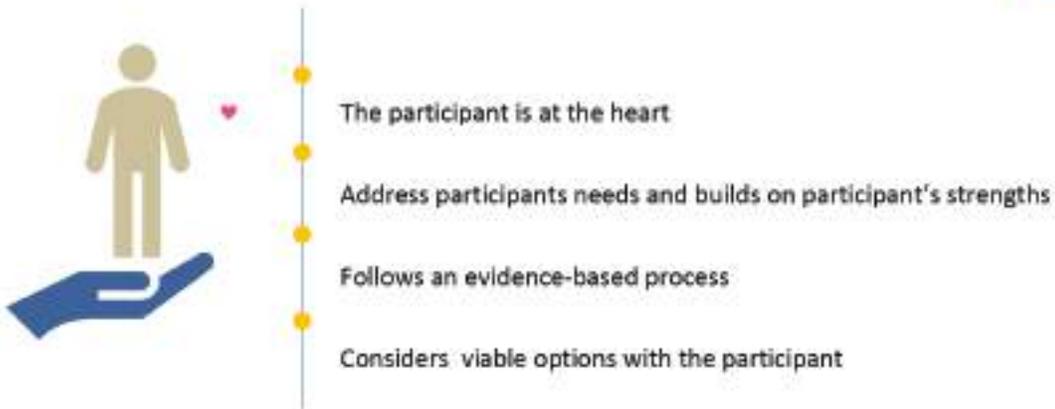
- Participant-centered and driven.
- Care-infused.
- Culturally grounded in humility.
- Crosscutting advocacy between and among various systems.
- Single point of contact and team support.
- Community-based.
- Pragmatic.
- Realistic.
- Flexible.

Say

Let's elaborate on each of these.



Participant-Centered and Driven



OAS



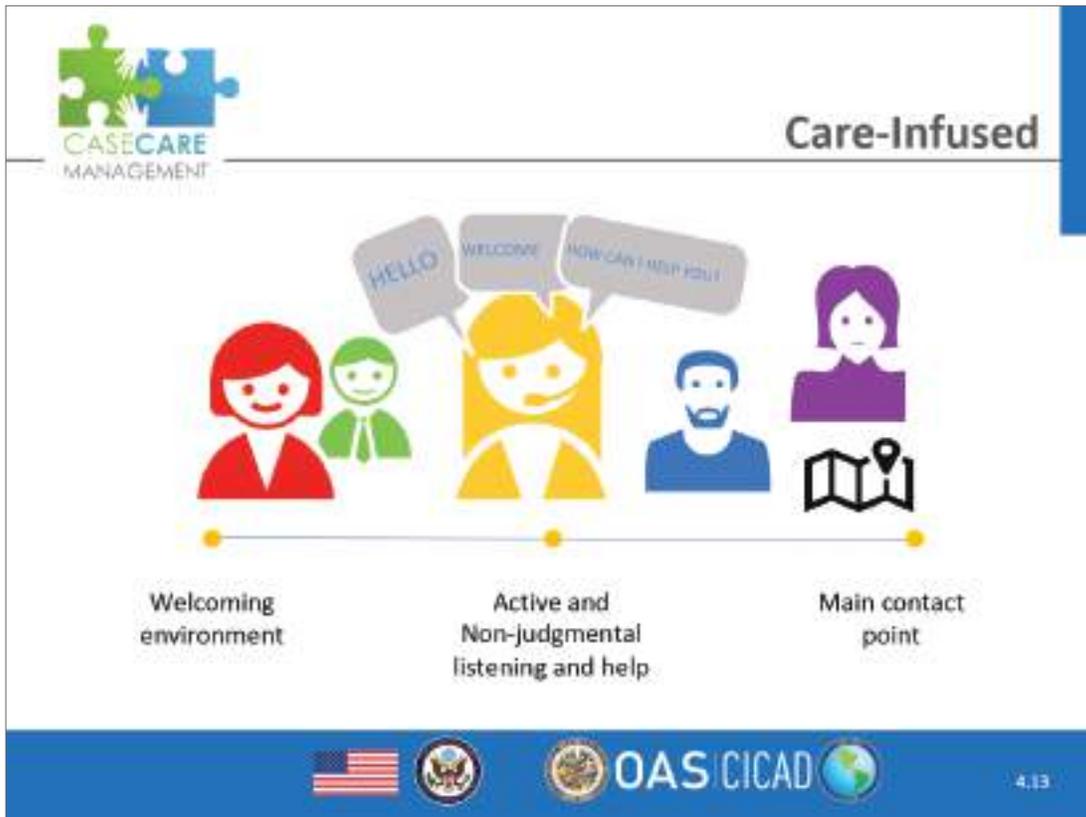
4.12

Say

The participant is at the heart of Case Care Management, and all actions are meant to serve the participant and their best interest.

Case Care Management responds to participants' needs and how they change over time, both in the near-term and in the medium to long-term.

Case Care Management helps the participant understand, identify, and clarify options based on evidence-based assessments, creating a treatment plan and referring them to relevant services.



Say

Case Care Management offers a welcoming environment, a feeling of understanding and care.

During the entirety of the Case Care Management process, the participant will feel welcomed, respected, and taken care of.

The participant will know who to contact and where to go in case of need.



Culturally grounded in Humility



Beyond cultural sensitivity

Based on interpersonal respect,
self-reflection and partnership

Recognizes participant
autonomy



OAS CICAD



4.14

Say

Cultural humility goes beyond simple cultural sensitivity.

Cultural humility has been defined as a long-life process of self-reflection, self-critiques, continual assessment of power imbalances, and the development of mutually respectful relationships and partnerships.

Cultural humility involves multiple elements such as motivation to learn from others, critical self-examination of cultural awareness, interpersonal respect, development of mutual partnerships to address power imbalances, and an openness to new cultural information.

Case Care Management appreciates and handles cultural differences with respect. It operates with cultural sensitivity, encouraging participants to be actively involved in the planning process, and recognizing them as the owner of their path towards recovery. It is particularly important to take note of the distinction between knowing and assuming, and to learn from the participant, listening, and questioning the possible prejudice in one's own mind.

Sources :

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, 9(2) 117-125.

Mosher, D. K., Hook, J. N., Captari, L. E., Davis, D. E., DeBlaere, C., & Owen, J. (2017). Cultural humility: A therapeutic framework for engaging diverse participants. *Practice Innovations*, 2(4), 221-233. <https://doi.org/10.1037/pri0000055>.



Crosscutting Advocacy



- Advocacy at multiple levels and with diverse stakeholders
- Awareness and training for service providers
- Regular communication
- Provides guidelines grounded in research



4.15

Say

Case Care Management advocates for participants at different levels within the justice system, public health system, and social services, always having their best interest in mind.

It constantly communicates with other systems or relevant stakeholders, helps participants navigate and understand the systems, and provides information and directions to access services.



Single Point of Contact



- Clear point of contact for the participant
- Ensures continuity
- Promotes coordination with other actors



OAS



4.16

Say

The participant can count on the Case Care Manager to be their single point of contact. Although there might be a team of people involved, a single person should be considered as this main point of contact for the participant.

The participant should know where to go and who to meet to ask questions. This also ensures continuity from the beginning to the end of the program.

A single point of contact promotes coordination with other actors such as health and social services or the justice authority.



Community-Based



- Develops relationships in the communities where participants live
- Assures that participants connect with key resources that will support their long-term integration
- Builds welcoming communities for their participants



4.17

Say

Case Care Managers connect with the community and visit participants in their own environment (e.g., home visits, meetings at the local café or for a lunch break near their job).

They also develop service agreements with treatment and recovery providers and social and health services agencies, as well as ensure smooth transition among services and treatment.

Case Care management works to create inclusive communities, overcome stigma, and build up acceptance and solidarity. The Case Care Manager should work towards becoming a well-known and respected figure throughout all of the systems (justice, health and social services and communities).



Pragmatic



- Understands priorities
- Works with participants to resolve specific, immediate issues
- Balances short-term focus with long-term focus



OAS



4.38

Say

Case Care Management helps prioritize needs and goals. It prioritizes understanding the aspects of participants' lives that need immediate attention and resolves specific, immediate issues, while still maintaining a long-term focus.



Realistic

- Understands SUDs
- Anticipates crisis and barriers
- Understands participants working at their own pace
- Works with participant to set realistic and manageable goals



OAS CICAD



4.19

Say

Case Care Management is realistic because it:

- Acknowledges and understands the natural course of an SUD as a process, which includes relapse.
- Foresees and addresses problems and coordinates with the treatment team in crisis prevention and crisis management.
- Understands and respects the participants' need to work at their own pace and set their own priorities
- Helps to set realistic and manageable goals, with built-in review and flexibility
- Includes the participant's perspective in the assessment and definition of success

Flexible

CASECARE
MANAGEMENT

- Adapts to individual's needs
- Constantly reevaluates progress and refocuses if needed

4.20



Case Care Management is flexible because it:

- Is able to adapt to each individual's needs and progress (or lack of thereof).
- Constantly reevaluates with continual assessment and, when no progress occurs or problems emerge, revises and refocuses.
- Drug treatment and recovery are not a linear journey. Be prepared for setbacks.
- A Case Care Manager knows what to do when a participant has a relapse. Case care managers do not drop participants who have a relapse, but rather finds ways to get them back on track



Reflective Exercise

Case Care Management Definition



OAS CICAD



4.21

Say

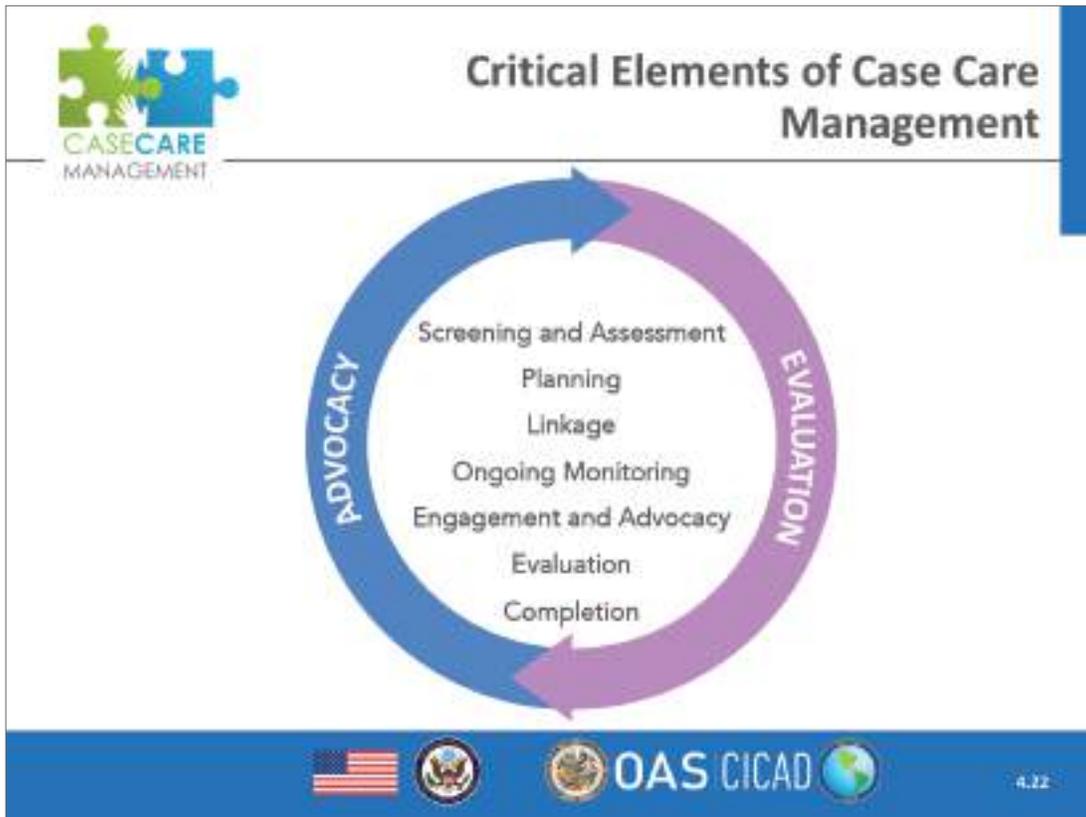
Now it is time to work on your own definition of Case Care Management. Please work alone for two minutes, reviewing the material of the module, and writing down your thoughts. Then get into groups to share ideas and write down a common definition for your group to be shared with all the participants.



The key questions to be addressed in the exercise are the following:

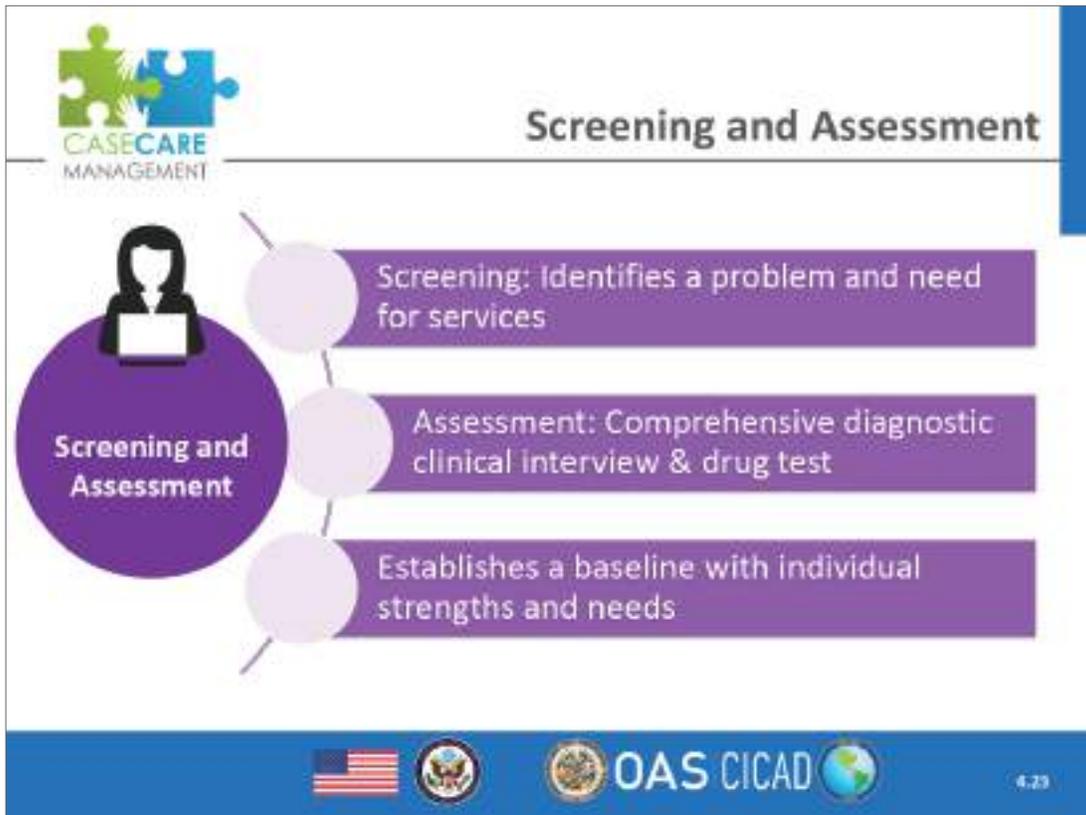
1. What, in your own words, is the definition of Case Care Management, brainstorming on the core values provided in Module 4?
2. Which definitions of Case Management are familiar to you and to your work?
3. Do you recognize some commonalities from programs in your country?
4. How do you see those commonalities working with Case Care Management?

Training instructions: Trainer should refer to page 256 of the Participant manual. Trainer should allow two minutes for personal reflection, 10 minutes for the group exercise, and the remaining time for reporting to the whole group and discussion. The total anticipated time for this exercise is 30 to 35 minutes.



Say

After analyzing the core values of Case Care Management, we will now focus on its critical elements, specifically its steps and functions. These include screening and assessment, planning, linkage, ongoing monitoring, engagement and advocacy, and evaluation and completion.



Say

Screening and assessment are not synonymous. They have different meanings, but are grouped together because they are closely linked to each other. The difference between screening and assessment is the following:

Screening tries to identify only whether a problem exists and what follow-up is needed.

Assessment tries to identify as closely as possible the nature of an SUD and other issues, and the level of intervention that may be needed. Assessment presents a comprehensive set of questions covering a range of fields to create a better understanding of participant needs and a realistic picture of the situation. It also includes a drug test.

Assessment is the foundation of Case Care Management. It works as a baseline for the other steps and for measuring a participant's progress.



Say

Based on the results of the assessment, Case Care Management planning should include identifying the participant’s main problems and strengths. Planning engages the participant in clarifying their personal goals, explaining program goals, and checking that they are on the same page. It also supports the participant in creating a treatment plan that matches their needs and the services available.



Say

In linkage, Case Care Management:

- Matches the participant with treatment and service providers based on the participant’s needs and service availability.
- Works to remove barriers and/or work around them efficiently.
- Secures a smooth transition to treatment for the participant.
- Makes “warm” referrals, ensuring that participants’ needs and expectations are met. When we speak about warm, we refer to the welcoming, non-judgmental, and problem solving-oriented attitude that makes the participants feel understood and taken care of.

The infographic is titled "Ongoing Monitoring" and is part of the "CASECARE MANAGEMENT" series. It features a central yellow circle with the text "Ongoing Monitoring" and icons of a scale of justice and two people. Three horizontal yellow bars extend to the right from the central circle, each containing a key point. The bottom of the infographic includes logos for the United States, the United Nations, and OAS/CICAD, along with a globe icon and the number "4-26".

Ongoing Monitoring

Regular communication with all stakeholders

Anticipates and addresses crisis, drop-outs and the causes

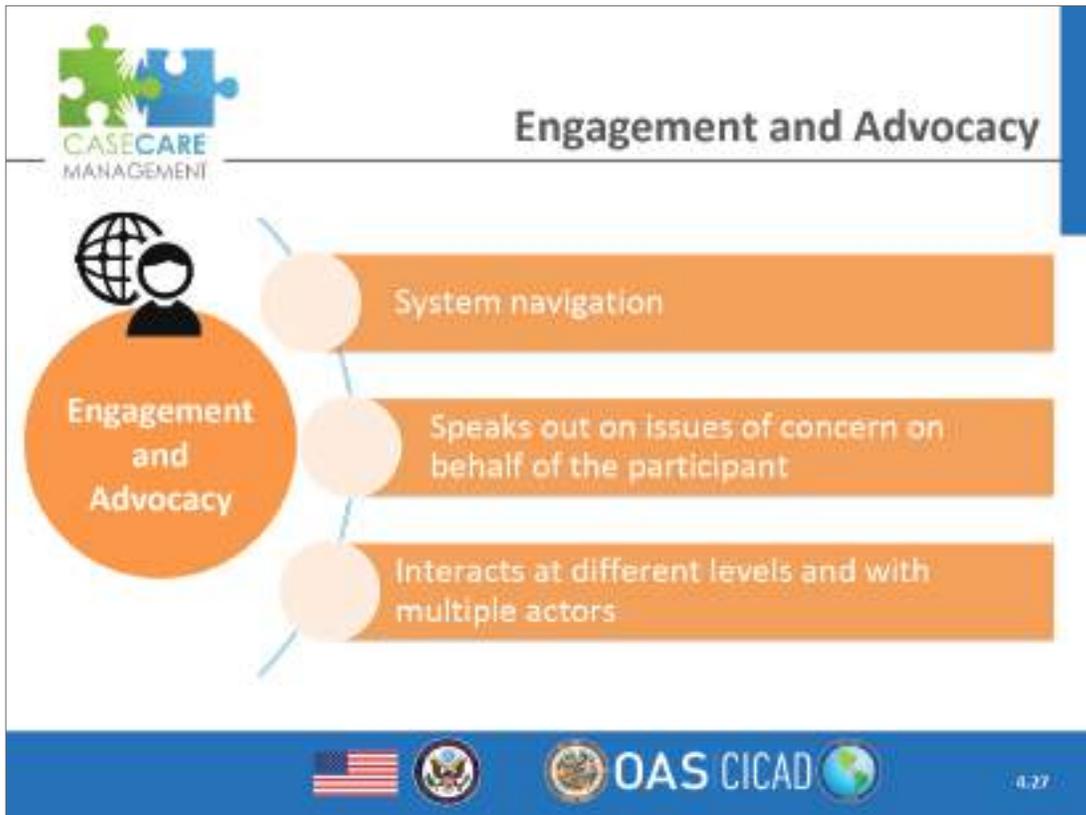
Ensure service are addressing established needs effectively

4-26



With respect to ongoing monitoring, Case Care Management:

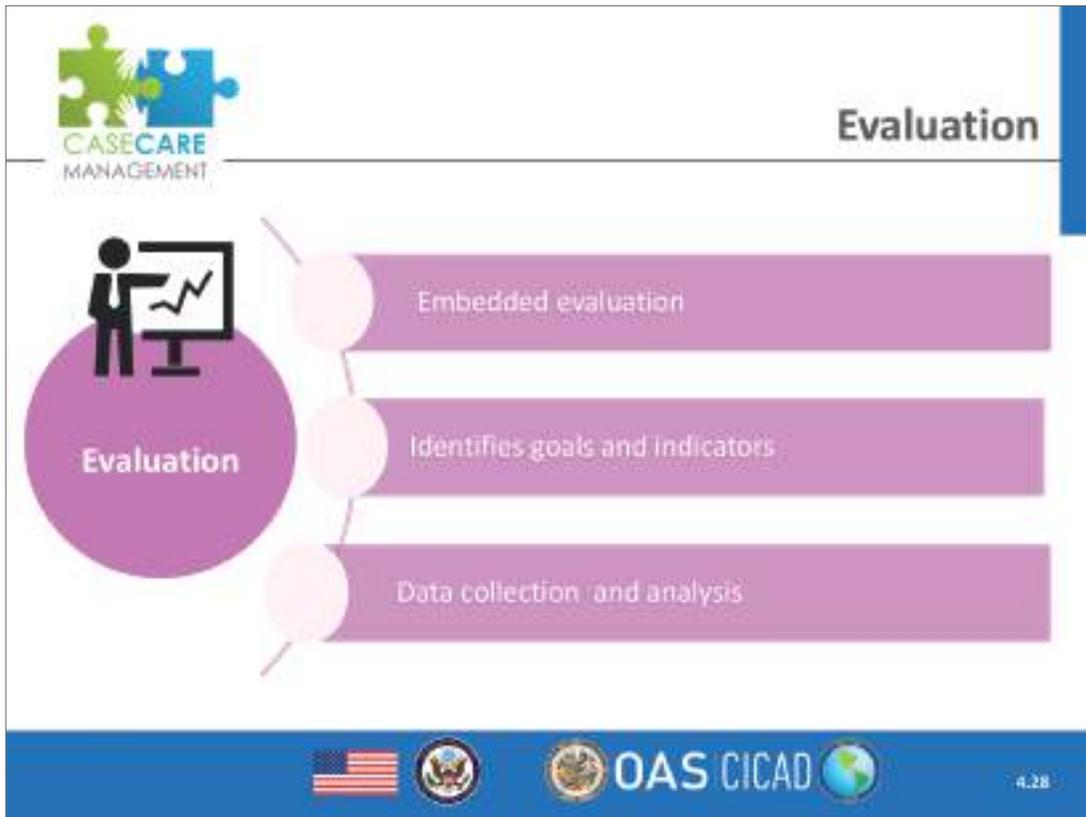
- Maintains constant communication with all stakeholders, including treatment and service providers, the participant, and justice system.
- Monitors relapse and treatment dropouts and their causes.
- Monitors the quality of services of the treatment providers and updates the referral registry accordingly.



Say

Engagement and advocacy are crosscutting elements in Case Care Management. They include:

- Educating participants to navigate the system and to acquire knowledge and life skills toward autonomy.
- Speaking out on issues of concern on behalf of the participant.
- Interacting at different levels in the systems and with multiple actors: in the justice and health system and in programs, families, and communities, always taking into account the best choice for the participant.



Say

Recurring evaluation is a key component of Case Care Management. Having an embedded evaluation system is useful to optimize resources. Being clear on what is important to evaluate and who the target audience is helps to create indicators and collect the right data. It allows for progress, easily identifies critical elements, generates statistics, and evaluates Case Care Management results.

Completion

CASECARE MANAGEMENT

NEXT LEVEL

Completion

Works with participant through program completion

Ensures transition to participant driven, long term community-based support

4-29

Say

According to program goals and expectations, Case Care Management will deal with program completion and inform the judicial authority and other key stakeholders of successful program completion. This depends on applicable local and national laws and on the degree to which Case Care Management is embedded within the justice system. In that case, “successful completion” of the program might mean avoiding new criminal charges for a certain period of time, termination of the charges, or treatment completion. Case Care Management works with participants through program completion (successful, neutral, and unsuccessful) and ensures transition to participant-driven, long-term, community-based support.

Creates a mechanism for reaching out to former participants to gather information on how they are doing during the social reintegration

Evaluates the long-term results of Case Care Management

**Say**

Follow-up activities after the program is completed are desirable but may depend on the individual program. There are cases where a follow-up after three, six, or twelve months with the participant is part of the evaluation program, but in others, the follow-up is not institutionalized and is left to personal initiative. Ideally, a follow up in the community would be an asset, but it should be included in the program planning to ensure that there are resources available and an opportunity to conduct it.

If the follow-up is embedded in the evaluation, it allows a measurement of the long-term results of Case Care Management in reducing recidivism and promoting successful reintegration.



Wrap up and Questions



OAS CICAD



4.31

Say

We have a few minutes before we close the session to answer questions you may have.

DEFINING CASE CARE MANAGEMENT

Resource page 4.1 Defining Case Care Management

Case Care Management is a form of Specialized Case Management and builds upon the long and rich history of Case Management. Over the last 35 years, the term Case Management has been widely used to describe a method of service delivery and a set of roles assumed by a service provider. Case management is also referred to as clinical case management, service coordination, or comprehensive psychosocial enhancement (Colombo Plan, 2017)

What is Case Management?

SAMHSA TIP 27. Definitions of Case Management (Colombo Plan, 2017)

- **Planning and coordinating** a package of health and social services that is individualized to meet a particular participant's needs (Moore, 1990).
- **"Helping people whose lives are unsatisfying or unproductive due to the presence of many problems which require assistance from several helpers at once"** (Ballew and Mink, 1996).
- "Monitoring, tracking and providing support to a participant, throughout the course of his/her treatment and after" (Ogborne and Rush, 1983)
- **Assisting the patient in re-establishing an awareness of internal resources** such as intelligence, competence, and problem-solving abilities; establishing and negotiating lines of operation and communication between the patient and external resources; and advocating with those external resources in order to enhance the continuity, accessibility, accountability, and efficiency of those resources (Rapp et al., 1992).
- **Assessing the needs of the participant and the participant's family**, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific participant's complex needs (National Association of Social Workers, 1992).

Over the last several decades, both clinical practice and empirical observations have supported findings that show increasing numbers of participants with substance use disorders (SUD) cycling in the justice system for non-violent offences. Case Care Management works with the participant, justice system, health system and communities to assess needs, create a treatment and service plan, engage with the participant, make connections and materialize opportunities with the overall aim to increase recovery and support social integration of individuals with SUDs."

Resource Page 4.2 How Case Care Management builds upon the classic Case Management Models

Case Care Management **includes some of the elements and functions of Case Management, creating a new participant centered model which is embedded in a multisystem approach** and includes multiple stakeholders to assess, plan and respond in a timely and appropriate manner to a participant's complex needs (including biopsychosocial factors, e.g. lack of housing, employment, education, social and family supports, and health and mental disorders including trauma-related disor-

ders). **Case Care Management advocates** for the participant and follows the participant's interest, engaging with the participant, promoting understanding of the justice and health system to secure access to treatment and services. Advocacy is one of the key features of Case Care Management, and is not limited to speaking on behalf of the participant but aims at creating services that fit the participant, rather than matching the participant with the existing services. **Case Care Management is community based and community oriented to achieve successful participant integration.**

BROKERAGE/GENERALIST MODEL

Key features of the Brokerage/Generalist Model (Colombo Plan 2012)

- Brokerage/generalist models try to **identify participants' needs** and help participant's access identified resources.
- This model allows for a **quick-response approach** that provides **immediate results** to participants by linking them with programs or services that will provide ongoing support.
- Planning may be limited to the participant's early contacts with the Case Manager rather than an intensive long-term relationship. Planning focuses on connecting the participant to another program or service.
- Ongoing monitoring, if provided, is fairly brief and does not include active advocacy.
- **The brokerage/generalist model is sometimes considered inferior because of the limited nature of the participant–case manager relationship and the absence of advocacy.**
- Nonetheless, this approach shares the basic foundations of case management and has proved useful in particular situations.

Case Care Management incorporates the following elements from the Brokerage/Generalist Model:

- **The participant is at the center of the process and much consideration and attention are provided to the participant's needs.**
- Throughout the steps of Case Care Management, assessment, planning and referral, **Case Care Management identifies and responds to participant's needs in a timely manner.**
- Planning is a critical element of Case Care Management: the participant is not passive, but engages and over time assumes increasing responsibilities, becoming the leading actor of change.

Based on the challenges of the Brokerage/Generalist Model, Case Care Management adds in its model:

- **Advocacy as one of the Case Care Management elements and functions**
- Case Care Management establishes a genuine rapport with the participant based on respect and continued relations overtime, with the Case Care Manager as the primary point of contact for the participant.

STRENGTHS-BASED MODEL

Key features of the Strengths-Based Model (Colombo Plan 2012):

- The strengths-based perspective of Case Management was originally developed to help people with **persistent mental illness** move from institutionalized care to independent living.
- The model provides participants with support for taking direct control over their search for

resources, such as housing and employment.

- **It examines participants' strengths and determines the assets they can use to obtain resources.**
- The Strengths-Based Model encourages use of **informal helping networks** (as opposed to institutional networks) to help participants take control and find their strengths.
- **The model emphasizes the participant–case manager relationship**

Case Care Management incorporates the following elements from the Strengths-Based Model:

- Case Care Management's ultimate goal is to **support the participant to achieve an independent life as a productive member of society, staying away from problematic substance use and being resilient to criminal behavior.**
- **Case Care Management works with a network of stakeholders in the multisystem approach to ensure that all participant's needs might find appropriate solutions, including employment and housing**
- Through the planning process, Case Care Management assesses and builds upon participant strengths to create **a personalized and flexible treatment and service plan** to support the participant to achieve their personal and program goals.
- Case Care Management creates a **strong participant-case manager rapport that lasts over-time.**

CLINICAL/REHABILITATION MODEL

Key features of the Clinical/Rehabilitation Model (Colombo Plan 2012):

- Clinical/Rehabilitation approaches to Case Management are those in which **clinical (therapy) and resource acquisition (case management) activities are joined together and addressed by the same person.**
- The Clinical/Rehabilitation approach has been widely used in the treatment of people with diagnoses of **both substance abuse and psychiatric problems.**
- An advantage is that the participant has only **one point of contact within a program.**
- Caseloads should be light, because providing multiple services is time-consuming.
- **This model is often used by default, because many SUD treatment programs do not hire people to provide only case management services. In these cases, caseloads often remain high which can promote counselor burnout.**

Based on the challenges of the Clinical/Rehabilitation model Case Care Management suggests keeping separate the roles of the Case Care Manager and therapist for the following reasons:

- **It might create confusion** in the handling of treatment services and Case Care Management.
- It leads to **case overload and occasional counselor burnout.**
- The double job is time consuming and not efficient in the short and long term.

Based on the strengths of the Clinical/Rehabilitation model:

- Case Care Management acts as a **main point of contact for the participant.**
- Case Care Management ensures that constant information is shared with the treatment provider and the justice authority as appropriate.
- **Case Care Management establishes a collaborative mechanism with the treatment pro-**

vider in the interest of the participant, monitors participant progress or lack thereof and suggests appropriate changes to the plan for the participant's consideration.

ASSERTIVE COMMUNITY TREATMENT MODEL (ACT)

- **Key features of the Assertive Community Treatment Model** (Colombo Plan 2012):
- ACT involves contact with participants **in their homes and natural settings**.
- It focuses on the **problems of daily living**.
- **Assertive advocacy is important**.
- Caseloads must be light.
- **The Case Manager and participant have frequent contact**.
- A team approach is followed with shared caseloads.
- Case Managers generally **make a long-term commitment to their participants**, although there are now some time-limited adaptations of ACT.
- ACT may be indicated for participants who face considerable barriers to accessing or engaging in treatment.
- **The ACT model has been used in the United States with people on parole** with histories of injecting drugs. Case Managers provided direct counseling services and worked with participants to help them develop skills to function successfully in the community. Case Management staff also provided family consultations and crisis intervention services. In addition, they operated group sessions to provide skills training in areas such as employment and relapse prevention.
- ACT is a **highly staff- and time-intensive model**.

Based on the strengths of the Assertive Community Treatment Model:

- **Case Care Management creates a genuine rapport with the participant** that lasts overtime and meets with the participants in multiple settings, including their homes and communities.
- Throughout the steps of Case Care Management, assessment, planning and referral, **Case Care Management identifies and responds to participants immediate needs in a timely manner and to participant's immediate needs and secures referral to services as appropriate and as discussed and planned with the participant**.
- **Case Care Management engages with the participant and advocates for the participant** with multiple stakeholders such as justice authorities, service providers, and employers, among others.
- **Case Care Management helps the participant understand and navigate the justice and health system in order to overcome barriers in accessing information and services**.
- **Case Care Management engages with the participant's family** and supportive network in the community, which provide crucial elements for successful social integration of the participant.

Based on the challenges of the Assertive Community Treatment model:

- According to country culture Case Care Management might suggest the creation of a **two person professional team to meet with the participant**.
- Case Care Management recommends **evaluating the maximum caseload** to be handled according to the resources available and the institutional capacity.
- **Case Care Management invests in initial and continuous training for Case Care Managers and suggests implementing supportive supervision for creating resilience**.

MODULE 5



Functions of Case Care Management

Content and timeline

Training goals and learning objectives

PowerPoint slides

Resource pages

MODULE 5

Module 5 Preparation Checklist

- Review the “Getting Started” section for general preparation information on page 13 of this manual.
- Preview Module 5.

Module 5 Content and Duration

Activity	Time
Module 5- Functions of Case Care Management	60 minutes
Presentation: The Functions of Case Care Management	50 minutes
Group Exercise: How to measure Case Care Management Success	10 minutes

Module 5 Goals and Objectives

Training Goals

- Present the functions of Case Care Management.
- Illustrate and analyze these functions providing an overview of how Case Care Management works in practice.

Learning Objectives

Participants who complete Module 5 will be able to:

- Understand and describe the functions of Case Care Management.
- Describe how the functions of Case Care Management are implemented.



MODULE 5

FUNCTIONS OF CASE CARE MANAGEMENT



OAS/CICAD 

5.1

Say

After defining Case Care Management, we will now analyze how the critical elements undergird the functions of Case Care Management.



MODULE 5

Objectives

Break down the Case Care Management critical elements and analyze the functions to understand how Case Care Management works in practice

Understand and describe the functions of Case Care Management in detail



OAS



5.2

Say

After completing this module, I expect you to understand the functions or steps of Case Care Management, and how Case Care Management works in practice. You will be able to name the functions and their order. Additional material is available in the resource page at the end of the module in your manual that will help you further understand what needs to be done to prepare for Case Care Management's daily work.

Training instructions: The trainer should prepare in advance and be familiar with all the resource pages in the chapter. He/she should also be able to direct the participants to this material during the presentation in order to answer questions from the audience.



Say

Here we see once again the critical elements of Case Care Management. Let's see how they work in practice.

Training instructions: The trainer might want to ask the participants if they are familiar with the steps of Case Care Management. Can they name the steps? Are they already implementing some of these steps?



Screening and Assessment



- Screening predicts participant suitability for the justice program and Case Care Management
- Assessment determines clinical and other services needed
- Participant consent is needed



OAS



54

Say

As we mentioned in the previous module, the difference between screening and assessment is the following:

Screening determines whether a problem exists, and what type of follow-up is needed. In our case, it determines whether the participant has an SUD and if he/she qualifies for the program.



There are a number of screening tools. Please refer to the list on *Resource Page 5.2 Case Care Management Screening Tools* (page 144 of your Participant Manual). There you can find some examples from the World Health Organization WHO and other international agencies. You might want to consider these examples for running preliminary screenings that could be used or adapted to your country.

Assessment is a detailed diagnostic. Before taking the assessment, the participant must be informed about the process and they must give their consent to share information with the justice system, treatment service providers, and other program partners.

Self-assessment from the participant might support in exploring their perception on where they are and what they need in terms of justice involvement and SUD. The self-assessment could provide useful information for Case Care Manager(s) to work and continue to aid with them throughout the process.



Say

On the slide, we can see some suggestions on the areas that should be explored during the assessment. The information gathered during the assessment is key to understand the participant’s situation and their needs and will create the baseline for all the following functions of Case Care Management and for monitoring progress.

Let’s have a quick look at these areas.



Training instructions: The trainer should read the categories and the subcategories aloud, engaging with participants and asking for feedback. The trainer should remind the participants that additional material on the assessment and examples of the interview areas can be found on the Resource *Page 5.3 Suggested Areas for Assessment (p. 144)* and Resource *Page 5.4 Example of Assessment Document (p. 146)* in their Participant Manual.



Ask What do we expect to learn from the assessment?

Say An overall picture of the SUD, including the primary substance, the level of use (past and current), and eventually any mental illness or trauma history. The assessment will also provide an overview of the most urgent basic needs to be met, such as critical medical conditions that require medical attention and basic needs such as housing, food, and clothes.

Assessing the general ability of the participant to function as well as the degree of individual support needed is important to determine which treatment and service options could be considered.

Assessment will also provide an overview of the participant's strengths and needs that can be addressed in service planning.



Ask

Which tools are needed? And which tools is the Case Care Manager expected to have or to create in this phase?

Say

The Case Care Manager should start compiling the participant file. It could be in paper or electronic format. It should contain the information that can be shared with the participant (e.g., information on participant rights, authorization to share information with organizations or individuals, consent to participate in the services) and the information that the Case Care Manager will compile over time.

Information related to the results of the assessment and the services suggestion, as well as the report for the justice authority, will be added to the participant file after completion of the assessment. It is important to remember that the participant file is the ultimate source of information and should always be kept up-to-date with information regarding the participant’s background and progress. All information should be found there and it should be updated after every meeting or conversation with the participant, with any news coming from the justice authority or service provider.



Training instructions: The trainer should mention *Resource Page 5.5 Example of Participant File at page 148 of the Participant Manual*. The trainer should also remind the participants that all of the documents in the resource pages are intended for training purposes, and could be used and adapted for Case Care Management pilot initiatives.



Planning with the Participant



- **Engaging with participant using motivational interviewing:**
 - OARS technique:
 - Open ended questions
 - Affirmation
 - Reflection
 - Summary
- Working together to define an individualized service plan
- Identifying suitable treatment and service match
- Identifying resources of care and payer
- Discussing participant's circle of care





5.8



The assessment identifies primary areas of strengths and needs. In the planning process, the Case Care Manager will work with the participant to create a service and life plan. Motivational interviewing skills could be used to engage the participant throughout the process. The acronym “OARS” stands for Open-ended questions, Affirmation, Reflection, and Summary. In Module 8, we will address the motivational interviews and provide more information on OARS.

The participant and Case Care Manager should work together to create an individualized service plan broken into achievable steps.

Options for treatment and other services are revised and included in the plan.

The participant and the Case Care Manager identify treatment and service matches based on the participant's needs and the services available in the referral service registry. Working with the participant, the Case Care Manager identifies potential resources for care and pay (including health insurance coverage, if it's available).

The Case Care Manager discusses with the participant possible collaboration with the participant's circle of care (e.g., family, friends, community members, spiritual leaders, and support groups).



Training instructions: The trainer should direct the participants to *Resource page 5.6 Planning and Engaging with the Participant: Goal Setting and Prioritizing* (on page 149 of the Participant Manual) for further information.



Say

What are the results of the planning? The Case Care Manager and the participant will have worked together to prepare a treatment and service plan that states the main goals and break them down into achievable and gradual steps. The plan should be highly individualized, take into consideration the participant’s needs, and be endorsed by the participant. The next steps would be to get in touch with the service provider to check on location availability and requirements.



Training instructions: The trainer should direct the participants to the *Resource Page 5.7 Example of Participant Plan* (on page 150 of the Participant Manual) which provides a concrete example on how to create a participant plan.

The results of the assessment, along with the plan, should be submitted to the justice authority as appropriate.

Some jurisdictions might also use a contract between the Case Care Manager, the participant, and the judicial authority to set out the terms and conditions of treatment and care. This ensures that everyone understands his or her respective responsibilities under the plan.

Ask

What do you think? How would it work in your country?

Training instructions: The trainer could initiate a brief and informal discussion on what would be feasible in the country. After the discussion, the trainer could reiterate that the participant file should always be kept up-to-date with information from the planning process with the participant, the report to the judicial authority, any information from the service providers, and any planned follow-up process.



Ask What about the tools that are needed in the planning?

Say The first tool should be a guided interview on the services that are needed to see if there is availability. In order to access this information, the Case Care Manager should have a referral service at hand.

We will elaborate more on this important tool in a moment. You can also find additional information on this on the resource page at the end of this module.

The referral service registry could be as simple as an Excel or Word document, or a more structured database. Either way, it should contain the information on the services available. It should not be limited to SUD and treatment services (although they are an essential part of it). It should also include information on service providers relevant to the participant.



Training instructions: The trainer should direct participants to the *Resource Page 5.8 How to Establish and Maintain a Referral Service Registry* (on page 151-152 of the Participant Manual), *Resource Page 5.9 Examples of Referral Services Database for Case Care Management* (on page 153-157 of the Participant Manual) to have them read the descriptions, the suggested services, and the examples provided. If times allows, ask participants for feedback and encourage them to share their thoughts.

After discussing the referral service registry, the trainer introduces the participant plan and the examples in the resource page.

The trainer should conclude by mentioning that the participant file needs to be continuously updated.



- Case Care Management prepares for a **warm referral**:
 - Preparation is key
 - Assesses if accompanying the participant is needed
 - Follows up with treatment and service providers regularly



Say

The next step is linking the participant to appropriate services. Case Care Management aims to have a “warm” referral. What does that mean? A “warm” referral means that all the aspects are taken care of and prepared in advance so that when the day arrives everything goes smoothly:

The Case Care Manager will have contacted the participant, reminding them about the appointment, contacted the arranged treatment provider, and have other services arranged and prepared for the appointment.

The Case Care Manager will have checked in on available transportation or arranged transportation for the participant as needed.

The Case Care Manager will know at this point if the participant would need to be accompanied when entering the relevant services, and will make the necessary arrangements to meet the participant’s needs. One example would be accompanying the participant while checking in for residential treatment.

The Case Care Manager should also always follow up with treatment and service providers after the referral and maintain regular communication with them.



Training instructions: The trainer should direct participants to the *Resource Page 5.10 Key Points for Case Care Managers When Making Referral* (on page 157 of the Participant Manual).



As a result of the planning preparation, the Case Care Manager will ensure that the participant is welcomed in the services needed in a timely and successful manner.



The Case Care Manager has the following tools to work with:

The referral service registry to consult and find the information needed to make the links happen.

The public transportation map (if applicable) to assess services available to the participant and to decide if there is a viable option to get to the appointment.

In the case that there is not a viable public transportation option, the Case Care Manager should explore options and costs for private transportation to be arranged.

The participant file is always a helpful resource to check on information regarding the participant while preparing linkages. It should be kept updated with the results of the referral.



Ongoing Monitoring



- Supporting the participant
- Following up regularly with the participant
- Touch base on engagement and progress
- Based on progress, the service plan may be adjusted



OAS CICAD



5.14

Say

The idea behind monitoring is to assist the participant in achieving their personal and progress goals. Remember, the participant is always the focus. We want to encourage the Case Care Manager to be fully supportive of the participant.

The Case Care Manager follows up regularly with the participant.

The frequency of contact depends on the participant's needs. It could be once a week, or once a month. At the beginning and during times of crisis and transition periods, the frequency is normally more intensive.

The Case Care Manager will follow up on:

- The participant's engagement in services
- The participant's progress
- Preventing crisis, relapse, or drop out
- Remember that the service plan is flexible and should be used to track progress. Based on the progress, the service plan may also be adjusted.

After each appointment with the participant, the Case Care Manager will update the file and records and follow up with the treatment provider to share relevant information and check in on the participant's progress.



Training instructions: The trainer should direct participants to the *Resource Page 5.11 Monitoring and Follow Up* (on page 158 of the Participant Manual).



Record keeping is an important aspect of Case Care Management because it shows professionalism, transparency, and accountability.

It can be time consuming and expensive to retrieve information for reporting to the supervisor or the judicial authority. Efficient record keeping can save substantial time and effort.

It could also be an asset in the billing process, or when applying for (or being audited for) licensing or accreditation purposes.

The Case Care Manager should always update:

- The participant file after an appointment with the participant and a follow-up with the treatment provider.
- The Referral Service Registry with relevant information on the treatment and service providers, noting any issues that arose.
- The participant treatment/service plan according to progress or situations that might occur.



CASECARE
MANAGEMENT

Tools



Set of questions to be asked as a follow up with participants

Set of questions to be asked as a follow up with treatment and service providers



OAS CICAD

5.16



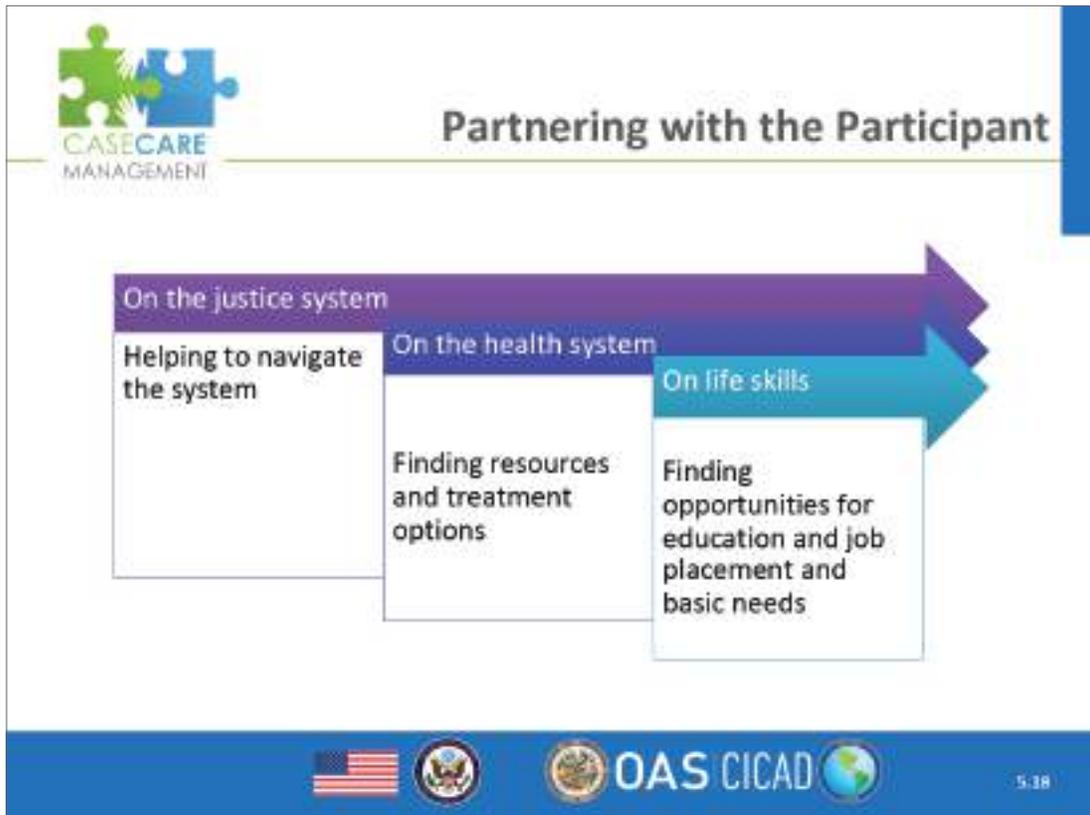
It could be helpful for the Case Care Manager to create a standardized set of questions to ask the participant and treatment provider, so that he/she stays on top of the participant's progress toward achieving personal and program goals.



We have said before that engagement and advocacy are crosscutting functions in Case Care Management and are present throughout the Case Care Management process.

Advocacy is both a value and a function and requires constant work.

The Case Care Manager engages with the participant, but also learns from the participant. The participants are experts on themselves too, not just us, and the Case Care Manager aims to advocate on behalf of the participant at different levels and with a diverse range of stakeholders.



The Case Care Manager partners with the participant and educates the participant on the justice system.

They help the participant to navigate the system, comply with program obligations, and educate them on the health system.

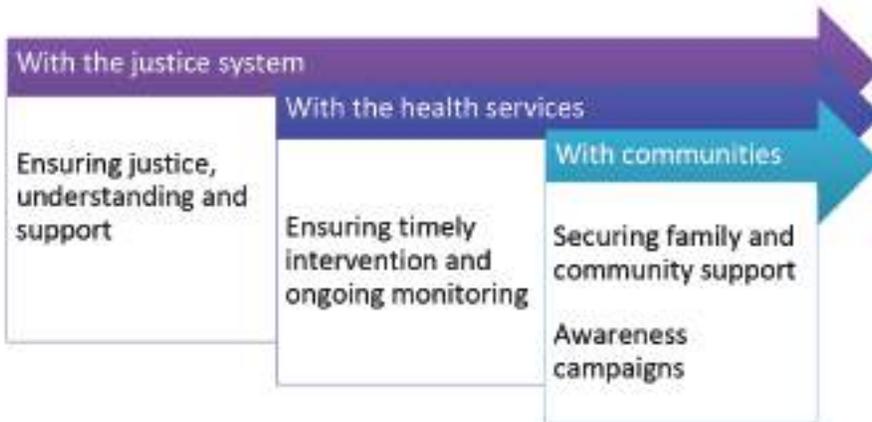
They support the participant in finding the right treatment options, finding resources to pay for treatment (e.g., applying for or keeping and accessing health insurance, asking family for support, exploring financial aid options).

Life skills include, but are not limited to:

- Assisting the participant in obtaining services to address their educational needs.
- Job placement.
- Basic needs such as housing, food, etc.



Advocating for the Participant



OAS CICAD



5.19

Say

A Case Care Manager advocates on behalf of the participant.

A Case Care Manager advocates with the justice system by:

- Ensuring that the judicial authority has a clear understanding of the participant's needs and challenges, making culturally appropriate decisions regarding program acceptance, progress, and completion.
- Securing the judicial authority's support to reinforce program requirements.
- Connecting the participant with health services.
- Ensuring timely placement that meets the participant's needs.
- Ensuring participant progress is supported and achieved.
- Ensuring a connection to the community.
- Advocating with families and communities to secure services and resources that support long-term recovery.
- Awareness campaigns supporting understanding and buy-in for recovery and social integration for the participants.



Evaluation



- Considers embedded evaluation
- Optimizes data collection on progress and creates statistics on results
- Considers audience, program and personal goals and indicators



5.20



Effective evaluation in Case Care Management can be beneficial for securing funding and achieving long-term program sustainability.

While establishing Case Care Management, consider building-in embedded evaluation mechanisms that could optimize the data collection process and critical elements, creating statistics and providing results.

When creating the evaluation, there should be clarity as to the purpose. It should discuss the audience, the program, and personal goals and indicators.

Training instructions: The trainer should inform the participants that monitoring and evaluation will be further addressed in more detail during Module 9 of the training.

Findings on the Treatment Alternatives for Safer Communities (TASC) specialized case management model suggest that combining clinically focused, multisystem service coordination with treatment placement and recovery management offers a unique participant service approach and increases the chances of a medium-long term social integration (TASC, 2019).

Source: TASC. (2019). TASC Specialized Case Management. https://www.tasc.org/tascweb/tertiary_page.aspx?ID=39



Interactive Exercise

How To Measure Case Care Management Success



OAS CICAD



5.21



Training instructions: The trainer should prepare in advance and direct participants to page 256 of the Participant Manual.

The trainer could invite the participants to work in groups and discuss the following questions:

1. What is the main goal of Case Care Management?
2. Who is the audience? What is the institution or figure that Case Care Management should report to?
3. Which indicators would be relevant to demonstrate the success of the program?

After the group exercise, the trainer asks a representative from each group to share their conclusion with the rest of the participants.

Let's have a look at this picture highlighting possible indicators for individual success. In the following slides, we will see possible indicators for Case Care Management success:



Say

- No new criminal charges filed
- Recovery plan established
- Substance-free over time
- Housing
- Positive interpersonal relations
- Education and employment
- Achievement of participant identified goals
- Treatment completion
- Self-perception, how does the participant feel about oneself?

Training instructions: The trainer should stimulate the discussion by including feedback from the previous exercise and highlight that evaluation is a key component of Case Care Management for presenting program results, validating program achievement, and securing sustainability and resources in the medium and long-term.

The trainer should also underline that it is up to each country to come up with objectives to be achieved; therefore, these topics are suggestions that should be considered and adapted to the actual country framework.



Case Care Management Success



Success with Case Care Management can include:

- Successful social integration of participants
- No participants returning to the justice system
- Family reunification

Defining the success of Case Management based on the system indicators:

- Number of cases
- Reduction on recidivism
- Relapse rate
- Average time for linkage
- Level of collaboration with stakeholders



OAS CICAD



5.23

Say

Some indicators for measuring in Case Care Management programs can include:

- Successful social reintegration of participants.
- No participants returning to the justice system.
- Defining the success of Case Management based on the system indicators.
- How many cases are handled?
- What is the rate of recidivism in the participants?
- How prevalent is an SUD in the participants/drug testing results?
- How long does it take to refer participants to treatment?
- What is collaboration with other stakeholders like (justice authority, treatment, health, and social services)?
- Family reunification



Case Care Management Success



Performance indicators:

- Treatment completion
- Stable housing
- Education or employment
- Recovery champions
- Absence of new charges, arrests or run ins in the justice system
- Collaboration mechanism with stakeholders



OAS CICAD



5.24

Say

Additionally, we could also include the following indicators:

- Treatment completion/progress in treatment/treatment retention factor.
- Stable housing/housing support.
- Education or employment/rate of unemployment.
- Recovery journey and recovery champions in the communities (substance-free life/length of abstinence).
- Absence of new criminal charges.
- Collaboration mechanism with stakeholders.
- Relationship and communication with justice authority.
- Relationship and communication with treatment providers.
- Relationship and communication with social services.



Completion



- Compliance with program completion criteria
- Report completion to relevant justice authority
- Certificate of completion
- Linkage to next level of care, when needed
- Open door policy



OAS



CICAD

5.25

Say

Program completion criteria needs to be defined by the judicial authorities when establishing Case Care Management and should be directly linked to the ATI program that they are supporting or service that they are referring to within or beyond the program itself.

“Warm” termination is recommended, as well as keeping an open-door policy in case the participant needs to step back and ask for help with or without the justice system involved.



Wrap up and Questions



OAS CICAD



5.26

Training Instructions: The trainer should summarize the steps of Case Care Management and open the floor to questions from participants.

FUNCTIONS OF CASE CARE MANAGEMENT

Resource page 5.1 Summary of the Case Care Management Functions

Screening and Assessment

- **Screening** determines whether a problem exists, and what type of follow up is needed.
- Screening in Case Care Management determines whether the participant has a SUD and if they qualify for the program.
- **Assessment** It is a detailed diagnostic review of all the participant's needs, not just one aspect of their condition.
- Assessment establishes a baseline for measuring a participant's progress because there is a record of the participant's condition at the start of treatment.
- Before undertaking the assessment, the participant must be informed about the process and their consent is requested in regards to sharing information with the justice system, treatment and service providers and other program partners.
- The expected results of the assessment are an overall picture of the SUD, an overview of the most urgent basic needs to be met, the general ability of the participant to function, as well as the degree of individual support needed.
- Assessment also provides an overview of the participant's strengths and needs that can be addressed in service planning.

Planning

- In planning, the Case Care Manager will work with the participant to start creating a service and life plan.
- Motivational interviewing skills are used to engage with the participant throughout the process.
- The participant and Case Care Manager work together to create an individualized service plan broken into achievable steps.
- The participant and the Case Care Manager identify treatment and service matches based on the participant's needs and services available in the referral service registry.
- The Case Care Manager and the participant identify potential resources for care and payment (including health coverage if available).
- The Case Care Manager discusses with the participant possible collaboration with the participant's circle of care (family, friends, linkages with the community, spiritual leader, support groups, etc.).

Linkage

- Linkage is connecting with the services needed.
- The Case Care Manager hopes to have a warm referral, preparing for linkages in advance so everything goes smoothly:
 - The Case Care Manager contacts the participant, reminding them about the appointment, contacting treatment and other services arranged and preparing for the appointment.
 - The Case Care Manager checks in on available transportation or arranges transportation for the participant.
 - The Case Care Manager will know at this point participants that would need to be accompanied when utilizing services and will make the necessary arrangements to meet the needs of the participants. One example would be accompanying the participant when checking in for residential treatment.
- The Case Care Manager should also always follow up with treatment and service providers after the referral and have regular communication with them.
- As a result of excellent planning, the Case Care Manager will see that the participant is timely and successfully utilizing the services needed.

On-going monitoring

- On-going monitoring is a process of assisting the participants in achieving their personal and progress goals.
- The Case Care Manager follows up regularly with the participant. The frequency of contact depends on the participant's needs. At the beginning, and during crisis and transition periods, the frequency is normally more intense.
- The Case Care Manager will touch base on:
 - Participant's engagement in services
 - Participant's progress
 - Preventing crisis, relapse or drop out
- The Case Care Manager is aware that the service plan is flexible and will track progress and adjust or amend the plan if needed.
- After each appointment with the participant, the Case Care Manager will update the file and records and follow up with the treatment provider to share relevant information and check in on participant progress.

Engaging and advocacy

- Advocacy is both a value and a function. It implies constant work throughout the Case Care Management process.
- The Case Care Manager engages with the participant, but also learns from the participant. The participants are experts in their own right.
- The Case Care Manager partners with the participant and educates the participant on the justice system and service options. The Case Care Manager's responsibilities include:
 - Helping the participant navigate the system and comply with program obligations;
 - Educating the participant on the health system;
 - Supporting the participant in finding the right treatment options;
 - Finding resources to pay for treatment, applying for, or keeping and utilizing health insurance, asking for family support, and exploring financial aid options; and
 - Assisting the participant in obtaining services to address their needs in education, job placement and basic needs such housing, food, etc.
- The Case Care Manager advocates on behalf of the participant:
 - With the Justice System: ensuring justice authorities have a clear understanding of the participants' needs and challenges ensuring culturally appropriate decisions regarding program acceptance, progress and completion and securing justice support to reinforce program requirements;
 - With the Health Services: ensuring timely placement that meets the participant's needs and ensuring the participant's progress is supported and achieved;
 - With the Communities: advocating with families and communities to secure services and resources that support long term recovery.

Evaluation

- Effective evaluation in Case Care Management could be beneficial in securing funding and achieving long term program sustainability.
- When establishing Case Care Management, consider building upon embedded evaluation mechanisms that could optimize the data collection process and critical elements, creating statistics and providing results.
- In creating the evaluation, the purpose should be clear. The following elements should be discussed: audience, program and personal goals and indicators.

Completion

- Completion is the last step of Case Care Management.
- Program completion criteria needs to be defined by the justice authorities when establishing the Case Care Management program.
- The Case Care Manager should report on successful completion to justice authorities, according to the indications provided in the program framework.
- Upon program completion, the participant should be awarded a certificate of completion or referred to the next level of care, when appropriate.
- Warm termination and an open-door policy are recommended in case the participant needs to step back and ask for help with or without justice system involvement.

Resource page 5.2 Case Care Management Screening Tools

There are a number of screening tools available as free resources on the web. The following list is meant to provide an overview, but it is not exhaustive of the resources that could be used.

Adapted from: National Institute of Drug Abuse <https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools>.

SUD – Assist Screening Tools

ASSIST- Screening test WHO

https://www.who.int/substance_abuse/activities/assist_test/en/

NIDA modified ASSIST (NM ASSIST)

<https://www.drugabuse.gov/nmassist/>

Screening to Brief Intervention (S2BI)

<https://www.drugabuse.gov/ast/s2bi/#/>

Brief Screener for Tobacco, Alcohol and other Drugs

<https://www.drugabuse.gov/ast/bstad/#/>

TAPS- Tobacco, Alcohol, Prescription medication, and other Substance use Tool

<https://www.drugabuse.gov/taps/#/>

CRAFFT

The CRAFFT is a well-validated substance use screening tool for adolescents aged 12-21. It is recommended by the American Academy of Pediatrics' Bright Futures Guidelines for preventive care screenings and wellness visits. <http://craftt.org>

Mental Health Screening Tools

- Brief Jain Mental Health Screen (BJMHS)
- Correctional Mental Health Screen (CMHS)
- Mental Health Screening Form III (MHSF-III)

Trauma History and Post Traumatic Stress Disorders

- Life Stressor-Checklist (LSC-R) or Life Events Checklist for DSM-5 (LEC-5)
- Posttraumatic Diagnostic Scale (PDS)
- Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)

Psychological Tests to Diagnose Personality Traits and Disorders

Minnesota Multiphasic Personality Inventory (MMPI), (MMPI2) and (MMPI 3)

Source: University of Minnesota (2022). The Minnesota Multiphasic Personality Inventory 3 (MMPI3).

<https://www.upress.umn.edu/test-division/MMPI-3>

Thematic Apperception Test (TAT)

Source: Stern, T. (2016). Understanding and Applying Psychological Assessment. ScienceDirect. <https://www.sciencedirect.com/topics/neuroscience/thematic-apperception-test>

Myers Briggs Type Indicator (MBTI).

Source: McDermott, N. (2022). Myers-Briggs Type Indicator: What To Know About This Popular Personality Test. Forbes Health. <https://www.forbes.com/health/mind/myers-briggs-personality-test/>

Rorschach Inkblot Test

Source: Frothingham, M. (2021). Rorschach Inkblot Test: Definition, History & Interpretation. <https://www.simplypsychology.org/what-is-the-roorschach-inkblot-test.html>

Resource page 5.3 Suggested Areas of Assessment for Case Care Management

Source: Adapted from Case Management for Addiction Professionals, Trainer Manual, developed for the U.S. Department of State Bureau for International Narcotics and Law Enforcement Affairs (INL) 2012 (Colombo Plan 2012)

This document is for training purposes only.

A thorough assessment includes collecting the following information about the participant:

1. Background and current status

- Family situation and relationships
- Trauma history

- History of domestic violence (either as a batterer or as a survivor)
- Marital status
- Cultural, racial/ethnic identity
- Sexual identity
- Religious affiliation
- Past and present legal involvement
- Financial and work situations
- Education
- Housing status
- Employment status
- Strengths and resources
- Goals for treatment

2. Past and current substance use

- Age at first use
- Substances used (including alcohol)
- Amounts used
- Method of use (e.g., injection, orally)
- Patterns of use
- Consequences of use
- Treatment episodes
- Family history of substance use problems

3. Medical conditions or complications, such as:

- Injection-related medical issues
- HIV/AIDS
- Tuberculosis
- Hepatitis
- Sexually transmitted diseases
- Liver disease
- Physical disability
- High blood pressure, diabetes, and other health problems

4. Emotional/behavioral/cognitive status

- Family history of mental health problems
- Participant history of mental health problems, including diagnosis, hospitalization, and other treatment
- Current symptoms and mental status
- Medications and history of medication adherence (medication may affect behavior, adherence or nonadherence to medication regimens can provide some idea of how well a participant will follow through in other areas)
- Cognitive function (e.g., Does the participant have a cognitive deficit? Will they be able to remember appointments? Can they understand and follow through with directions?)

5. Readiness to change (this needs to be reassessed often)

- Where is the participant in the stages of change cycle?
- What is the participant ready to work on? (Some participants will prefer one case management option, but not another.)
- How ready are they to take a step toward change?

6. Relapse or continued use potential (related to readiness to change)

- How is the participant managing cravings?
- Can they identify personal relapse triggers?
- What is the participant's recovery environment?
- What kind of support do they have for recovery?
- Are they still spending time with friends or family members who use drugs or alcohol?
- Does their family support recovery?

7. Immediate threats to the participant's safety—Is the participant:

- Expressing thoughts of suicide?
- Threatening harm to someone else?
- In danger?

Suspicious of immediate danger should be investigated by asking questions: Do you feel safe at home? Do you feel safe in your current relationship? Is someone threatening you now or making you feel unsafe?

8. General ability to function

- Ability to obtain and follow through on medical services
- Ability to apply for benefits on their own
- Ability to obtain and maintain safe housing
- Skill in using social service programs
- Skill in accessing mental health and substance abuse treatment services

Assessing these areas of functioning helps the Case Manager determine the participant's strengths, degree of impairment, and barriers to the participant's recovery. These areas can be assessed by asking the participant about his or her past experiences (e.g., When did you last see a doctor? Did you make the appointment yourself? Are you receiving government benefits? Did you complete the application yourself?). The Case Care Manager may have to perform many services on behalf of the participant until the participant can master these skills.

9. Vocational skills

- Basic reading and writing skills
- Ability to follow instructions
- Ability to arrange for necessary transportation
- Manner of dealing with authority
- Ability to be punctual
- Communication skills

Of course, assessment also includes evaluating participant strengths and recovery capital. Additional information on recovery capital have been provided in Module 2 of this course.

Resource Page 5.4 Example of Assessment document for Case Care Management

This document is for training purpose only.

Source: Adapted from Sample Screening Questions to Help Determine Need for Case Management Services and Level of Case Management Services Needed. New York State, Department of Health, 2011.

Participant Name: _____ ID #: _____

Date of Screening: _____ Staff: _____

1. **Presenting Problem(s)/Immediate Needs** (Do you or your family members need help with any urgent or pressing problem right now?)
2. **Other Case Care Management Providers** (What other agencies are you working with? What services do they provide you? Are you working with a case manager or receiving case care management anywhere else? Where, and with whom? Are these services meeting your needs?)
3. **Fluency in _____ and Ease in Navigating Care Systems** (Do you have any difficulty understanding _____? Filling out forms in _____? Do you find it easier to talk to service/care providers with someone translating for you? Do you have any trouble making your own appointments, understanding instructions, getting what you need from any type of service agencies?)
4. **Immigration Issues (if appropriate)** (Are you a citizen or documented resident? If not, do you need help with immigration issues?)
5. **Housing** (Do you have any problems with your current housing? Is your housing safe and stable? Is your housing in good repair, with adequate furniture and working appliances? Do you have a working phone? Do you already have or need assistance paying rent/upkeep?)
6. **Collateral Needs/Disclosure Issues** (Do your children, partner(s), or other close supports have needs that affect your ability to get treatment? Do you have a steady source of emotional support from family and friends? Do you need any help telling anyone (loved ones, partners, etc.) that you have substance use concerns?)

7. Medical Coverage/Insurance/Resources for Medical Care (Are you covered for medical costs by any type of medical insurance? Do you need help getting your medical care or medications paid for? Do you have any problems, limitations, or restrictions with your current coverage?)

8. Medical Needs (How is your health right now? Are you currently experiencing any symptoms or disabilities? Do you have any illnesses? How recently have you seen your medical providers? Are you able to make and get to your appointments easily? Do you need any help getting your prescriptions filled and taking your medications?)

9. Source of Income/Employment Situation (Do you have a steady source of income right now? Does your income meet your basic expenses? Do you have any serious outstanding bills? Do you need any help applying for or keeping your benefits?)

10. Current Legal Charges/Incarceration (Are you on parole or probation? Currently serving any type of sentence [i.e., community service hours]? Any outstanding warrants, summonses, cases pending?)

11. Mental Health (Have you ever seen a mental health counselor? Received psychiatric care? Are you currently seeing a mental health counselor? Are you currently prescribed medications for depression or other mental health concerns? Who do you speak to when you feel down?)

12. Domestic Violence (Do you ever feel unsafe in your current living situation? Do you ever feel you or a family member/partner would resort to force when interacting? In the past have you ever been involved in a violent relationship?)

13. Substance Use (Are you currently using drugs or alcohol? If so, are you currently enrolled in treatment? Do you consider yourself in recovery? If currently using, do you believe you need substance use treatment or other support?)

14. Basic STD/HIV Education/Health Care Support (Do you have questions about HIV infection and AIDS? What works for you and what doesn't when it comes to safer sex [safer drug use]? Do you want to work with someone to help you learn techniques to reduce the risk of transmitting the virus to others or getting exposed to other infections?)

15. Supportive Service Needs (How is your diet lately? Do you have a regular source of healthy food? Are you maintaining your weight? Do you need help obtaining groceries or meals? Do you have enough clothing to keep you comfortable and protected? Can you get transportation from your home to your appointments/grocery store easily? Do you need a referral for legal help?)

16. Vocational/Educational Needs (How do you rate your reading and writing skills? Do you ever have difficulty following verbal or written instructions? How do/did you get along with supervisors? Are you normally on time and punctual to work and appointments?)

17. Transportation/Telephone/Computer/Internet Skills (How did you get here today? Do you rely on others for your transportation needs? What is the best way to reach you? How do you contact persons when you need help or assistance? Who do you contact when you need help or assistance?)

SUMMARY

MAIN AREAS OF INTERVENTIONS:

- 1.
- 2.
- 3.

LINKAGES/REFERRAL SUGGESTIONS:

- 1.
- 2.
- 3.

FOLLOW UP ACTIONS

- 1.
- 2.
- 3.

Resource Page 5.5 Example of Participant File for Case Care Management

Source: Adapted from Case Management Skills and Practices, Trainer Manual, developed for the U.S. Department of State Bureau for International Narcotics and Law Enforcement Affairs (INL) 2017 (Colombo Plan 2017)

This document is for training purposes only.

Name:
Referral source: Self() Other:
Immediate needs:
SUD assessment:
Summary of prior treatment and responses:
Justice Authority/criminal records/current charges:
Level of motivation:
Strengths:
Needs:
Key results from the assessment/Problem identification:
Suggested referral to treatment:
Justice Authority feedback:
Important updates:
Summary of the discussion from the last appointment (to be written after each appointment):
Next appointment (to be updated after each appointment):

Resource page 5.6 Planning and Engaging with the participant: Goal setting and Prioritizing for Case Care Management

Source: Adapted from Case Management for Addiction Professionals, Trainer Manual, developed for the U.S. Department of State Bureau for International Narcotics and Law Enforcement Affairs (INL) 2012 (Colombo Plan 2012)

This document is for training purposes only.

Goals are general statements from the participant about what they are hoping to get out of the treatment experience (e.g., “I want to get a job”; “I want a closer relationship with my family”) (Colombo Plan 2012) Each goal, especially a long-term goal (e.g., completing schooling), should be broken down into short-term objectives.

Objectives are the actions to be taken to achieve a goal or to address barriers to goal achievement.

Effective objectives are:

- Specific (*What exactly will you accomplish?*)
- Measurable (*How will you know when you have accomplished an objective?*)
- Attainable (*Is achieving this objective realistic with effort and commitment? Do you have the resources to achieve this objective? If not, how will you get them?*)
- Relevant (*Why is this objective significant to your life? Do you value it?*)
- Time- specific (*When will this objective be achieved?*)

Distinct, manageable objectives keep people from feeling overwhelmed and provide a benchmark against which to measure progress.

The Case Care Manager can help the participant break down goals into manageable, measurable objectives by asking questions such as:

- *What will be your first (or next) task?*
- *What will you do in the next 1 or 2 days (weeks)?*
- *What have you already been doing to achieve this goal? What else can you do?*
- *Who can help you?*
- *On a scale of 0–10, how confident are you that you will do this next task?*

Objectives need to be prioritized. A participant in recovery can easily be overwhelmed by working on too many objectives at the same time. Generally, objectives can be prioritized in the following order:

- Emergencies (including life-threatening situations, e.g. serious illness, suicidal thoughts, life-threatening withdrawal symptoms from opioids or CNS depressants, family violence or abuse, and disaster situations).
- Basic needs (e.g. housing, food, employment and money needs, transportation and safety)
- Other needs (e.g. general medical care, child-care, schooling, planning and goals for the future)

Meeting participants’ emergency and basic needs is a priority. The Case Care Manager can help participants prioritize objectives or next tasks by asking questions such as:

- *What would you like to work on first?*
- *Which of the objectives that we’ve talked about are most important to you?*
- *Which of these objectives do you think you can achieve first?*
- *Which of these objectives do you think will help you most in your recovery?*

Other important elements of setting objectives include:

- Identifying needed resources (including referrals) and support;
- Identifying possible barriers to and solutions for achieving objectives;
- Learning a process for systematically setting goals;
- Understanding how to achieve desired goals and objectives through the accomplishment of smaller objectives;
- Gaining mastery of themselves and their environment through brainstorming ways to overcome possible barriers to a goal or objective; and,
- Experiencing the process of accessing and accepting assistance from others in setting goals and attaining them.

These and other outcomes make planning and setting goals and objectives as important as the final outcome in some cases: It's about the process not just the desired results.

Resource page 5.7 Example of Participant plan for Case Care Management

Source: adapted from the Case Management Skills and Practice, Trainer Manual developed for the U.S. Department of State Bureau for International Narcotics and Law Enforcement Affairs (INL) 2017 (Colombo Plan 2017)

This document is for training purpose only

Participant name: _____

Program admission date: _____

Next review date: _____

Type of goal	Progress	Completion
SUD Treatment: Obj 1: Obj 2: Obj 3:		
Health (Physical/Mental/General Care): Obj 1: Obj 2: Obj 3:		
Social integration Goal: Obj 1: Obj 2: Obj 3:		
Continuing Care/Recovery Support Goal: Obj 1: Obj 2: Obj 3:		
Family: Obj 1: Obj 2: Obj 3:		
Housing: Obj 1: Obj 2: Obj 3:		
Basic needs (food/transportation, etc.): Obj 1: Obj 2: Obj 3:		
Educational and Vocational Goals: Obj 1: Obj 2: Obj 3:		
Employment: Obj 1: Obj 2: Obj 3:		

Legal charges: Obj 1: Obj 2: Obj 3:		
Religious/Spiritual/Recovery Goal: Obj 1: Obj 2: Obj 3:		
Sport and Leisure Obj 1: Obj 2: Obj 3:		

My signature affirms that I actively participated in this planning and I received a copy.

Participant/DATE: _____

CASE CARE MANAGER/DATE: _____

SUPERVISOR/DATE: _____

Resource page 5.8 How to establish and maintain a Referral Service Registry for Case Care Management

Source: adapted from the Case Management Skills and Practice, Trainer Manual developed for the U.S. Department of State Bureau for International Narcotics and Law Enforcement Affairs (INL) 2017 and Case Management Skills and Practice, Trainer Manual developed for the U.S. Department of State Bureau for International Narcotics and Law Enforcement Affairs (INL) 2017 (Colombo Plan 2017)

Case Care Managers need to create and maintain a Referral Service Registry; a database or list containing updated and reliable information on governmental agencies, nongovernmental organizations, faith-based organizations, and support groups that provide services that are relevant for the participants. These resources may be local, regional or national organizations.

The **following steps** are critical to establish a referral network. These steps include:

1. **Identifying all potential service needs of the participant population and categorizing them.** These organizations should include but are not limited to:

- **Treatment programs for substance use disorders (SUDs)** (residential, hospital based, outpatient);
- **Treatment programs for mental disorders** (crisis care, hospital based, outpatient);
- Resources for general **medical care**;
- **HIV/AIDS services** (voluntary counseling and testing and medical services, including antiretroviral treatments);
- **Legal services**;
- **Family therapy services**;
- **Family planning** and other services for pregnant and postpartum women;
- **Housing programs** (housing financial assistance, halfway houses, transitional living programs);
- **Educational and training programs**;
- **Vocational services programs** (job referral, sheltered workshops for those with mental or physical disabilities, job skills training);
- Programs offering general **financial assistance**; and,
- **Community peer support groups** for those with SUDs (Narcotics Anonymous, etc.), those living with AIDS, and other special populations, such as women, female and male sex workers, and men who have sex with men.

2. Identifying **reliable resources** within the Case Care Manager's **geographical areas of work**.

3. **Choosing appropriate agencies** as referral resources.

4. When creating a Referral Service Registry, the Case Care Manager should include **comprehensive information about each organization**, including its location, target audience, criteria for admission, how it accepts referrals, and potential barriers.

Examples of suggested information to be collected include:

- Name, address, office hours, phone numbers;
- List of services;
- Experience with participants with substance abuse problems;
- Experience with special populations;
- Availability; and,
- Costs.

5. The Case Care Manager should also **personally follow up with each referral agency** to ensure that the **following actions are in place before the participant can be referred to the services**.

- Identify the appropriate person to contact.
- Find out if a letter of introduction is appropriate.
- Set up a meeting, if appropriate; otherwise, visit and observe.
- Learn the referring agency's policies and procedures.
- Discuss the participant's specific needs that must be met and the demographics of the participant population.

How to maintain the Referral Service Registry for Case Care Management

The Case Care Manager is responsible for maintaining updated information on the Referral Service Registry. The following actions are suggested:

- The Case Care Manager should update any relevant information on the Referral Service Registry after a conversational meeting with the service provider.
- The Case Care Manager should update information on contacts and details on the registry if aware of staff changes in the service providers.
- The Case Care Manager should check the Referral Service Registry regularly, minimum once a month, and revise the information, especially on location changes, changes in the hours of operations, or if a program has closed and is no longer available.
- Update the Referral Service Registry when the Case Care Manager finds a new service provider or is aware of the termination of activity of an established service provider.
- Update the section related to costs of treatment and availability or waiting list.

In particular, the Case Care Manager should make sure the following information in the database remains current:

- Name of the organization
- Address
- Contact person
- Hours of operation
- Telephone number and mail address
- List of services provided
- Service area/locations
- Program capacity
- Criteria for admission
- Costs

Resource page 5.9 Example of Referral Services Database for Case Care Management

Source: adapted from the Case Management Skills and Practice, Trainer Manual developed for the U.S. Department of State Bureau for International Narcotics and Law Enforcement Affairs (INL) 2017 and Case Management Skills and Practice, Trainer Manual developed for the U.S. Department of State Bureau for International Narcotics and Law Enforcement Affairs (INL) 2017 (Colombo Plan 2017)

This document is for training purposes only.

Case Care Management Referral Service Registry	
SUBSTANCE USE DISORDERS TREATMENT	Comments/Special Issues:
Name of organization:	
Address:	
Contact person:	
Phone/Email:	
Hours of operation:	
List of services provided:	
Experience with special population:	
Multiple locations:	
Service area:	
Criteria for admittance:	
Availability/Waiting List:	
Program capacity:	
Costs:	
Other:	
TREATMENT FOR MENTAL HEALTH DISORDERS	Comments/Special Issues:
Name of organization:	
Address:	
Contact person:	
Phone/Email:	
Hours of operation:	
List of services provided:	
Experience with special population:	
Multiple locations:	
Service area:	
Criteria for admittance:	
Availability/Waiting List:	
Program capacity:	
Costs:	
Other:	
MEDICAL CARE	Comments/Special Issues:
Name of organization:	
Address:	

Contact person:	
Phone/Email:	
Hours of operation:	
List of services provided:	
Experience with special population:	
Multiple locations:	
Service area:	
Criteria for admittance:	
Availability/Waiting List:	
Program capacity:	
Costs:	
Other:	
HIV/AIDS SERVICES	Comments/Special Issues:
Name of organization:	
Address:	
Contact person:	
Phone/Email:	
Hours of operation:	
List of services provided:	
Experience with special population:	
Multiple locations:	
Service area:	
Criteria for admittance:	
Availability/Waiting List:	
Program capacity:	
Costs:	
Other:	
LEGAL SERVICES	Comments/Special Issues:
Name of organization:	
Address:	
Contact person:	
Phone/Email:	
Hours of operation:	
List of services provided:	
Experience with special population:	
Multiple locations:	
Service area:	
Criteria for admittance:	
Availability/Waiting List:	
Program capacity:	

Costs:	
Other:	
FAMILY THERAPY SERVICES	Comments/Special Issues:
Name of organization:	
Address:	
Contact person:	
Phone/Email:	
Hours of operation:	
List of services provided:	
Experience with special population:	
Multiple locations:	
Service area:	
Criteria for admittance:	
Availability/Waiting List:	
Program capacity:	
Costs:	
Other:	
FAMILY PLANNING SERVICES	Comments/Special Issues:
Name of organization:	
Address:	
Contact person:	
Phone/Email:	
Hours of operation:	
List of services provided:	
Experience with special population:	
Multiple locations:	
Service area:	
Criteria for admittance:	
Availability/Waiting List:	
Program capacity:	
Costs:	
Other:	
HOUSING PROGRAMS	
Name of organization:	
Address:	
Contact person:	
Phone/Email:	
Hours of operation:	
List of services provided:	

Experience with special population:	
Multiple locations:	
Service area:	
Criteria for admittance:	
Availability/Waiting List:	
Program capacity:	
Costs:	
Other:	
EDUCATIONAL TRAINING PROGRAMS	Comments/Special Issues:
Name of organization:	
Address:	
Contact person:	
Phone/Email:	
Hours of operation:	
List of services provided:	
Experience with special population:	
Multiple locations:	
Service area:	
Criteria for admittance:	
Availability/Waiting List:	
Program capacity:	
Costs:	
Other:	
VOCATIONAL SERVICES PROGRAMS	Comments/Special Issues:
Name of organization:	
Address:	
Contact person:	
Phone/Email:	
Hours of operation:	
List of services provided:	
Experience with special population:	
Multiple locations:	
Service area:	
Criteria for Admittance:	
Availability/Waiting List:	
Program capacity:	
Costs:	
Other:	
FINANCIAL ASSISTANCE	Comments/Special Issues:

Name of organization:	
Address:	
Contact person:	
Phone/Email:	
Hours of operation:	
List of services provided:	
Experience with special population:	
Multiple locations:	
Service area:	
Criteria for admittance:	
Availability/Waiting List:	
Program capacity:	
Costs:	
Other:	
COMMUNITY SUPPORT GROUPS	Comments/Special Issues:
Name of organization:	
Address:	
Contact person:	
Phone/Email:	
Hours of operation:	
List of services provided:	
Experience with special population:	
Multiple locations:	
Service area:	
Criteria for admittance:	
Availability/Waiting List:	
Program capacity:	
Costs:	
Other:	

Resource page 5.10 Key Points for Care to Case Management When Making Referrals

The Case Care Manager appreciates the importance of ensuring that the participants will be timely and successfully referred to services. The term *warm referral* is often used to define the preparatory work undertaken by the Case Care Manager to prepare for this transition, making sure that the following aspects will be addressed:

Identifying Possible Barriers: The Case Care Manager and the participant should discuss possible barriers as a follow-up to the referral, asking questions such as: *Can you see any reason why this might not work for you?* There may be a number of possible barriers, such as emotional factors (shame, fear, sense of powerless and distrust) and more concrete reasons, such as lack of money or child care. The Case Care Manager might want to use problem solving techniques to help the participant find ways to address barriers.

Preparing an information package for the participant: Participants need to be prepared for referrals and

should know what to expect. The Case Care Manager can prepare an information package for the participant, and the information for the referral will be analyzed together and questions will be answered.

Some of the basic and necessary information to be included in the package are:

- The name of the program
- The name of the contact person
- The phone number
- The address
- A brief description of the services the program provides
- The operating hours of the program facility
- Any fees charged
- The admission process

The Case Care Manager might develop additional tools to be added to the registry and might have a ranking of the preferred and priority referrals for easy use of the referral guide.

Additional aspects to be considered are the following:

- Differentiate the situations in which the participant needs to be accompanied to the appointment with the service provider by the Case Care Manager and the cases where it is appropriate to send the participant alone.
- Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality regulations and professional standards of care.
- Evaluate the outcome of the referral and complete an observation in the participant file and in the referral registry as appropriate (Colombo Plan 2012)

Resource page 5.11 Monitoring and Follow Up

The Case Care Manager should follow up and regularly contact the service provider after the referral to check on participant progress and to gather relevant information on the service provider that should be used to update the Referral Service Registry (Colombo Plan 2012).

The following are examples of the information that could be useful to collect after the referral:

- Feedback from the participant on the linkage process and how welcomed the participant felt by the service provider.
- Feedback on the barriers that the participant expects and how to overcome them.

For the Case Care Manager, part of the follow up process is continuing to support and engage with the participant by:

- Exchanging relevant information with the service provider, always respecting privacy and confidentiality standards;
- Being informed on recovery progress, and problems inhibiting progress to ensure quality of care, gain feedback, and plan changes in the course of treatment;
- Coordinating all treatment and social services activities provided to the participant by other resources; and,
- Periodically reviewing the participant's goals and making other referrals as needed.

MODULE 6



Models of Case Care Management

Preparation checklist

Content and timeline

Training goals and learning objectives

PowerPoint slides

Resource pages

MODULE 6

Module 6 Preparation Checklist

- Review the “Getting Started” section for general preparation information on page 13 of this manual.
- Preview Module 6.
- Prepare for the interactive exercise: assemble the following:
 - A stack of letter-sized (or A4-sized) paper for each table
 - Pads of Post-it notes for each table
 - Place colored markers and a stack of colored paper on each table

Module 6 Content and Duration

Activity	Time
Module 6- Models of Case Care Management	95 minutes
Presentation: Models of Case Care Management	15 minutes
Embedded interactive exercises on Case Care Management Models	15 minutes
Presentation: International Examples of Case Care Management	60 minutes
Reflective Exercise: Case Care Management Models	5 minutes
Lunch	60 minutes

Module 6 Goals and Objectives

Training Goals

- Present the different types of and options for Case Care Management.
- Illustrate international examples of Case Care Management from the Americas and Europe.

Learning Objectives

Participants who complete Module 6 will be able to:

- Understand and describe the different types and options for Case Care Management.
- Describe international models of Case Care Management



MODULE 6

MODELS OF CASE CARE MANAGEMENT



OAS | ICAD 

6.1

Say

Module 6 analyses the models of Case Care Management, as well as the elements and building blocks that make up the model.



MODULE 6

Objectives

Understand and describe the different types of Case Care Management:

- Embedded vs. Independent
- Centralized vs. Decentralized
- Publicly funded vs. Privately funded

Discuss which Case Care Management Model will work best in your country



OAS CICAD



6.2

Say

By the end of this module, I expect you to be able to describe the different options for creating a Case Care Management model. You will also have formed an idea of which model could work best in your country. You will also have the opportunity to discuss these issues with your colleagues and share your views with the group.



6 Key Features of the Case Care Management Models



OAS CICAD

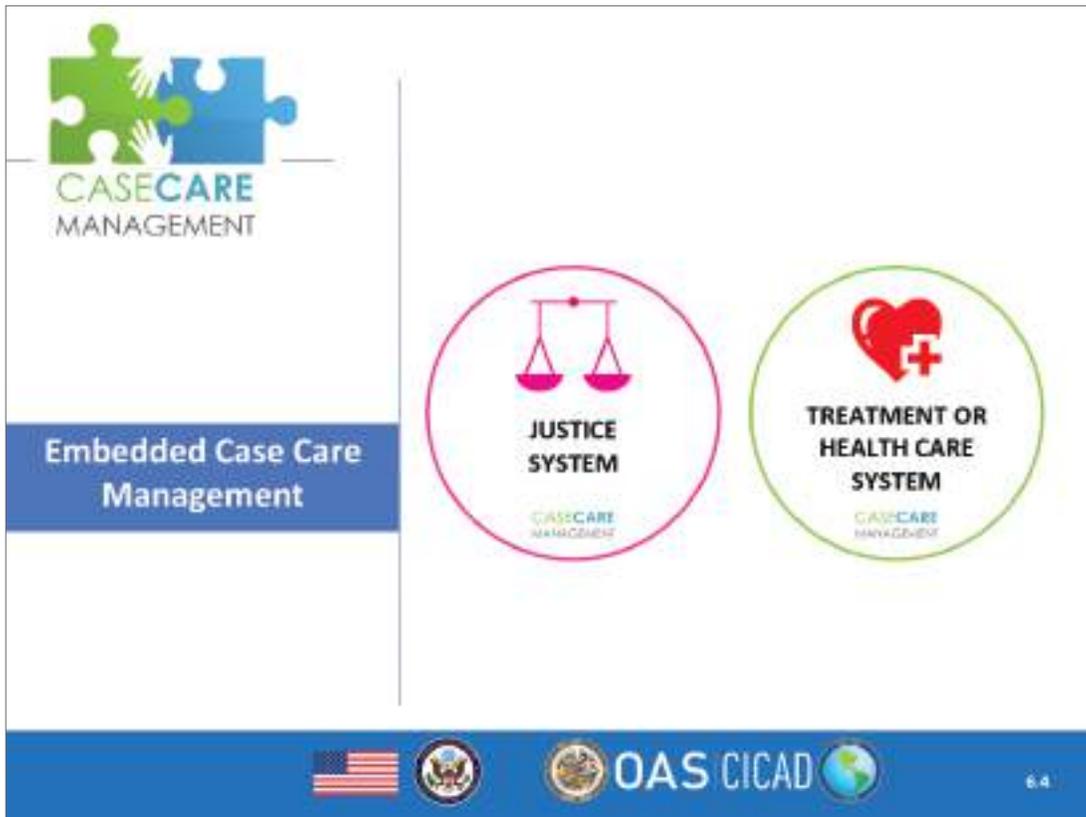


6.9

Say

There are three levels of Case Care Management models we should look at. There is the system level, the operational level, and the funding level. In each level, there are two options, leading to a blend of possible combinations and nuances for building your own model.

We will start looking at the system level where we have two options: embedded and independent.



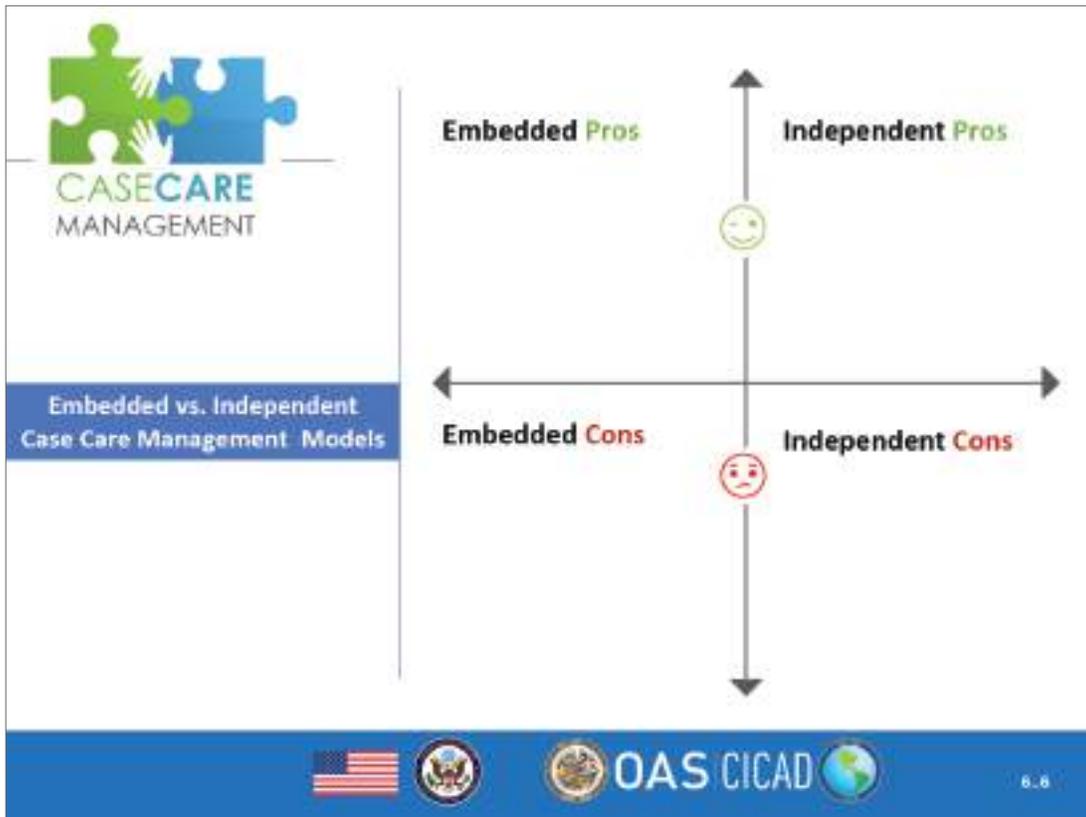
Say

Embedded Case Care Management is a Case Care Management service embedded in, or organized under the aegis of, some other institution, e.g., the criminal justice system or health system. If Case Care Management embedded in the justice system, it is often located within the office handling probation.

Case Care Management could also be integrated into the treatment system or health care providers, and offered in conjunction with treatment services. In such a case, it is particularly important that there is a clear distinction between the two functions—treatment provider and Case Care Manager—to avoid confusion, especially if both roles are performed by the same person.



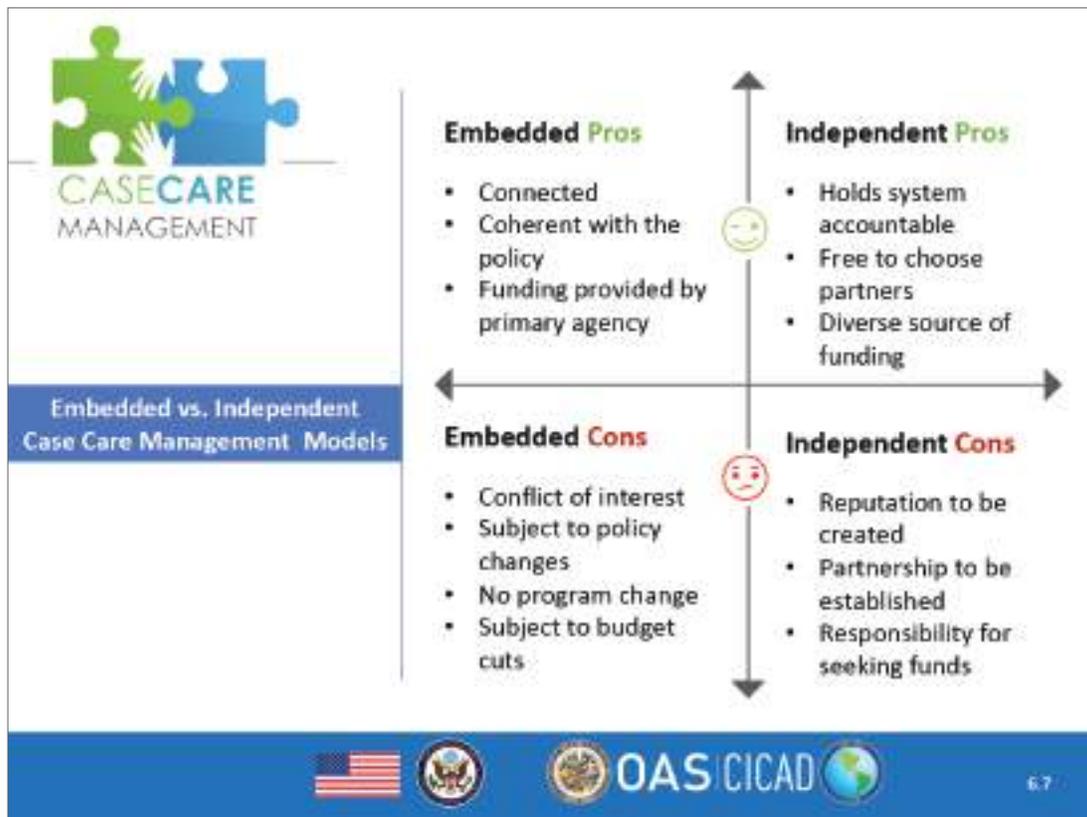
In the Independent Case Care Management model, Case Care Management is run by an independent organization, preferably a non-governmental organization (NGO) that is not directly under the aegis of any CCM stakeholder. Rather, this independent organization creates a collaborative partnership with all stakeholders.



Training Instructions: The trainer should refer to page 257 of the participant manual.

This exercise is part of a series of three exercises, following the same dynamic. Its purpose is to stimulate participant engagement and thinking about the elements presented in the training, enhancing their understanding of the course material, and anticipating some of the content that will be taught.

In this exercise, the trainer will ask participants to share their thoughts on the pros and cons of the embedded and independent models and facilitate the discussion. The co-trainer will note down the answers on the flip chart for future reference.



Say

In the EMBEDDED model the advantages are:

- The connections between the justice and health sectors are generally already in place, so no additional work is required to establish them.
- The Case Care Management is necessarily coherent with prevailing public policy, because it is part of the government. There is no need to be concerned about internal coherence.
- The funding comes from a state agency and thus no need for external fundraising activities.
- In the embedded model, Case Care Management coordination might also be placed under the Ministry of Health or Interior instead of under the Ministry of Justice to facilitate the provision of health care in prison and upon release.

The disadvantages are:

- There might be a conflict of interest concerning what Case Care Management seeks to achieve and what the system will allow it to achieve. For example, if Case Care Management is placed within a probation office in the criminal justice system, professionals might face a conflict of interest between their obligation to enforce the law and focusing the goals of the participant.
- Where Case Care Management is embedded with a specific treatment or service provider, it might be limited to facilitating treatment progress. It also might create a conflict of interest if other treatment/service providers are enlisted.

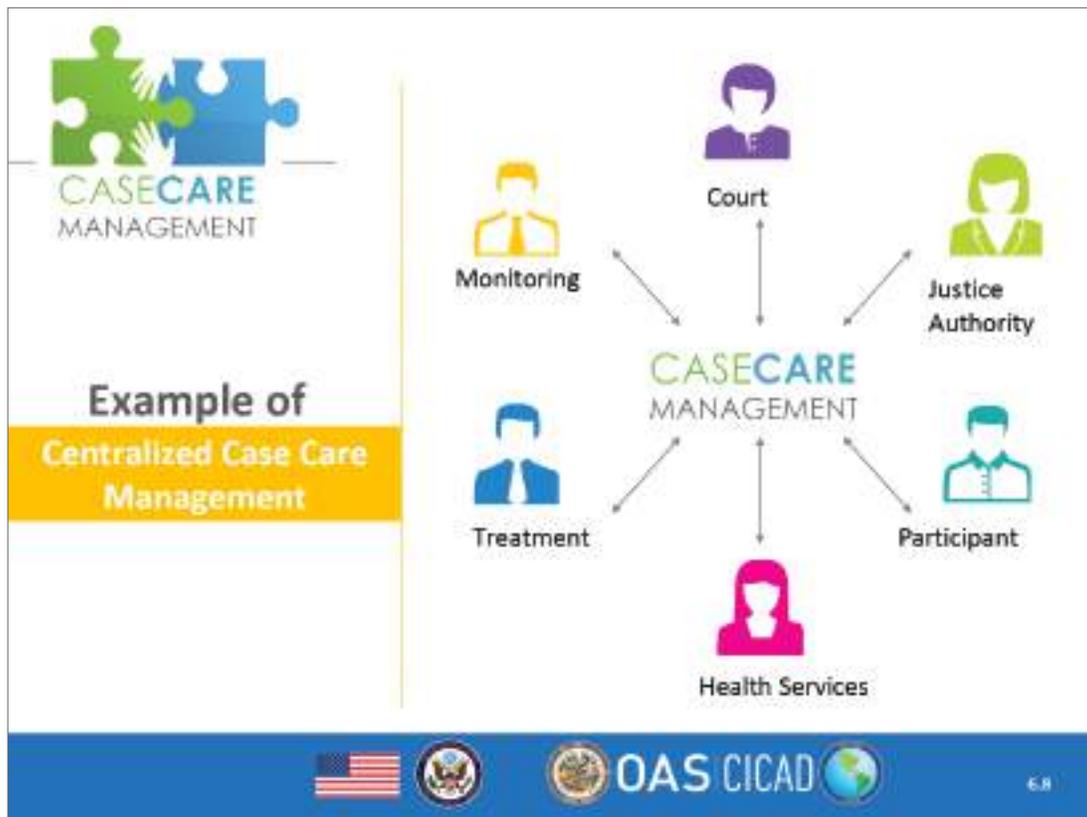
- In an embedded system, Case Care Management is subject to changes in public policy and political will.
- It could be difficult to promote improvements an existing Case Care Management system.
- Case Care Management might be subject to budget cuts; relying solely on government contributions could lead to the project being cut off.

In the INDEPENDENT Case Care Management model, the advantages are:

- Case Care Management is able to navigate both within the system and between systems, holding them accountable due to its independent nature. It acts as a broker of services and as a guarantee that essential services are provided by the various actors.
- It is free to choose its partners and engage with multiple and diverse actors.
- It can count on diverse sources of funding and is able to fundraise with different entities.
- It can offer independent options for commissioning to ensure sustainability for Case Care Management. Funding from across the system to support financially

The disadvantages in the independent Case Care Management model are:

- Case Care Management must establish its own reputation, since it is not part of the state.
- Case Care Management to create and build upon partnerships.
- Funding is less certain; Case Care Management cannot count on constant/secure income.
- Securing sufficient funding might end up becoming a burden for the project, and financial instability might impact Case Care Management's implementation and continuity.



Say

At the operational level, Case Care Management can be centralized or decentralized.

Regardless of whether it is embedded or independent, at the operational level we define a Centralized Case Care Management model as one with a single agency that performs all of the Case Care Management functions and steps with which we are already familiar.

The Centralized model is inspired by the Single Agency model. The main characteristics of the Centralized model are:

- Small grassroots agency or major provider of services for a single problem or to a single population (may be “the only game in town”).
- Tends to control a niche aspect in the social service market by default (other agencies are not interested or refuse to serve participants), whether due to that jurisdiction’s history, by design, or due to its funding mandate.
- A Case Care Manager is hired by and accountable solely to that single agency.

A centralized model can:

- Respond to crises more quickly.

- Tend toward more cohesive or homogeneous values than other models.
- Tend to have a single point of access to substance abuse treatment or other services for participants.
- Maintain sole control over implementation and coordination of case management program.
- Have participants report to a single individual concerning all problems.
- Allow for responding with more flexibility to individual participant needs.
- Have the opportunity to exercise a broad range of skills.
- Be more self-determining and self-accountable (i.e., it can monitor its own services).

The centralized model has the following negative features:

- More responsibility or burden on front-line case management staff to establish connections with other community agencies.
- Case Care Managers may feel especially burdened or taxed by having the sole responsibility for the participant.
- Can require considerable training to equip the Case Care Manager to deal autonomously with the diverse needs of participants.

Source: Substance Abuse and Mental Health Services Administration. Comprehensive Case Management for Substance Abuse Treatment. Chapter 3 – Case Management in the Community Context: An Interagency Perspective. Treatment Improvement Protocol (TIP) Series, No. 27. HHS Publication No. (SMA) 12-4215. Rockville, MD: Author, 2012. Figure 3.1, pg. 31-33

In the Decentralized Case Care Management model, there are **two or**



Say

more agencies performing some of the functions of Case Care Management. Decentralized models can be either embedded or independent:

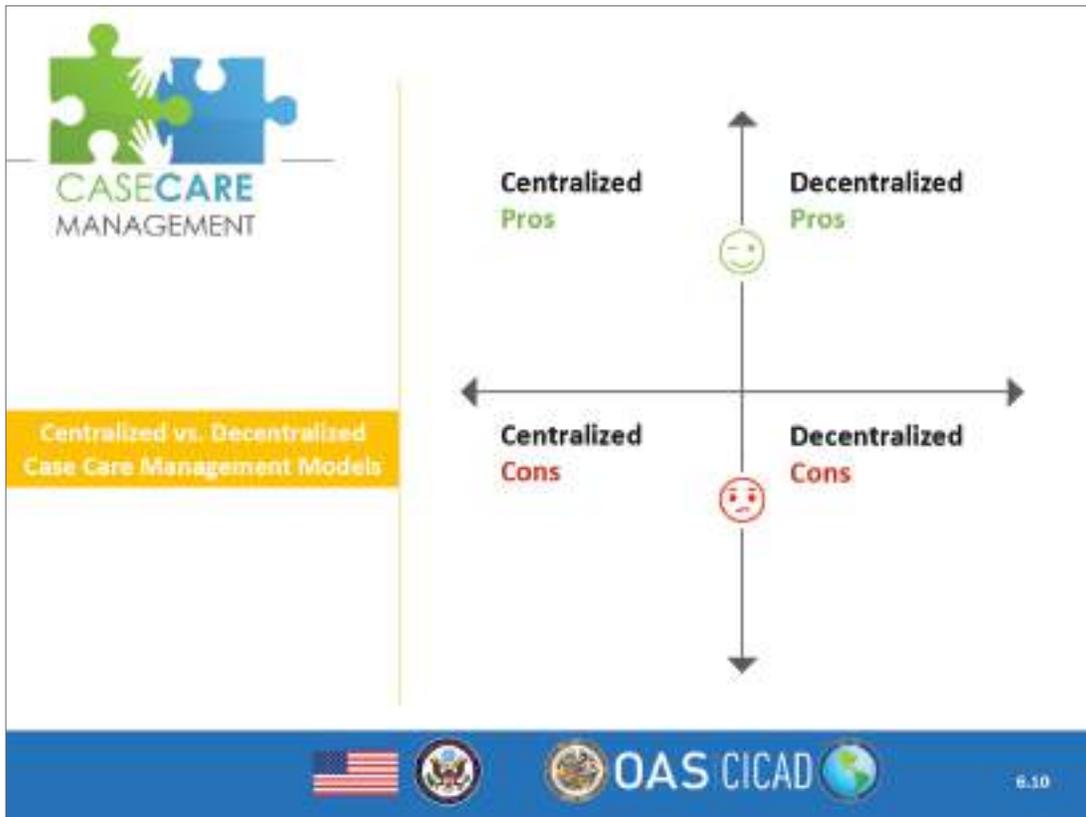
Embedded and decentralized Case Care Management is when Case Care Management is operated under the aegis of a system, and the functions of Case Care Management are performed by more than one agency. One **example** could be a Case Care Management program operated within a Probation Office, with different Case Care Management functions performed by three partners: assessment and planning run by NGO #1, referral and monitoring by NGO #2, and evaluation by an independent agency.

Independent and decentralized Case Care Management is when the independent organization relies on two or more organizations to undertake the Case Care Management functions. **An example of an independent and decentralized model** could be an NGO that subcontracts another civil society partner to run the assessment and the toxicology, undertakes the planning and referral with its own staff, collaborates with an external partner for the follow-up and monitoring of participant, and works with another external partner on advocacy and reporting.

Say

The decentralized Case Care Management model relies on formal and/or informal partnerships with other organizations to perform the Case Care Management functions.

Training Instructions: The trainer should refer to page 257 of the Participant Man-

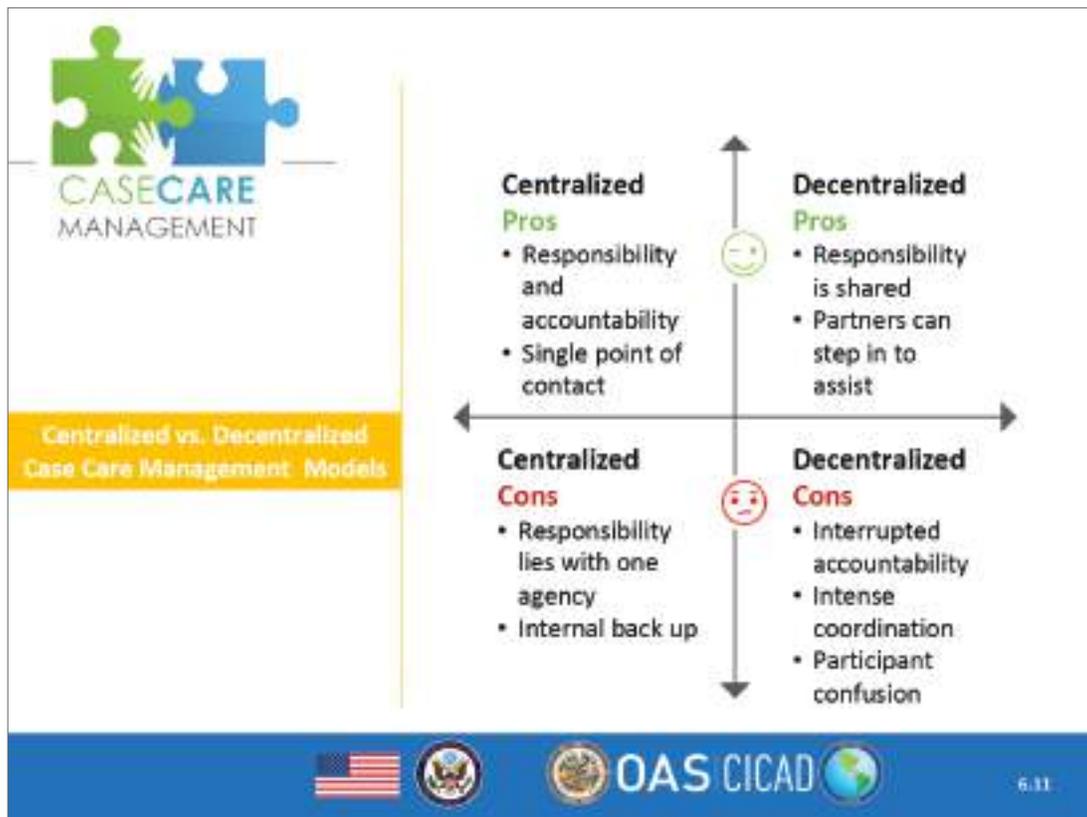


ual.



This exercise follows the same dynamic of the previous exercise. The trainer asks participants to share their thoughts on the pros and cons of the centralized and decentralized models and facilitates the discussion. The co-trainer writes down the answers on the flip chart for future reference.

Let's review the pros and cons of the centralized and decentralized



Say

models.

In the CENTRALIZED model the pros are:

- Responsibility and accountability lie with a single agency who has control over all the steps.
- There is a clear single point of contact for the participant and for the stakeholders in the system.

The cons are:

- Having ultimate responsibility for Case Care Management means the agency needs to have a solid structure, strong quality control standards, and internal coordination.
- In the case of any problem or if support is needed, the agency needs to have a back-up plan within the agency itself or have external providers that can step in.

In the DECENTRALIZED model, the positive aspects are that:

- The agencies share responsibilities.
- In case of problems, there are other actors that can immediately step in and help.

The negative aspects are:

- Accountability is more complex, as there are multiple agencies responsible to the participant.
- It needs more coordination (internal and external) to function properly.
- Participants might become confused, if it is not clear to them who they should contact for certain kinds of issues.

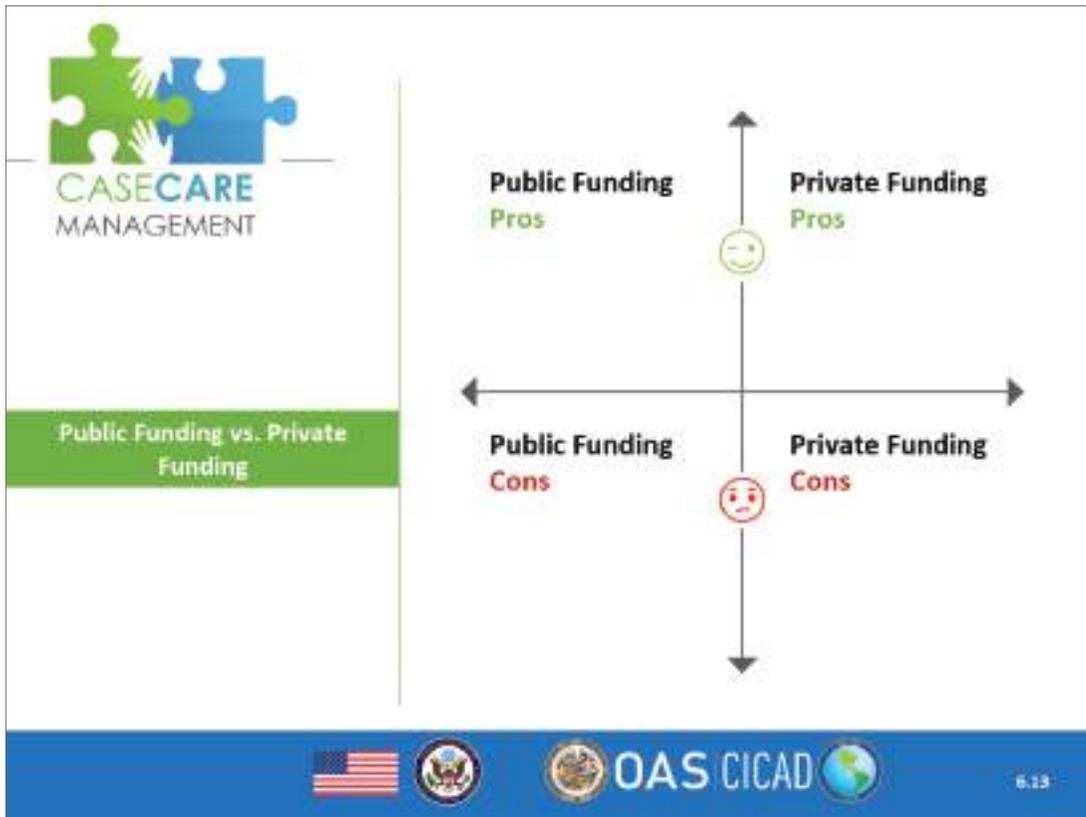


Say

Regarding financing, Case Care Management can receive public or private funding.

Public funding is given by the government, while private funding can come from a diverse range of donors such as foundations, private grants, philanthropic organizations, and volunteer work.

Embedded Case Care Management models are more likely to receive public funding due to their special connection with ministries and public agencies, much like reputable independent NGOs might receive public funding for their services.



Training Instructions: The trainer should refer to page 257 of the Participant Manual.



This exercise follows the same dynamic of the previous exercise. The trainer asks the participants to share their thoughts on the pros and cons of each funding options and facilitates the discussion. The co-trainer writes down the answers on the flip chart for future reference.



In the case of PUBLIC FUNDING the pros are:

- Case Care Management can count on a reliable source of income.
- It might be easier to kick-start the project.

The cons are:

- Case Care Management might be subject to changes of political will and priorities.
- Support can change with policy changes.
- Public funding generally decreases over time. Once the pilot projects end, there might be no follow-up.
- Pressure might be high to provide quick results, as it is difficult to mobilize support for long-term commitments.

The pros of PRIVATE FUNDING are:

- It allows for more independence and flexibility.
- Funding is diversified.
- Donors might have priorities and might be interested in specific aspects of the work.
- There is less vulnerability to changes in policy.

The cons are:

- There might be more financial instability.
- It requires a high-maintenance fundraising job.
- There is a high level of accountability to the donors, who might want to look at how their money is spent.



Considering Hybrid Funding



OAS CICAD



6.15

Say

There is an increasing interest for the hybrid funding model. HYBRID FUNDING combines the pros of public and private funding and allows more flexibility. Sometimes it is the only option if one source of funding is not enough to run a program. Public funds can cover one aspect and private funds or grants can cover another.

There is a range of funding sources available, and it is important to create synergies between them.

It is important not to exclude international grants, which might be available for Case Care Management evaluations, or to exclude contributions from academia, civil society, and other such. These might not have monetary resources, but they have knowledge and may be able to provide in-kind support.

Source: Additional information on the WHO Help in Prison Programme (HIPPED) for further consideration and eventually exploring funding opportunities.

<https://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/who-health-in-prisons-programme-hipp>



Examples of International Case Care Management Models

Embedded Case Care Management Models	Independent Case Care Management Models
<ul style="list-style-type: none"> • Belgian Liaison Model • Canadian Experience: Center for Addiction and Mental Health Toronto (CAMH) • Chilean Model: La Dupla • Programa Aleros Uruguay • U.S. Drug Treatment Court Model 	<ul style="list-style-type: none"> • Proyecto Hombre • San Patrignano • TASC






6.16



After having analyzed the building blocks for the implementation of Case Care Management, we will now look at examples of Case Care Management in the Americas and Europe.



Training Instructions: The trainer should refer to *Resource Page 6.1 International Models of Case Care Management* (at pages 181-186 of the Participant Manual) which provides more information on each model described in the current module.

EMBEDDED CASE CARE MANAGEMENT MODELS



OAS | ICAD



6.17

Say

We will start with the embedded Case Care Management models.



CASECARE
MANAGEMENT

Belgian Liaison Model

- Ghent Drug court established in 2008 – 1st European Drug treatment court
- Creation of the Liaison, responding to drop outs and securing coordination
- Centralized Model: All actions are performed by the Liaison
- Public Funds



OAS CICAD

6.18

Say

The first model we will analyze is the Belgian Liaison Model, which is embedded into the Drug Court System in Ghent, Belgium.

Belgium promoted an alternative to incarceration model, shifting the focus from punishment to treatment, and had Belgian experts look for best practices abroad. They took inspiration from the U.S. and Canadian Drug Treatment Courts. The Belgian Drug Court, established in Gent in 2008, is the first European experience replicating and adapting the U.S. and Canadian models to a national framework.

During the pilot implementation of the drug treatment court, some key challenges emerged that needed to be addressed. Participants were entering the alternative program but lacked appropriate preparation and counselling. This led to poor treatment performance and high dropout rates. In order to address these important issues, a new professional figure called the Liaison was introduced.

Liaison services are provided by Consultation Platform Mental Healthcare East Flanders (Popov GGZ, using its Flemish acronym), a publicly funded NGO working with the Drug Treatment Court.



CASECARE
MANAGEMENT

**CAMH Drug Treatment
Courts, Canada**

- Center for Addiction and Mental Health (CAMH) in Toronto established 1998
- CAHM provides CCM and treatment services
- Wrap around, trauma informed and participant centered services
- Embedded in the system and centralized but with many partners and collaboration
- Hybrid funding



OAS/CICAD

6.39

Say

The Center for Addiction and Mental Health in Toronto is embedded with the Drug Treatment Courts System in Canada, and was established in 1998 as part of the Federal National Anti-Drug Strategy.

The mandatory minimum sentencing provisions in the Criminal Code (where drug addiction is a factor in the offence) and the Controlled Drugs and Substances Act (CDSA) allows for an exemption for DTC participants who complete the program, while still holding them accountable. Legislation also allows for unique and lengthy DTC bail conditions, with DTC bail lasting throughout the participants' active participation in the program. The courts are provincial courts and the federal government therefore respects the provincial/territorial authority for the administration of justice.

The CAMH Drug Treatment Court model amalgamates the therapeutic treatment and the Case Care Management functions, whilst maintaining their separate and distinct functions. The Case Care Management model assigns a Case Care Manager to each participant who will follow his/her progress from the outset of the Drug Treatment Court program and continue as needed through Phase 1 completion (graduation) and throughout Phase 2 (probation). The Case Care Manager provides a wrap-around service that is grounded in trauma-informed, participant-centered care. This service provides for basic needs; addresses and improves social determinants of health and setting; works toward achieving and realigning goals; delivers risk assessments; provides an all systems navigation; produces assessments and referrals; works on advocacy and accompaniment; and includes the involvement of peer support. It does so via a whole-team approach, and places an emphasis on ethical, professional, and strong therapeutic rapport.

CAMH operates with hybrid funding.



CASECARE
MANAGEMENT

La Dupla,
Chile

- Embedded in the Chilean Drug Treatment Court, established in 2004, modelled after U.S. drug court
- La Dupla: Team of two professional figures (a psychologist and a social worker) conducting CCM
- Embedded in justice system, health system and the National Agency for Alcohol and Drug Prevention and Treatment (SENDA)
- Public funding through SENDA



OAS/CICAD

6.20

Say

Drug Treatment Courts in Chile started as a pilot project in the city of Valparaíso in 2004.

This approach was created by Chilean judges and prosecutors, with the support of the United States Embassy in Chile, the Ministry of Health, the Paz Ciudadana Foundation, and the organization then known as the National Drug Council (Consejo Nacional para el Control de Estupefacientes/CONACE) that is now called the National Service for Drug and Alcohol Prevention and Rehabilitation (Servicio Nacional para la Prevención y Rehabilitación del Consumo de Droga y Alcohol, or SENDA, using its Spanish acronym).

Thanks to the cooperation established with the United States, Chilean judges could travel abroad to get to know the U.S. model. In 2012 a Memorandum of Understanding was signed with the relevant stakeholders, and the Drug Treatment Court adult program was officially established under the aegis of the Ministry of Justice.

La Dupla Psicosocial is a team of two professionals: a psychologist and a social worker. They use a biopsychosocial approach to interact with people that have substance use disorders, using an interdisciplinary perspective in addressing coexisting and interrelating biological, psychological, and social problems. La Dupla Psicosocial is in charge of the Case Management throughout the entire process, from the first meeting with the participant to the completion of the program.

La Dupla Psicosocial is an embedded model, which is decentralized and publicly funded through SENDA and the Ministry of Justice.



CASECARE
MANAGEMENT

Programa Aleros,
Uruguay

- Established 2012
- Model of community intervention addressing most urgent needs
- Engages with participant informally and connects them to more institutionalized services
- Team of two professionals
- Decentralized model - creating linkages
- Public funding



6.21

Say

Programa Aleros is a model of community intervention established in 2012, implemented in local municipalities by civil society organizations. It employs a team of two professionals that engage with people with SUDs in different locations (e.g., community centers, shelters, social programs, places of employment, leisure and health centers, and homeless encampments) with the primary objective to create a linkage with services, offer assistance and guidance in addressing primary needs, and connect people to treatment and/or health care resources.

Programa Aleros has public funding. Aleros is a program of the National Network of Attention and Drug Treatment (RENADRO in its Spanish acronym) of the National Drug Board of Uruguay.



CASECARE
MANAGEMENT

Case Care Management
in U.S. Drug Treatment

- First launched in 1989 in Miami, Florida
- Inspired countries in the Americas and beyond
- Case Care Management is part of the treatment team comprised of service providers and stakeholders
- U.S. Drug Court supports any of the Case Care Management models
- Public funding



OAS CICAD

6.22

Say

Drug courts are an innovative and effective solution to addressing substance use within the criminal court system. The first drug court was established in 1989 in Miami, Florida and the model has since been replicated across the U.S., the Americas, Europe, and beyond.

These court programs offer individuals the opportunity to enter long-term drug treatment and agree to court supervision instead of receiving a jail sentence (in post-conviction model) or instead of facing trial and possible sentencing (in a pre-conviction model).

The intensive program requires participants to maintain recovery, take on responsibilities, and work towards lifestyle changes. Under the supervision and authority of the court, their progress is monitored. Ultimately, drug courts reduce crime and create real, positive change in people's lives.

U.S. Drug courts support all of the Case Care Management models we have discussed. Case Care Management is a key component to secure coordination and collaboration among the many stakeholders involved in drug courts.

Case Care Management provides support to the drug court model, overseeing and coordinating in the following areas:

- Linking the participant with relevant and effective services.
- Monitoring services and connecting participants with them.
- Sharing relevant information gathered during assessment and monitoring with the entire drug court team

Case Care Management in the U.S. drug courts operates with public funding.

Sources:

National Drug Court Resource Center. *What are drug courts?* Information retrieved Dec 13, 2019 at <https://ndcrc.org/what-are-drug-courts-2/>

Monchick, R., Scheyett, A., Pfeifer, J., (2006) *Drug Court Case Management*, National Drug Court Institute, Retrieved December 13, 2019 at

<https://www.ndci.org/wp-content/uploads/Mono7.CaseManagement.pdf>

INDEPENDENT CASE CARE MANAGEMENT MODELS



OASIS/CICAD



6-23

Say

We will now discuss the independent Case Care Management model.



CASECARE
MANAGEMENT

Proyecto Hombre, Spain

- Established in 1984
- Spanish example of Case Care Management in prison setting and post conviction to promote effective social reintegration
 - Motivation and derivation program
 - Global intervention program
- Case Care Management model: Centralized
- Hybrid funding



OAS CICAD

6.24



Since 1984, Proyecto Hombre has worked with more than 18,000 people with substance use disorders, promoting access to treatment and social reinsertion programs.

According to Article 25 of the Constitution of Spain, all judicial interventions limiting personal freedom must be oriented towards reeducation and social reinsertion.

Operating within this framework, Proyecto Hombre works both in prison settings and in social reinsertion programs, offering opportunities to people with substance use disorders to start reshaping their life while simultaneously serving their sentence.

The *Motivation and Derivation Program* works with people with substance use disorders in prison to inform them about treatment options, increasing their motivation to achieve abstinence and preparing them to access treatment programs upon prison release. The program is available in 31 prisons around Spain.

The *Global Intervention Program* was established in 1998 as a pilot and consolidated in sub-

sequent years. It is an example of a therapeutic community in a prison setting and represents a joint venture between the prison institution *Soto del Real* in Madrid and Proyecto Hombre. The program is a holistic approach embracing Proyecto Hombre methodology, based on biopsychosocial interventions that promote personal development, interpersonal skills, and empowerment and employability skills.

Phase 1 (Motivation): Assessment, motivational interviewing, and group therapy on drugs, health, relapse prevention, and personal interviews.

Phase 2 (Community): Personalized pathway to social reintegration, increasing personal responsibilities within the community, seminars and education on employment skills, social and communication skills, coping skills, and strengthening family ties.

The Global Intervention Program is available in six prisons around Spain.

This Case Care Management model is centralized and has hybrid funding.



CASECARE
MANAGEMENT

San Patrignano, Italy

- Established in 1978 in Rimini, Italy
- Italian NGO: Therapeutic Community Model
- Gender and age appropriate treatment and Case Care Management intervention leading to social reinsertion
- Case Care Management Model: Independent and decentralized working with the Office of External Clinical Execution
- Hybrid funding: Mainly private, including large contribution from voluntary work



OAS CICAD

8.25

Say

According to Italian law, drug use is considered an administrative offence. Drugs are illegal, but their use alone does not constitute a crime. In addition, Articles 90 and 94 of the Decree of the President of the Italian Republic 309/1990 (DPR 309/1990) allow offenders with drug and/or alcohol disorders to apply for alternative sentencing, exiting prison on probation with to seek addiction treatment.

San Patrignano is among the Italian treatment providers who welcome minors, female, and male offenders, integrating them into community life and a rehabilitation and social reinsertion program. It is the largest residential drug rehabilitation community in Europe, providing drug-free treatment to young people completely free of charge. It funds itself from the wide variety of high-quality enterprises that it has set up to provide those in rehabilitation with job training and a sense of meaning and dignity.

San Patrignano implements a decentralized Case Care Management model, collaborating with the Offices for External Clinical Execution (Uffici di Esecuzione Penale Esterna, or UEPE, using its Italian acronym). San Patrignano is a key stakeholder covering some of the crucial functions of Case Care Management in the Italian alternatives to incarceration model.

Its legal office performs the Case Manger functions and works with the Italian national addiction services to run toxicological assessments. It also has a team of psychologists and psychiatrists to diagnose co-existing mental illness. The Offices of External Clinical Execution work with referrals and participants entering treatment, and with the social services in the reintegration phases.

San Patrignano has hybrid funding.



CASECARE
MANAGEMENT

Treatment Alternatives
for Safe Communities
(TASC), USA

- Created in the late 70s in Illinois
- Works as a bridge between the justice system, health care system and community
- Ensure access to treatment-based interventions across the justice system spectrum
- Clear example of Specialized Case Management in the United States
- Utilizes independent centralized model and operates with hybrid funding



OAS CICAD

6.28



TASC Inc. of Chicago, Illinois, was founded in 1976 by Melody Heaps in partnership with the Illinois Dangerous Drug Commission and the Circuit Court of Cook County. Initially, it used federal funding to provide treatment placement, and clinical tracking and monitoring services to complement traditional probation for people with problematic heroin consumption. (At the time, a large number of Vietnam veterans were entering the criminal justice system for offenses related to heroin use.) Within five years, TASC had grown beyond Cook County to reach every jurisdiction in Illinois.

Over the decades, TASC has expanded its services for people involved in the justice system, from pre-arrest diversion to reentry programs, and has developed programs for juvenile justice, public health, and child welfare systems.

The TASC model was in many ways a precursor to the Drug Treatment Courts.

Every point in the justice system, from pre-arrest to probation and parole, is a decision point where people may be diverted to needed services in the communities. TASC Specialized Case Management helps ensure that individuals are assessed correctly and connected with the services they need, as well as assisting them with remaining engaged with relevant services as they make significant changes in their lives.

TASC uses an independent centralized model and operates with hybrid funding.

Source: TASC. (2018). 40+years promoting Health and Justice

Case Care Management Models



Training Instructions: The trainer should refer to page 258 of the Participant Manual.

Say

Before wrapping up this session, I would like you to take a few minutes to write down your thoughts and answer the following questions:

Based on the information provided in this module, which combination of approaches do you think will be the most effective in your jurisdiction?



Which combination of approaches do you think would be the most practically possible to implement?

Which barriers or difficulties to implementation do you foresee?

Training Instructions: At the end of the exercise, the trainer can ask the participants to share their thoughts and facilitate a brief discussion about them. The trainer should mention that participants' input will be used during the interactive exercise on Module 10 on action planning. The time dedicated to answering these questions is relevant and important to achieve the desired results for this training.



Wrap Up and Take-Home Message

“Be the change you wish to see in the world.”

Mahatma Gandhi



OAS CICAD



6.28

Say

All the organizations and programs we have learned about today were created by people who saw a problem in their societies and communities and wanted to do something about it. Back in the 1970s, the main problem was heroin consumption. Today, thanks to extensive research, we know more about drugs, drug consumption patterns, brain development, and the consequences of drug use. However, we should still remember that deep down, we are all human beings with hopes, dreams, and problems, and we take this into consideration when planning for Case Care Management.

Many of these programs have now existed for more than 40 years, but each started as a small pilot program, in situations exactly like where each of you are now. We should not be afraid to be ambitious, even as we take the first small steps.

MODELS OF CASE CARE MANAGEMENT

Resource page 6.1 International Models of Case Care Management

A. Embedded Case Care Management Models in the Drug Court Framework

Belgian Liaison Model: Popov GGZ - Belgium

According to **Belgian law** (Federal Drug Policy Note 2001 and Communal Declaration 2010) **addiction** is considered a **public health issue**. The **main goal of the national strategy** is to **prevent and limit the risks of substance use disorders and their consequences for the society as a whole** (Triple R 2017).

Belgium promotes an **alternative to incarceration model**, shifting the **focus from punishment to treatment, with Belgian experts looking for best practices abroad**. They took inspiration from the US and Canadian Drug Treatment Courts (DTCs). **The Belgian Drug Court, established in Gent in 2008**, is the **first European** model that replicates and adapts the US and Canadian model for a national framework.

During the pilot implementation of the Drug Treatment Court, some **key challenges emerged that needed to be addressed**. **Participants** were entering the alternatives measures to exit prison setting, **lacking appropriate preparation and counselling leading to poor treatment performance and high drop-out rates**. In order to address these important issues, a new professional figure called the **Liaison** was introduced.

Popov GGZ is an independent NGO working with the Drug Treatment Court and providing Liaison services with the participants. The Belgian Liaison is an example of **embedded Case Care Management**. An evaluation report described the **Liaison as a human support figure, reflecting the concept of the good neighbor** (Triple R 2017). The Liaison performs all the functions of the Case Care Manager, shares the core values, is embedded in the multisystem approach, and focuses on promoting successful social integration of the participants therefore **reducing recidivism and achieving inclusive communities**.

More information on Popov GGZ and its work can be found at <https://www.popovggz.be>.

CAMH Drug Treatment Courts - Canada

Drug Treatment Courts in Canada began under the jurisdiction of the **Department of Justice Canada** with the **Toronto model in December of 1998** as part of the **Federal National Anti-Drug Strategy**, as part of the Federal Government's commitment **to address crime and drug use in Canada** and form part of the **federal government's criminal justice strategy**. The **mandatory minimum sentencing provisions** in the **Criminal Code (where drug addiction was a factor in the offence)** and the **Controlled Drugs and Substances Act (CDSA)** provide for an exemption for **DTC participants who complete the program, while still holding them accountable**. Legislation also allows for the unique and lengthy **DTC bail conditions, with DTC bail lasting throughout the participants' active**

participation in the program. The courts are **provincial courts** and, therefore, the **federal government respects the provincial/territorial authority for the administration of justice** (CAHM 2019).

CAMH is an Addictions and Mental Health Hospital and Research Centre, offering both inpatient and ambulatory treatment services. The Drug Treatment Court program is **one of CAMH's clinical programs, which operates within the larger Acute Care program.** The Drug Treatment Court program provides **clinical services including case care management, treatment groups, individual counselling, psychiatric assessment, and opiate substitution therapy and drug screening for Drug Treatment Court participants.**

The CAMH DTC model amalgamates the therapeutic treatment and the Case Care Management functions but they do have distinct functions. The Case Care Management model allows for an **assigned Case Care Manager to each participant who will follow the participant from the beginning of the DTC program and as needed to Phase 1 completion (graduation) and throughout Phase 2 (probation).** The Case Care Manager provides a **wraparound service which is grounded in trauma-informed, participant-centered care, providing for basic needs, addressing and improving Social Determinants of Health, setting, achieving and realigning goals, risk assessment, all systems navigation, assessment and referrals, advocacy, accompaniment, involvement of peer support, a whole-team approach and a focus on ethical, professional and strong therapeutic rapport.**

For more information, please visit the Toronto Drug Treatment Court Website at <https://www.tdtc.ca>.

Chilean Case Care Management Model: La Dupla - Chile

Drug Treatment Courts in Chile started as a pilot project in the city of Valparaíso in 2004. It was originally an **initiative of judges, prosecutors and defendants** that, with the support of the **United States embassy** in Chile, the **Paz Ciudadana Foundation** and at that time **National Drug Council** (Consejo Nacional para el Control de Estupefacientes/**CONACE**), which is currently known as **Servicio Nacional para la Prevención y Rehabilitación del Consumo de Drogas y Alcohol/SENDA**) and the **Ministry of Health, created the Chilean model.** Thanks to cooperation with the United States, Chilean judges could travel abroad to familiarize themselves with the US model. **In 2012, a Memorandum of Understanding (MoU) was signed with the relevant stakeholders and the Drug Treatment Court adult program was officially established under the aegis of the Ministry of Justice.**

Therapeutic Justice is at the core of the Drug Treatment Court model and implies a constant and close coordination and cooperation among all the stakeholders involved in the program. The **Case Management** within the Chilean Drug Treatment Court is managed by a team of two professionals called **Dupla Psicosocial**. The two professionals are a **psychologist** and a **social worker**. They implement a **biopsychosocial approach to interact with people with substance use disorders**, using an interdisciplinary perspective in **addressing coexisting and interrelating biological, psychological and social problems.**

La Dupla Psicosocial is an **embedded model, decentralized** and is **publically funded through SENDA and the Ministry of Justice.**

La Dupla Psicosocial is **in charge of the Case Management throughout the entire process, from the first meeting with the participant to the completion of the program.** They run the initial **screening**, using a **standardized screening tool (the Alcohol, Smoking and Substance Involvement Screening Test - ASSIST)** and follow up with an assessment interview to determine participant eligibility for the program and whether they can obtain the suspension of the legal proceeding with the aim of entering treatment. La Dupla Psicosocial **engages with participants in pretrial detention, as well**

as with **participants, referred by the public prosecutor or defendant, have already obtained the suspension of the procedure.**

La Dupla **refers the participant to treatment and maintain close and constant contact with the treatment and services providers,** which are mainly private institutions offering rehabilitation programs. SENDA and the Ministry of Justice created quality benchmarks for substance use treatment and provide assistance, supervision and training to create treatment professionals able to handle people with substance use problems who are in conflict with the law, educating them on the continuum of the justice system as well as its requirements and expectations.

Programa Aleros - Aleros Program - Uruguay

The Aleros Program (Programa Aleros in Spanish) is a government supported program in **Uruguay promoting social integration of people with substance use problems at the community level.** Established in 2012 (the program is implemented **by civil society organizations, under the aegis and leadership** of the **National Network for Drug Attention and Treatment (Red Nacional de Atención y Tratamiento de Drogas, RENARDO is its Spanish acronym)** and receives **public funding from the National Drug Board** (Junta Nacional de Drogas).

The Aleros Program is **a model of community interventions,** implemented in **local municipalities by civil society organizations. These organizations employ a team of two professionals engaging with people with SUDs in different areas** (streets, community centers, shelters, social programs, employment, leisure and health centers among others) with the primary objective **to create a linkage and offer assistance and guidance** to address primary needs and connect with treatment and/or health care resources. The intervention is **a form of non-institutionalized treatment,** promoting **weekly meetings with the program participants, building up a rapport and working on future plans and strategies to respond to their needs** (Romar, Curbelo, Estela 2015). The Case Care Model implemented is a **decentralized model** in which the functions are covered by more than one agency.

The interaction is **very informal,** and the professionals are **creating a connection with the participants** and value their views and active engagement in the development of a personalized and flexible life plan. Particular attention is paid to **combining rehabilitation and reentry in the workforce or finding formal job placement** that supports participants and provides them with **stability and support while their motivation in life changes.** Aleros is a program of the National Network of Attention and Drug Treatment (RENADRO in its Spanish acronym) of the National Drug Board of Uruguay.

Drug Court Model - USA

Drug courts are an innovative and effective solution to addressing substance use within the criminal court system. The first drug court began in 1989 in Miami, Florida and the model has since been replicated in the U.S., Europe and beyond. These court programs offer individuals the opportunity to enter long-term drug treatment and agree to court supervision rather than receiving a term of incarceration. The **intensive program requires participants to maintain recovery,** take on responsibilities, and work towards lifestyle changes. Under the supervision and authority of the court, participant's progress is monitored. Ultimately, drug courts reduce crime and create a positive change in people's lives.

Drug court programs often include:

- **Participation over a series of months or years to establish and maintain long-term recovery strategies;**
- **Frequent and random drug tests;**

- **Clinical treatment** for substance use disorders;
- **Case management as part of a treatment team**, ensuring participants are connected to employment opportunities, community service, pro-social activities, and education;
- Frequent appearances in court;
- **Rewards for maintaining treatment plans and sanctions for failure to meet obligations; and,**
- Support and encouragement from the drug court team.

Case Management in the drug court setting is a key component to secure coordination and collaboration among the many drug court stakeholders (Monchick, Scheyett, Pfeifer 2006) Case Management provides a support to the drug court model, by coordinating in the following areas:

- **Linking** the participant with relevant and effective services;
- **Monitoring** the services and connecting participants with them; and,
- **Sharing relevant information** gathered during the assessment and monitoring stages with the entire drug court team (Monchick, Scheyett, Pfeifer 2006).

U.S. drug courts operates with public funding.

B. Independent Models of Case Care Management

Proyecto Hombre - Spain

Since 1984 Proyecto Hombre has worked **with more than 18,000 people with substance use disorders, promoting access to treatment and social integration programs**. According to the **Constitution of Spain, Article 25, all justice interventions limiting personal freedom shall be oriented towards reeducation and social integration**. The same concept is reflected in **Article 1 of the Spanish General Penitentiary Law** (Ley Organica General Penitenciaria L) (OGP 2003). Operating in this framework, Proyecto Hombre works both **in prison settings and in social integration programs**, offering opportunities to people with substance use disorders to start reshaping their life while simultaneously serving their sentence.

The Motivation and Derivation Program addresses people with substance use disorders **in prison to inform them about treatment options, increasing their motivation** in achieving abstinence and preparing them to access treatment programs upon prison release. The program is available in **31 prisons in Spain** and currently **enrolls 1,600 people**. **Since 1993, the program has served 36,197 people** (Proyecto Hombre 2017).

The Global Intervention Program, which was established in **1998** as a **pilot program** and has been **consolidated over the years, is an example of a Therapeutic Community in a prison setting** and demonstrates a joint cooperation between the prison institution in Madrid (Soto del Real) and Proyecto Hombre. The program offers **a holistic approach embracing the Proyecto Hombre methodology**, based on bio-psychosocial interventions aimed at promoting personal development, interpersonal skills as well as empowerment and employability skills. The Global Intervention Program is implemented in two phases:

Phase 1 - Motivation: Assessment, motivational interviewing, and group therapy on drugs, health, relapse prevention and personal interviews

Phase 2 - Community: Personalized social integration path, increasing personal responsibilities in the community, seminars and education on employment orientation, social and communication skills, coping skills, family reunion and bonding.

The Global Intervention Program is available in **6 prisons** throughout Spain and **since 1998 has served 7,691 people** (Proyecto Hombre 2017)

The Case Care Management model is centralized and counts on hybrid funding.

More information on Proyecto Hombre is available at <https://proyectohombre.es>.

San Patrignano - Italy

According to **Italian law**, drug use is considered an administrative offence but does not constitute a crime. **Article 90 and 94 of the DPR 309/1990** allow **offenders with drug and/or alcohol disorders to apply for alternative sentencing, exiting prison on probation with the goal of seeking treatment for their addiction problem** (Annual Report on Drug 2017).

The Italian law is inspired by the principle that **prisons often do not constitute the ideal place to facilitate access to, and retention in, treatment for addiction**, and therefore alternative measures are intended **to facilitate access to, and retention in, treatment programs providing public health intervention while simultaneously addressing public security**.

The **Offices for External Clinical Execution** (Uffici di Esecuzione Penale Esterna, UEPE is its Italian acronym) is a **key stakeholder covering some of the crucial functions of Case Care Management in the Italian alternatives to incarceration model**. In Italy there is **no provision for compulsory treatment**, and in order to exit prison for treatment purposes the **offender has to submit an application** to the judge and undertake a toxicological examination administered by the national addiction services to certify the status of addiction and the need for treatment (Triple R 2017). The UEPE works with the treatment provider, the justice system and social services to oversee access to treatment, and to supervise the adherence to the therapeutic program and its implementation according to the Italian law.

As of December 2017, **3,146 people accessed alternatives to incarceration** (Article 94 of the DPR 309/1990), demonstrating an increasing trend since 2015. **The registered treatment retention factor is 90%, showing the success of the measure.**

San Patrignano is among the **Italian treatment providers who welcome minors, female and male offenders in alternative measures, integrating them into community life and the rehabilitation and social reinsertion programs**. San Patrignano is the largest residential drug rehabilitation community in Europe, providing treatment to young people completely free of charge, earning its income from the wide variety of high quality enterprises it has set up which provide those being rehabilitated with job training, and a sense of meaning and dignity.

Since 1980, San Patrignano has served 4,172 people in conflict with the law, substituting more than 4,200 years of prison and converting them into rehabilitation programs.

In the last year (2018 data), San Patrignano served 187 residents in alternative sentencing, followed 578 court trials and substituted 110 years of prison, saving the Italian state more than 8 million euros (San Patrignano 2018).

San Patrignano is an example of an independent and decentralized Case Care Management model. Its legal office is performing the Case Manager functions and working with the Italian National Services on addiction to run the toxicological assessment. The agency employs a psychologist and psychiatrist to check on co-existing mental diseases with the Offices of External Clinical Execution for the referral and entrance into treatment, and with the social services in the integration phases. Furthermore, **the Case Manager maintains a close relationship with the person responsible for**

the treatment program and the supervisor, keeping each other informed on the progress in the rehabilitation of the resident. The San Patrignano legal office advocates and educates residents on their rights and duty to comply with the alternative measures and sends regular reports as required by the justice system.

More information on San Patrignano can be found at www.sanpatrignano.org.

Treatment Alternatives for Safe Communities (TASC) - United States

Treatment Alternatives for Safe Communities (TASC) was created as a pilot program funded by the United States federal government with the aim of creating a response to the increasing number of Vietnam veterans entering criminal courts for their heroin consumption. Other programs followed with the intent of diverting non-violent offenses out of the court system and into supervised drug treatment in the community.

TASC Inc. of Chicago, Illinois was created in 1976 by Melody Heaps in partnership with the Illinois Dangerous Drug Commission and the Circuit Court of Cook County. It used federal funding to create an independent agency that provided treatment placement, clinical tracking, and monitoring services as an adjunct to traditional probation for people with problematic heroin consumption. Within 5 years, TASC had grown beyond Cook County to reach every jurisdiction in the State of Illinois. Over the decades, TASC has expanded its services for people involved in the justice system, from pre-arrest diversion, through reentry, and has also developed programs for juvenile justice, public health, and child welfare systems (TASC 2018).

From the beginning, TASC's core services have included a clinical strength and needs based assessment, participant advocacy, treatment placement, reporting to referral sources, and ongoing care coordination, all grounded in a steady commitment to diverting people away from government institutions and into community based health and recovery. The TASC model was a precursor to the Drug Treatment Courts.

Every point in the justice system, from pre-arrest to probation and parole, is a decision point where people may be diverted to needed services in the communities (TASC 2018). TASC Specialized Case Management helps ensure individuals are assessed correctly and placed into the services they need, but also that they remain engaged in services as they make significant changes in their lives. TASC offers a comprehensive assessment to help participants define where they start. For people with substance use disorders, accessing treatment is often just the beginning of a new life path. TASC helps individuals in conflict with the law navigate the justice system, access services and find peer and community support to meet their most urgent needs (TASC 2018).

The TASC specialized case management services support the full range of alternatives to incarceration. The men and women that TASC serve are reintegrated into their communities, reducing the likelihood of recidivism and re-incarceration. Across Illinois, these programs help relieve pressure on the justice system, saving taxpayers money, making communities safer, and providing individuals with opportunities to rebuild their lives.

TASC offers consulting and technical assistance around the globe.

TASC implements an independent centralized model and operates with hybrid funding.

More information on TASC can be found at www.tasc.org.

MODULE 7



Case Care Manager Interacting in the Multisystem Approach

Preparation checklist

Content and timeline

Training goals and learning objectives

PowerPoint slides

Resource pages

MODULE 7

Module 7 Preparation Checklist

- Review the “Getting Started” section for general preparation information on page 13 of this manual.
- Preview Module 7.
- Prepare for the interactive exercise: assemble the following:
 - A stack of letter-sized (or A4-sized) paper for each table.
 - Pads of Post-it notes for each table.
 - Place colored markers and a stack of colored paper on each table.

Module 7 Content and Duration

Activity	Time
Module 7- Case Care Management interacting in the Multisystem Approach	120 minutes
Presentation: Case Care Manager and the Justice System	10 minutes
Interactive Exercise: Case Study 1	20 minutes
Presentation: Case Care Manager and the Participant	10 minutes
Interactive Exercise: Case Study 2 and 3	20 minutes
Presentation: Case Care Manager and Health and Social Services	10 minutes
Interactive Exercise: Case Study 4	20 minutes
Presentation: Case Care Manager and Communities	10 minutes
Interactive Exercise: Case Study 5	20 minutes
Break	15 minutes

Module 7 Goals and Objectives

Training Goals

- Present how the Case Care Manager works with the justice system.
- Illustrate how the Case Care Manager works with the participant.
- Provide an overview about how the Case Care Manager works with health and social services.
- Provide an overview how the Case Care Manager works with communities.

Learning Objectives

Participants who complete Module 7 will be able to:

- Understand and describe how the Case Care Manager works with the justice system.
- Understand and describe how Case Care Manager works with the participant.
- Understand and describe how Case Care Manager works with health and social services.
- Understand and describe how Case Care Manager works with communities.



MODULE 7

CASE CARE MANAGER INTERACTING IN THE MULTISYSTEM APPROACH



7.1

Say

In the previous modules, we learned about the core values, critical elements, functions, and models of Case Care Management. This module discusses how the Case Care Manager works with different actors and examines how Case Care Manager engagement with each of them adds value.

The module is very interactive and offers case studies and concrete examples to help the participants familiarize themselves with the daily work of the Case Care Manager.



MODULE 7

Objectives

Understand how the Case Care Manager works with the justice system

Understand how the Case Care Manager works with the participant

Understand how the Case Care Manager works with health and social services

Understand how the Case Care Manager works with communities



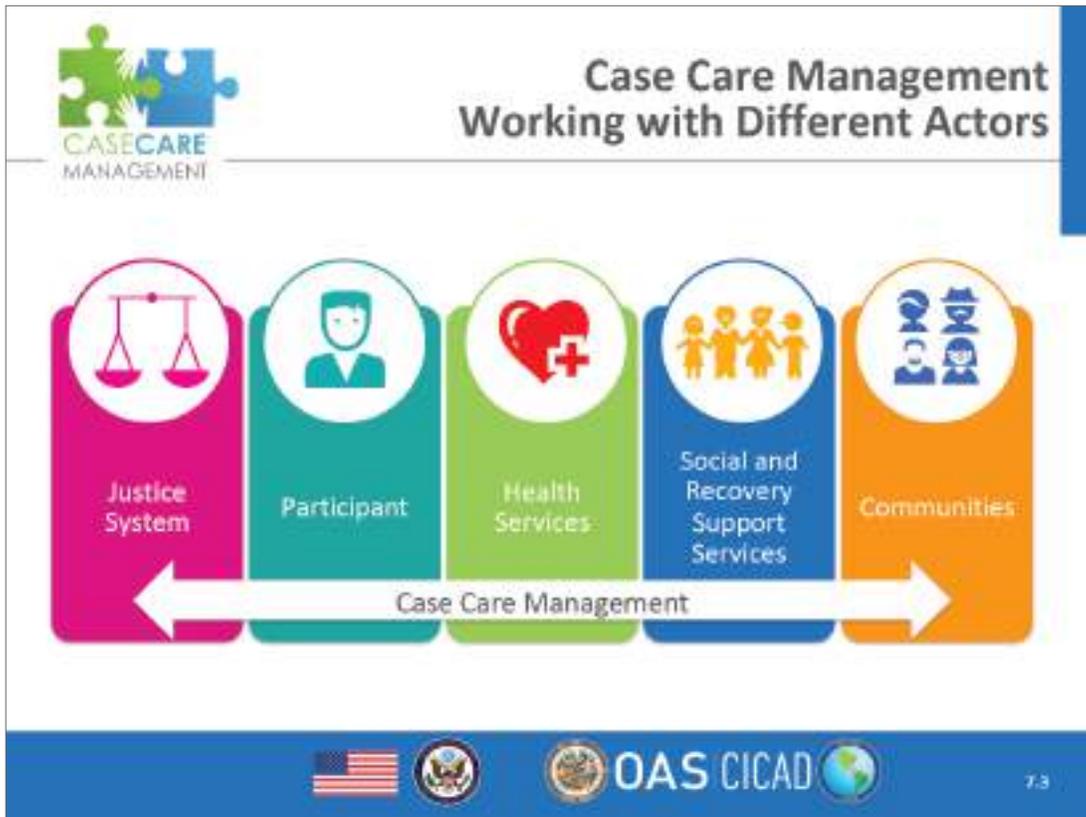
OAS



7.2

Say

By the end of this module, you will understand how the Case Care Manager role works, and its relationship with the justice system, the participant, health and social services, and communities.



Say

I will briefly recap some elements we discussed in the previous modules. In this slide, you will see a chart presenting the main stakeholders that the Case Care Manager works with. We will analyze the kind of relationship the Case Care Manager should establish with each of these stakeholders.



As we saw in Module 3, there are numerous points along the criminal justice continuum where Case Care Management can provide treatment-based alternatives to incarceration for people with an SUD.

Training instructions: Review input and suggestions from Module 3 on the justice system as appropriate. By this point of the training, based on the feedback provided by the participants, trainers might be able to form a preliminary idea of the possible programs that could host Case Care Management interventions.

Looking at the justice system figure, the trainer could remind participants that there are multiple options for a Case Care Management intervention along the justice system continuum. Similarly, although participants may already have some ideas for Case Care Management implementation, it is good to keep in mind that Case Care Management can assist the justice system at multiple points in the criminal justice system to provide nonviolent offenders with alternatives.

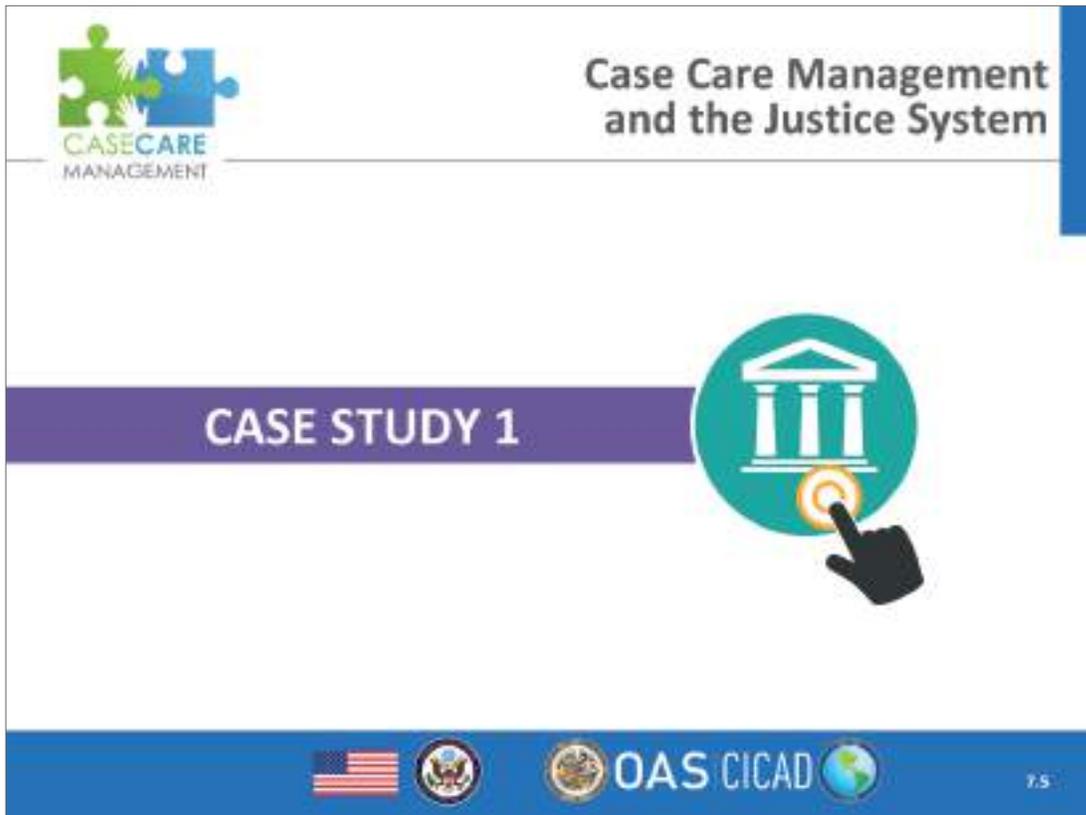


There are several options that could be considered. Among them are:

1. Diversion.
2. Drug Treatment Court (DTC).
3. Correction.
4. Re-entry.

What do you think? Which area would you be interested in further exploring and may-be address in the group exercise?

Training instructions: The co-trainer should write down the comments from the participants on the possible options for Case Care Management in the country. This information is relevant to help the trainer and participants in determining options for the subgroups in the Module 10 interactive exercise.



We are going to work on a case study to analyze how Case Care Management interacts with the Justice System.

Case Study 1 is found at page 200 of the Participant Manual. Let's read the case aloud.

Case Study 1

One Monday morning in a courtroom, Judge R. is seated in her office, preparing for the day and reading the papers in the heavy folder on her desk. Flipping through the pages, she finds a death certificate. She realizes that this is the third death certificate she has received this month. She reads further looking for the details of the person that has died. At the top of the death certificate, she finds the information: Robert, 25, overdose. Robert had been in her courtroom three times in the past few months. He was a shy man, and barely said a word during his hearings, allowing his attorney to do the majority of the talking. There had been some concerns that he was using drugs, but a proper drug test or screening had never been completed. Judge R. feels frustrated and emotional about Robert's death and the other deaths that have occurred and will likely continue to occur. She sees that as a failure of the justice system. As a judge, she wants to make a difference, make the right decisions, and help people, but sometimes it is very difficult to identify the proper services. Judge R. starts contemplating what could have been done differently to better assist Robert and other people like him. She feels quite alone.

 **Ask**

How could Case Care Management have helped Judge R?

Additional question:

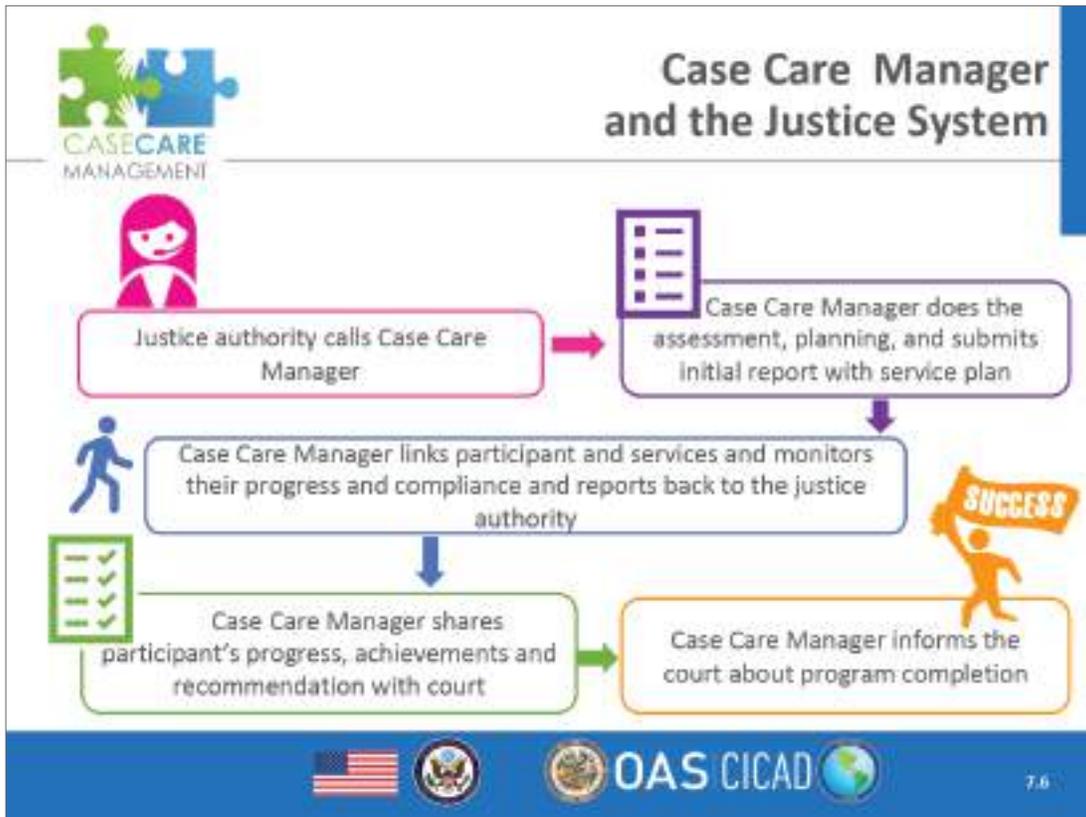
- For those of you who are judges, how does this case study relate to your experience?

Open the floor to comments and facilitate the discussion.

The following are important points that should emerge from the discussion. (If not, be sure to bring them up yourself.)

The death certificate demonstrated a failure of the justice system.

- There was suspicion of an SUD but no screening or test was conducted.
- A Case Care Management approach could have been used to provide a standardized assessment.
- The judge feels alone.
- Case Care Management could provide peace of mind, taking care of the participant, preparing a plan, and following up with the judicial authority.



This slide summarizes the steps of the Case Care Manager's interaction with the judicial authority:

- The judicial authority takes the lead and calls the Case Care Manager to run the assessment whenever an SUD is suspected.
- The Case Care Manager runs the assessment and handles planning stage with the participant, and then reporting to the judicial authority for consideration and approval.
- The Case Care Manager makes the warm referral/linkage and monitoring process, reporting back, and communicating regularly with the judicial authority.
- The Case Care Manager shares the participant's progress, achievements, and recommendations with the court.
- The Case Care Manager informs the court about program completion.

Case Care Manager Adds Value for the Justice System

JUSTICE AUTHORITY

- Reliable partner
- Standardized quality assessment
- Clinical information and expertise
- Engagement and reporting
- Connected with the communities

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The Case Care Manager adds value to the judicial authority and is a reliable partner.

The Case Care Manager is just a call away and can provide standardized quality assessment, system planning, and clinical information and expertise.

The Case Care Manager engages with the participant, assuring the judicial authority that their cases are professionally handled.

The judicial authority receives regular reports on participant progress, thanks to the strong relationship and synergies that the Case Care Manager has established with the service providers. The justice authority will also be informed if problems emerge and actions that are taken to resolve these problems.

The Case Care Manager promotes connections to the local community and social reintegration.

In order to further strengthen the partnership with the judicial authority, if possible, the Case Care Manager’s office should be placed in a convenient and accessible location (close to the court, if that is an option), to facilitate daily interaction and participant accessibility to the services.



The Case Care Manager is a champion for the participant. He/she always have the participant’s best interest in mind.

The Case Care Manager creates a rapport with the participant based on mutual respect and transparency, sets the tone from the very first meeting, is proactive, and uses Motivational Interviewing techniques to engage with the participant.

The Case Care Manager protects participant confidentiality. He/she safeguards the privacy of the participant and know what information should be shared with the judicial authority.

The Case Care Manager understands the clinical nature of addiction and knows that relapse is part of the process.

The Case Care Manager ensures goals and service planning are established with the participant, participant focused, and designed to achieve both program expectations and participant needs.



The Case Care Manager **respects the participant** and **does not undermine the participant’s ownership of the process**. They always encourage the participant to undertake gradual and progressive responsibility and leadership.

I am now going to present to you two case studies about how a Case Care Manager can interact with participants. In both of them, the Case Care Manager receives a call from a participant. Let’s have a look at the scenarios. They are on page 200-201 of the Participant Manual.

Case Study 2 (Positive Scenario)

Melania, 35, is calling her Case Care Manager to tell him that she just got a new job. Melania is on probation and has limited working experience. She was worried about not being able to find a job. The Case Care Manager encouraged her to meet with Rainbow, a local NGO that runs a program called Write Me. At Rainbow, volunteers meet with participants to assess their experience and strengths, assisting them in writing their resume, collecting the needed documentation, and preparing for job interviews. Melania is an eager reader and loves books. Her dream is to find a job in a local library or as a sales assistant in a bookshop. She found a job at the new bookstore downtown. She is very excited and starts on Saturday.

Ask

What are the elements of this case study that you deem more relevant?

Additional questions:

What do you think of the rapport between the Case Care Manager and the Participant?

What about how the Case Care Manager identifies some of the participant's strengths and needs?

How about the way in which they link the participant to the resources she needs?

Key learning points in Case Study 2:

- The Case Care Manager knows the participant and has created a positive rapport, demonstrated by the fact that the participant is calling to inform him about the good news.
- The Case Care Manager has identified a need (finding a job) and some possible issues (not being able to write a resume and not having sufficient working experience).
- The Case Care Manager connected the participant to a resource (the local NGO Rainbow).
- As a result, the participant successfully applied for and got the job.

Case Study 3 (Negative Scenario)

Roger called his Case Care Manager on Friday evening. He needed to speak with someone. He received very sad news that morning, had been overwhelmed all day, and could not find a suitable plan to move forward. His wife Gina was diagnosed with breast cancer. The doctor said there are treatment options and that they should schedule a surgery. There is also a new, experimental medication that is not covered by their health insurance, but Gina might qualify to be in the testing program. Roger wants to be supportive, help his wife by spending time with her, and drive her to medical appointments, especially after all the years where she supported him. However, his wife's medical care might interfere with his ability to attend treatment programs himself. Roger is in an intensive outpatient drug treatment program due to his severe SUD problem. If he steps in to care for his wife, he might not be able to keep his job, which is very much needed, as it is their only income. Roger is confused about competing priorities and worried about the future.

A purple speech bubble containing the word "Ask" in a bold, purple, sans-serif font.

What are the elements of this study case that you deem more relevant?

Additional questions:

What about the idea of the Case Care Manager answering the phone after normal hours?

What about helping out with the wife's medical needs?

What about prioritizing?

Key points Study Case 3:

- The Case Care Manager answers the phone, disregarding the fact that it is Friday evening.
- The Case Care Manager looks for treatment options for Roger that allow him to care for his wife and keep his job.
- The Case Care Manager analyzes the wife's situation, connecting the participant to the cancer research center, helping them find resources to pay for treatment and to apply for a grant or testing program.
- The Case Care Manager refers Roger and his wife to a cancer support group.
- Remember: the Case Care Manager helps the participant prioritize his next steps. If he is not well, he cannot take care of anyone else.
- The organization in charge of Case Care Management is responsible for sharing a code of conduct suggesting how to address ethical issues and how to establish and maintain healthy boundaries. Ultimately, it is the Case Care Manager who knows the participant and the circumstances that will take the final decision whether or not to answer the phone.



Case Care Manager Assisting the Client



- Navigating the system
- Overcoming barriers
- Prioritizing needs and goals
- Respecting client ownership
- Checking in for progress and challenges
- Meeting clients at a convenient location
- Supporting client's journey towards stability



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7.9

Say

The Case Care Manager is the **contact person for the participant**: he/she support participants in navigating the systems, and help them to understand how the justice, health and social systems work, while not taking away participants' ownership of the process.

The Case Care Manager **understands the participant's needs and SUD dynamics**, is proactive in identifying and addressing needs and obstacles as appropriate (e.g., housing, transportation, health insurance, writing a resume, job interviews, family reunion, child custody, etc.).

The Case Care Manager is a **champion** for the participant, is aware that the participant faces multiple challenges and might have competing urgent needs, but also identifies and values the participants' strengths.

The Case Care Manager **respects the participant** and **does not undermine the participant's responsibilities**. Instead, they encourage the participant to undertake gradual and progressive responsibility and leadership.

The Case Care Manager helps the participant prioritize and reduce goals into incremental, achievable steps that produce concrete progress.

The Case Care Manager **listens to and learns from the participant** (instead of a top-down approach) but is also a skilled and highly trained professional that is able to use Motivational Interviewing (MI) and encourage the participant. The participant is the main actor here and should be empowered to achieve the participant's planned goals, objectives, and activities. The Case Care Manager meets with the participant in different locations based on the participant's needs and convenience (e.g., at the office, in the participant's home visits, at a nearby park, etc.).

The Case Care Manager **is present throughout the program** and consistently reaches out and connects with the participant, checking in to assess progress, listening to concerns, and providing support and motivation.

The Case Care Manager supports and incentivizes the participant's journey toward stability, long-term recovery, and social integration.

Case Care Manager Supporting Health and Social Services

HEALTH SERVICES

- Cooperation
- Identification and removal of Barriers
- Linkages/Participant Referral
- Monitoring
- Reporting

SOCIAL SERVICES

- Collaboration
- Identification and removal of Barriers
- Linkages/Participant Referral
- Transition
- Communication
- Reporting

Case Study 4

7.10



Say

The Case Care Manager creates a collaborative partnership with both Health and Social Services.

Let's have a look at them both.

With HEALTH SERVICES

Case Care Management wants to foster cooperation, not competition: It creates collaborative mechanisms with treatment providers and provides participant referrals.

Case Care Management creates further job opportunities for treatment and services, making referrals and working hand-in-hand with the treatment providers during the program, monitoring and assisting in crisis prevention and management.

It unites strengths to achieve better results. One example of fruitful and mutual cooperation is that the reporting work is simplified: a Case Care Manager reports to the judicial authority, providing accurate information on participant progress and achievements.

With SOCIAL SERVICES

Similar to the work done with the health services, a Case Care Manager promotes collaboration with social services to address a participant's needs and secure timely referral/linkages with services. A Case Care Manager also assists in the participant's transition from one service to the next, and upon graduation/completion of the program. It also ensures that communication protocols are in place so that service providers know how to help and what to expect. Similar to the collaboration with the health services and treatment providers, a Case Care Manager shares or takes over the job of reporting to the judicial authority when required.

In Summary:**HEALTH AND SOCIAL SERVICES****The value-added of CCM for the HEALTH system:****Positive Aspects**

- A Case Care Manager is a **reliable partner** to work with. He/she are a well-respected and trusted professional both in the justice system and treatment services.
- A Case Care Manager **shares the burden of taking care of the participant.**
- A Case Care Manager is the **primary point of contact for the treatment and services providers:** each knows whom to notify in case of needs, concerns, or problems that arise with a participant.
- A Case Care Manager **will conduct some of the reporting to the judicial authority.**

Negative Aspects

- Greater **coordination is needed** to make it work.
- **Communication protocols** need to be in place.
- **Regular in-person or over the phone meetings** are required.

Say

Let's now turn to Case Study 4, which presents a concrete example of collaboration between Case Care Management and the treatment provider.

Case Study 4

The Case Care Manager is looking at her agenda. Andrew, her participant, missed his appointment today. This seems odd to her. Andrew has been in the program for two months and is doing fairly well. He always shows up on time and attends treatment regularly. He seemed motivated and had plans to resume his studies and graduate from college before summer. Andrew wants to be a realtor and is working part time at a real estate agency. The Case Care Manager picks up the phone and calls Andrew. No answer. Then, the Case Care Management calls the treatment provider to check on Andrew.

Ask

What do you think the treatment provider will say?

Think of a possible scenario to discuss with the group.

Some of the options that can be analyzed include:

- Nothing serious: Andrew simply forgot the appointment. He got a call that distracted him. Once he saw the lost call from the Case Care Manager, Andrew called back and explained what had happened.

Suggested action to be taken: Andrew should set up a reminder on his phone for all of his upcoming appointments, and the Case Care Manager should call him to remind him about each appointment.

- Something happened: The treatment provider confirms that Andrew did not attend the last treatment session and provides additional details. The week before, Andrew seemed nervous. Something might be happening in his life.

Suggested action: The Case Care Manager follows up with Andrew and finds out what happened. Andrew lost his part-time job because he had an argument with a colleague and was fired. The Case Care Manager could help Andrew understand the reason behind this and assess if he would benefit from an anger management course or find additional resources that might be useful to him.

Lessons learned from Case Study 4:

- The Case Care Manager did well in contacting the participant first and then the treatment provider.
- Missing an appointment can be a signal that something is happening.
- The Case Care Manager is an asset to health and social services and helps them figure out participant's needs.



What about partnerships? We can have different models on how to establish partnerships. Let's have a look at three of them: the Single Agency, Informal Partnerships, and Formal Consortium models. We will analyze the advantages and disadvantages of each, before deciding which one would be more feasible in the context of your country.

The overarching goal of case management is to connect individuals to the services and resources they need.

The goal of interagency case management is to connect agencies to one another to provide additional services to participants. All organizations have boundaries. However, case managers or "boundary spanners" move across them to facilitate interactions among agencies.

SINGLE AGENCY

In the Single Agency model, the Case Manager personally establishes a series of separate relationships on an as-needed basis with professional colleagues or counterparts in other agencies.

This means that there is less focus on organizational process than in other case management models and more focus on participant-related tasks.

Interagency Case Management services are built on informal agreements.

THE INFORMAL PARTNERSHIP

In the Informal Partnership model, staff members from several agencies work collabora-

tively but informally as an ad hoc team constituted to provide multiple services for participants on a case-by-case basis.

This model establishes and maintains informal partnerships or networks to respond to the needs of multiple populations with multiple problems.

Its initial motivation for forming partnerships may be funding-driven as well as need-driven.

Frontline case management staff from partnership agencies meet informally as a group, and without a formal contractual obligation, to discuss participant cases.

THE FORMAL CONSORTIUM

The Formal Consortium model links case managers and service providers through a formal written agreement. Agencies work together for multiple participants on an ongoing basis and are accountable to the consortium.

To ensure coordination among consortium members, a single agency typically takes the lead in coordinating activities and has the final word over use of selected resources and interagency processes.

A formal consortium can enhance the systems of care for participants with SUDs by meeting on a regular basis on behalf of shared participants in order to exchange information and coordinate services.

Source:

Substance Abuse and Mental Health Services Administration (SAMHSA). (2000) Comprehensive Case Management for Substance Abuse Treatment, Treatment Improved Protocols TIPS 27. Center for Substance Abuse Treatment, available at <https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215>

Steadman, H. J. (1992). Boundary spanners: A key component for the effective interactions of the justice and mental health systems. *Law and Human Behavior*, 16(1), 75–87. <https://doi.org/10.1007/BF02351050>

Cook, R.D. (1977) Detection of Influential Observations in Linear Regression. *Technometrics*, 19, 15-18. <http://dx.doi.org/10.2307/1268249>

Case Care Manager Working with Communities

COMMUNITIES

- Education
- Engagement
- Recovery support
- Family support
- Work placement

Case Study 5

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Communities are a key partner in Case Care Management. They are the place where we want the participant to be successfully inserted.

Case Care Managers work with the communities to create opportunities to promote education on SUDs, promote understanding and welcoming approaches and to overcome stigmas and misconceptions.

A Case Care Manager engages with local communities to mobilize support for the recovery and social integration.

A Case Care Manager reaches out to civil society, spiritual leaders, and support groups to create a supportive network for the participant, and works with civil society to raise awareness on recovery and support recovery champions.

At the same time, the Case Care Manager encourages family cohesion and positive models of supportive families.

A Case Care Manager creates ties with local businesses and facilitates participant reentry into the workforce through internships, apprenticeships, and temporary jobs.

Let's read Case Study 5, which provides an example of the kind of relation with communities we want to establish. Please open page 202 of the Participant manual.

Case Study 5

There is a bakery close to the Case Care Manager's office. It used to be a family-owned shop, but the new owner had no family to take over the business and decided to sell. The new owner is young and comes from a nearby city. He follows the philosophy of using local products, organic ingredients, and high-quality raw materials. During their lunch break, the Case Care Manager meets with a participant at the new bakery for a coffee to have a follow-up meeting. The owner emerges from the kitchen after the meeting is over and approaches the Case Care Manager, asking questions about his job. During the conversation, John, the baker, tells the Case Care Manager about his best friend who used drugs and wound up in prison, but is finally getting out and going to treatment. John knows about addiction and is interested in learning more about Case Care Management and how local businesses can support people in recovery. The Case Care Manager tells him about the possibility of offering internships at the bakery.

Key aspects of the case study to be addressed in the discussion:

- The Case Care Manager meeting with the participant in an informal setting.
- The Case Care Manager engaging with the community, being open to answer questions from the public about his job and to create connections.
- The baker's history that includes a close friend having a SUD problem and approaching the Case Care Manager without prejudice or stigma.
- A local shop that wants to help.
- The Case Care Manager could explore other opportunities for job placement and social reintegration such as the participant starting up a small business, or job opportunities due to state or movement incentives offering tax breaks to employers who offer jobs to marginalized groups
- The Case Care Manager working with a local shop that might offer discounts or special rates for the treatment program.



Training instructions: The trainer should have prepared in advance by reading Case Study 5 and the accompanying teacher's note in the *Resource Page 7.1* of this manual at page 303. The trainer should also refer to page 201 of the Participant manual.



Case Care Management Adds Value for the Communities

- Helps the communities understand addiction and recovery, overcoming stigma, and abandoning misconception
- Works with a diverse range of stakeholders to provide a social- psycho- spiritual integration and the support network of the participant building up desistance
- Connects with families to reunite family ties, promoting models of supportive care
- Connects with civil society to create inclusive cities



OAS CICAD



7.13

Say

As we saw in the Case Study, there are additional benefits when Case Care Management actively works with the surrounding community.

A Case Care Manager **understands communities**. Once a rapport is established with the participant, the Case Care Manager meets with participants in their own communities (house visits, at the local café, etc.).

A Case Care Manager **meets with families**, assesses the family's influence and assists in creating and/or rebuilding rapport with supporting families (clarify the importance of assessing the family and keeping the participant away from abusive or dysfunctional families).

A Case Care Manager **engages with local communities, educating on SUDs** and advocating for **recovery and recovery support, along with the recovery champions**.

A Case Care Manager **meets with spiritual leaders** to gain further support and information about formal or informal opportunities to support the participant's social reintegration.

A Case Care Manager **reaches out to local businesses** to create relations and opportunities for participants to get internships, job training, and job placements (Provide some examples: Fifteen by Jamie Oliver).

Overall vision: working towards the creation of **INCLUSIVE CITIES**: cities that are aware and respectful and provide **opportunities for social reintegration** of people going through difficult periods in life. Substance use disorder is a disease. Some types of consumption are more evident than others, but all need treatment and social support. **The more accessible and socially accepted a substance is, the more its consumption is likely to increase. The communities are not there to either stigmatize or promote substance use, but to provide social support to those who need it and are willing to reenter society as contributing, functional individuals.** These people are a resource and should be treated as such.

Source: Best, D. Coleman, C. (2019) Strengths-Based Approaches to Crime and Substance Use: From Drugs and Crime. From Drugs and Crime to Desistance and Recovery.



Wrap up and discussion



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7.14

Training instructions: Briefly summarize the contents of the module and ask the participants the following questions:



1. *After having analyzed the case studies what do you think really helps in Case Care Management work?*
2. *What elements do you need to learn more about?*
3. *What is missing?*

CASE CARE MANAGER INTERACTING IN THE MULTISYSTEM APPROACH

Resource page 7.1 Case Study 1 Slide 7.5 p. 192

One Monday morning in a courtroom, Judge R. is seated in her office, preparing for the day and reading the papers in the heavy folder on her desk. Flipping through the pages, she finds a death certificate. She realizes that this is the third death certificate she received this month. She reads further, looking for the details of the person that has died. At the top of the death certificate she finds the information: Robert, 25, overdose. Robert had been in her court room three times in the past few months. He was a shy man, and had barely said a word during his hearings, allowing his attorney to do a majority of the speaking. There had been some concerns that he was using drugs, but a proper drug test or screening had never been completed. Judge R. feels frustrated and emotional about Robert's death and the other deaths that have occurred and will likely continue to occur as a result of failure of the justice system to provide the proper services. As a judge, she wants to make a difference, make the right decisions, and help people, but sometimes it is very difficult to identify the proper services. Judge R. starts contemplating what could have been done differently to better assist Robert and other people like him. She feels quite alone.

Read the case study case again and underline any helpful hints you find.

How could Case Care Management have helped Judge R?

Resource page 7.2 Case Study 2 and 3. Slide 8.8 p. 194

Case Study 2 (Positive Scenario)

Melania, 35, is calling her Case Care Manager to tell him that she just got a new job. Melania is on probation and has limited work experience. She was worried about not being able to find a job. The Case Care Manager encouraged her to meet with Rainbow, a local NGO that runs a program called Write Me. At Rainbow, volunteers meet with participants to assess their experience and strengths, assisting them in writing their resume, collecting the needed documentation and preparing for job interviews. Melania is an eager reader and loves books. Her dream is to find a job in a local library or as a sales assistant in a bookshop. She got a job at the new bookstore downtown. She is very excited and starts on Saturday.

The trainer will lead the discussion and identify the key learning points in Case Study 2.

Case Study 3 (Negative Scenario)

Roger called his Case Care Manager on Friday evening. He needed to speak with someone. He received very sad news that morning, was feeling overwhelmed all day and could not find a suitable plan to move forward. His wife Gina was diagnosed with breast cancer. The doctor said there are treatment options and that they should probably schedule a surgery. There is also a new experimental medication that is not covered by their health insurance, but Gina might qualify to be in the testing program. Roger wants to be supportive and help his wife, especially after all the years she supported him, by spending time with her and driving her to medical appointments. However, his

wife's medical care might interfere with his ability to attend treatment programs himself. Roger is in an intense outpatient drug treatment program due to his severe SUD problem. If he steps in to care for his wife, he might not be able to keep his job, which is very much needed as it is their only income. Roger is confused about competing priorities and worried about the future.

The trainer will lead the discussion and identify the key learning points in Case Study 3.

Resource page 7.3 Case Study 4. Slide 7.10 p. 196

The Case Care Manager is looking at her agenda. Andrew, her participant, missed his appointment today. This seems odd to her. Andrew has been in the program for two months and is doing fairly well. He always shows up on time and attends treatment regularly. He seems motivated and had plans to resume his studies and graduate from college before summer. Andrew wants to be a realtor and he is working part time at a real estate agency. The Case Care Manager picks up the phone and calls Andrew. No answer. Then, the Case Care Manager calls the treatment provider to check on Andrew.

What do you think the treatment provider will say?

Think of a possible scenario to discuss with the group.

The Trainer will ask an open question to the participants about the response from the treatment provider and ask them to think of possible outcomes.

Resource page 7.4 Creating partnerships

Source: Characteristics of the Three Interagency Models, Substance Abuse and Mental Health Services Administration. Comprehensive Case Management for Substance Abuse Treatment. Chapter 3 – Case Management in the Community Context: An Interagency Perspective. Treatment Improvement Protocol (TIP) Series, No. 27. HHS Publication No. (SMA) 12-4215. Rockville, MD: Author, 2012. Figure 3.1, pg. 31-33

The overall goal of Case Care Management is to connect individuals to the services and resources they need (TIP 27, 2012).

The goal of interagency Case Care Management is to connect agencies to one another to provide additional services to the participants. All organizations have boundaries. However, case managers or “boundary spanners” move across these boundaries to facilitate interactions among agencies (Steadman, 1992)

The three models of creating community linkages are: the **SINGLE AGENCY**, the **INFORMAL PARTNERSHIP**, and the **FORMAL CONSORTIUM** (Gillespie and Murty, 1994).

In the SINGLE AGENCY model, Case Care Management:

- Establishes a series of separate personal relationships on an as-needed basis with professional colleagues or counterparts in other agencies;
- Retains full and autonomous control over the case and is accountable only to the parent agency;
- Is less focused on the organizational process than other case management models, but is more focused on participant related tasks; and,
- It is hired by, and solely accountable to, the single agency.

In the INFORMAL PARTNERSHIP model, Case Care Management:

- Works on a temporary team to create a collaborative mechanism with several agencies on an informal basis, providing multiple services for participants on a case-by-case basis;
- Establishes and maintains informal partnerships or networks to respond to the needs of multiple populations with multiple problems;
- Shares the responsibility for a participant's well-being, although accountability for the actual services provided remains with the individual agencies. (Note: It is very important that all team members are aware of their separate and distinct roles while working with the participant(s).) Efforts may be duplicated if communication lines are not kept open and all team members are not kept aware of the case manager's efforts;

- Might have an initial motivation for forming partnerships which is funding and need-driven;
- May evolve from a single agency model or be the model of choice from program inception; and,
- Is less likely to have a lead agency than a formal consortium.

In the FORMAL CONSORTIUM, Case Care Management:

- Engages with partners through a formal written contract. Agencies work together for multiple participants on an ongoing basis and are accountable to the consortium;
- Ensures coordination among consortium members. A single agency typically takes the lead in coordinating activities and maintains final control over selected resources and interagency processes (Cook,1977);
- Can enhance the systems of care for participants with SUDs by meeting on a regular basis on behalf of shared participants, in order to exchange information and coordinate services. This model offers all participants an opportunity to get to know each other, collaborate, and advocate on behalf of affected families;
- Shares accountability across agencies and the Case Care Manager is accountable to the consortium; and,
- Tends to have a longer-term or more chronic orientation than other case management models.

Resource page 7.5 Case Study 5. Slide 7.12 p. 197

There is a bakery close to the Case Care Manager's office. It used to be a family owned shop, but the new owner had no family to take over the business and decided to sell. The new owner is young and comes from a nearby city. He follows the philosophy of using local products, organic ingredients and high-quality raw materials. During their lunch break, the Case Care Manager meets with a participant at the new bakery for a coffee as a follow up meeting. The owner emerges from the kitchen after the meeting is over and approaches the Case Care Manager, asking questions about his job. During the conversation, John, the baker, tells the Case Care Manager about his best friend who used drugs and wound up in prison, but is finally getting out and going to treatment. John knows about addiction and is interested in learning more about Case Care Management and how local businesses can support people in recovery. The Case Care Manager tells him about the possibility of offering internships in the bakery.

The trainer will lead the discussion and identify the key learning points in Case Study 5.

MODULE 8



The Profile of a Case Care Manager

Preparation checklist

Content and timeline

Training goals and learning objectives

PowerPoint slides

Resource pages

MODULE 8

Module 8 Preparation Checklist

- Review the “Getting Started” section for general preparation information on page 13 of this manual.
- Preview Module 8.
- Prepare for the interactive exercise: assemble the following:
 - A stack of letter-sized (or A4-sized) paper for each table.
 - Pads of Post-it notes for each table.
 - Place colored markers and a stack of colored paper on each table.

Module 8 Content and Duration

Activity	Time
Module 8- The Profile of a Case Care Manager	60 minutes
Presentation: The Profile of a Case Care Manager	15 minutes
Presentation: How to hire a Case Care Manager	15 minutes
Presentation: How to train a Case Care Manager	15 minutes
Reflective Exercise: Case Care Manager Profile	15 minutes

Module 8 Goals and Objectives

Training Goals

- Present the profile of a Case Care Manager.
- Illustrate how to hire a Case Care Manager.
- Present how to train a Case Care Manager.

Learning Objectives

Participants who complete Module 8 will be able to:

- Understand the profile of a Case Care Manager.
- Understand how to hire a Case Care Manager.
- Understand how to train a Case Care Manager.



MODULE 8

THE PROFILE OF A CASE CARE MANAGER



OAS/CICAD 

8.1

Say

In Module 8, we will learn about the professional profile of a Case Care Manager, elaborating on the key elements to look for when selecting, hiring, and training a Case Care Manager.



MODULE 8

Objectives

Understand the profile of a Case Care Manager

Understand how to hire a Case Care Manager

Understand how to train a Case Care Manager



OAS



8.2

Say

By the end of the module, I expect you to understand and be able to describe the professional profile of a Case Manager. You will also be familiar with the skills that should be considered when hiring a Case Care Manager and the training that is suggested.



Profile of a Case Care Manager

A professional with an outstanding respect for human beings

Believes that everyone has the right to a fulfilling life and the ability to achieve it

Great listener

Able to coordinate participant needs and follow the steps of the Case Care Management system

Knowledgeable of relevant systems and well respected in them, yet stands independently as a professional, providing the linkage between and within systems



OAS



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Ask

Who is a Case Care Manager?

Say

A professional with great respect for human beings. A Case Care Manager should be humble and respectful in all situations.

A Case Care Manager believes that everyone has the right to a fulfilling life and the ability to achieve it.

A Case Care Manager should be willing to support the participant to achieve a fulfilling life and overcome obstacles.

A Case Care Manager is a great listener: Active listening is a prerequisite for a Case Care Manager. The professional should be able to listen to participants and not overload participants with information or suggestions, but rather to provide them with the opportunity to express themselves in their own words.

Coordination is key in Case Care Management, therefore the professional should be able to coordinate participant needs and follow the steps of the Case Care Management system. A Case Care Manager should be able to match the participant needs and perform the Case Care Management functions.

A Case Care Manager should be knowledgeable of and well respected in the relevant systems, yet also stand independently as a professional, providing the linkage between and within systems: A Case Care Manager needs to have knowledge of the justice, health, and social services systems from their previous job experience. Case Care Managers also need to have a good reputation as trustworthy professionals; otherwise, the stakeholders will not respect or work with them.



Qualifications:

Bachelor's degree in human services, social work, psychology or related fields or equivalent work experience

Minimum of **2 years professional experience** in social services or related areas

Knowledge of:

- SUDs and symptoms
- The code of ethics for SUD treatment professionals
- Relevant drug and alcohol laws
- The justice system

Computer literate and excellent writing and communication skills




E.4



Let's have a look at the desired qualifications for the job.

Bachelor's degree in human services, social work, psychology—or equivalent, related experience. We are targeting professionals that have a range of competencies, but we do not want to exclude someone who has the potential for the job just because he or she does not hold a university degree.

Minimum of two years professional experience in social services or related areas is an asset.

Case Care Managers should have knowledge of:

- SUDs and their symptoms, to be able to conduct assessments and service planning and to be able to appropriately interact with the participant.
- The code of ethics for substance use treatment professionals.
- Relevant drug and alcohol laws.
- The justice system.
- Computer skills, excellent writing, and communication skills, all of which are essential to perform in the job.



How to Hire a Case Care Manager



Skills that are essential to perform the job

Empathy

Caring attitude

Good communicator

Listening skills

Respect for Case Care Management core values

Sound personal judgment



OAS/CICAD



85

Say

Some interpersonal skills are crucial to be able to work as a Case Care Manager. Let's have a look at them:

- Empathy: the ability to relate emotionally with participants, showing understanding.
- Caring attitude: being welcoming and making the participant feel welcome.
- The Case Care Manager should possess strong listening skills, and the ability to listen in a genuine, respectful way.
- The Case Care Manager should be a good communicator, being able to engage with the community to educate and reduce the stigma around participants.
- The Case Care Manager should share and implement the Case Care Management core values.
- The Case Care Manager should have sound personal judgment since he/she will often be asked to make decisions autonomously. Also, supervisors need to be able to trust the Case Care Manager's



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MANAGEMENT



Ability to be independent and autonomous

Strong problem-solving skills

Ability to cope with pressure; not easily overwhelmed

Cultural humility; understanding that there are multiple ways of accomplishing tasks

Eager to learn new paths and ways to implement their work

Flexible, creative, kind

Lived-experience in recovery is considered an asset



OAS CICAD

8.6

Ask

judgement.

Say

How do you find the right candidate for the job?

As previously mentioned, a Case Care Manager needs to be able to work independently and autonomously.

A Case Care Manager should have solid problem-solving skills and should be able to work with the participant to come up with solutions, and not be easily overwhelmed.

A Case Care Manager should demonstrate cultural humility and understand that there are multiple ways of accomplishing tasks.

A Case Care Manager should be eager to learn new ways to do their work, and be flexible, creative, and kind.

Training instructions: Trainers could mention that, “In some cases, having personally lived through an experience could be an asset.” The idea is to explain that people that were once participants can achieve a level of stability and social integration, and attain enough education to become suitable to be considered for Case Care Management po-



How to Train a Case Care Manager

Technical knowledge that should be taught and periodically refreshed by trainings:

Further understanding of SUD

Enhanced knowledge and understanding of the DSM-5 and other mental health screening tools

Improved understanding of the justice system and how to make it understandable for participants



OAS



8.7

Say

sitions themselves.

After hiring Case Care Managers, training them is another important aspect that should be considered.

Although Case Care Managers should have previous knowledge of the issues we discussed, but a refresher course should also be offered on the following topics, to increase their technical knowledge and ability to deal efficiently with the participants:

- State-of-the-art science about Substance Use Disorders (SUDs), including neuroscience, diagnosis, behavioral implications, treatment modalities, and implementation.
- The Diagnostic and Statistical Manual of Mental Disorders (DSM–5) and other mental health screening tools.
- The justice system and how to make it understandable to participants.

Teaching Instructions: Trainers should remind participants of



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MANAGEMENT

- ✓ Assessment and linkage processes
- ✓ Goals setting
- ✓ Services and treatment offer and requirements
- ✓ Burn out prevention




OAS CICAD



Reference Page 5.2 with further information on screening tools”.

Other aspects Case Care Managers should be trained on include:

- How to conduct the assessment and linkage processes.
- How to work with participants to identify and prioritize goals and break them down into achievable steps.
- Available treatment services and providers, and which are best suited for different participants.
- Placement requirements with service providers.
- Understanding the early signs of exhaustion that lead to burnout, and how to address them.



Training Instructions: Burn out undermines the health of the professional as well as their capacity to support individuals in recovery. We encourage to read more on burnout and compassion fatigue visiting the SAMHSA website and at the following link https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-01-01-016_508.pdf”.



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MANAGEMENT



Skills that can be taught

Motivational interviewing includes:

OARS techniques:

- Open ended questions
- Affirmation
- Reflective listening
- Summarize

(Sobell and Sobell, 2008)



OAS CICAD

2.9

Say

Motivational interviewing (MI) is a counseling approach developed in part by clinical psychologists William R. Miller and Stephen Rollnick in the early 1980s, and recognized as an evidence-based practice by the Substance Abuse and Mental Health Services Administration, (SAMHSA) in 2008. It is a direct, participant-centered counseling style for eliciting behavior change. A person who talks about the benefits of change is more likely to make that change, whereas a person who argues and defends the status quo is more likely to continue his or her problematic behavior.

Case Care Managers should be familiar with Motivational Interviewing and we strongly suggest they receive training on it. Motivational Interviewing can facilitate participant consideration and acceptance of services that will further recovery and social integration goals”.

Training instructions: The trainer should inform the participants that there is a summary of Motivational Interviewing and OARS techniques in *Resource Page 8.1 Motivational Interviewing* on pages 216-217 of the Participant Manual.

Say

Let’s briefly examine the four core interviewing or communication skills that are important in Motivational interviewing. They can be remembered by the acronym “OARS,” which stands for:

O - Open ended questions

Open-ended questioning supports dialogue and allows the participant to tell their story.

Begin with “What,” “How,” “Tell me about,” “Describe,” etc. Examples of open-ended questions include:

What do you think will be some of the things that might be problematic?

How are you managing your cravings now?

Tell me about your experiences in...

Describe your living situation.

A - Affirmation

Affirmation uses supportive statements to verify and acknowledge participants' behavior changes and attempts to change.

Examples of affirmation include:

Affirmation are positive statements about participants that reflect their strengths and healthy steps toward change to support self-efficacy.

R - Reflective listening

Reflective listening involves listening carefully to participants and then making a reasonable guess about what they are saying; in other words, it is like forming a hypothesis.

Listening is fundamental to Motivational Interviewing writ large, and reflective listening is a basic skill used in all four processes of MI. Behind the discipline of reflective listening is a trust that helps participants explore their own experiences and perceptions—even those that may be uncomfortable. Remember, the more you listen, the greater the opportunity for the participant to speak. The more the participant speaks, the greater the chances they will talk themselves into change.

Reflections also validate what participants are feeling and, in doing so, they communicate that the Case Care Manager understands what the participant has said. For example: *It sounds like you are feeling upset at not getting the job.* If correct, the participant usually confirms this. When reflections are correct, participants usually respond affirmatively. If the guess is wrong, for instance, *It sounds like you don't want to quit smoking at this time,* participants usually quickly deny the hypothesis by saying something along the lines of: *No, I do want to quit, because I am very dependent and am concerned about major withdrawals and weight gain.*

Reflective listening always uses a statement, not a question, and has the following features:

You drop your voice at the end of the sentence (indicative of making a statement instead of asking a question); and,

You reflect on the content of what the participant said, or on the participant's feelings.

Examples of reflections include:

It sounds like you are worried.

You are feeling uncomfortable.

You're wondering if your wife will sign the divorce papers.

S - Summarize

Summarizing relates or links what participants have already expressed and moves them on to another topic, or has them expand the current discussion further. Summaries are also a good way to either end a session (i.e., offer a summary of the entire session), or to transition a talkative participant to the next topic.

Source:

Miller, W. R., & Rollnick, S. (2013). *Applications of motivational interviewing. Motivational interviewing: Helping people change (3rd edition).* Guilford Press.

Sobell, LC., Sobel, MB. (2008) Motivational interviewing strategies and techniques: rationales and examples. Available at: http://www.nova.edu/gsc/forms/mi_rationale_techniques.pdf.

Stinson, J.D., Clark, M.D. (2017) Motivational Interviewing with Offenders: Engagement, Rehabilitation, and Reentry.



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MANAGEMENT



Skills that can be taught

- ✓ Trust and relationship-building
- ✓ Organizational skills
- ✓ Communication skills
- ✓ Record-keeping
- ✓ Building up Resilience for Case Care Manager



OAS CICAD

8.10

Say

In addition to Motivational Interviewing, there are other skills that should be taught. They include:

- **Trust and relationship-building:** The Case Care Manager should build a rapport with the participant, build trust with the justice system, create a cooperative mechanism with the treatment services, and engage with families and communities.
- **Organizational skills:** The Case Care Manager should learn how to prioritize, determine how to support each participant by break down goals into achievable steps, create linkages to treatment and services, find solutions to service accessibility barriers, and update the referral services database regularly.
- **Communication skills:** The Case Care Manager should be able to communicate effectively and accurately, developing effective working relations with the justice system and service providers, participant advocacy, probation, and parole hearings, communicating with the justice authority and partners, facilitating individual and group orientation sessions, and interviewing participants.
- **Record-keeping:** It is extremely important that the Case Care Manager completes and maintains all the required participant documentation, including results of assessments, service planning, reports to the judicial authority, progress notes, and program completion.
- **Building up resilience within themselves:** A Case Care Manager should be familiar with techniques for building up resilience and find help when needed. Access to burnout prevention programs and accessing supportive supervision would be an asset.



Training for Case Care Managers is an important component that will enhance their ability to perform their job.

There are a number of resources and training opportunities you can consider. I want to highlight the work of the International Society of Substance Use Prevention and Treatment Professionals, which is a trusted partner of INL, OAS/CICAD, and the Colombo Plan in delivering worldwide courses for professionals working in the area of substance use prevention and treatment.

The International Society of Substance Use Prevention and Treatment Professionals (ISSUP) is a global, non-profitable and non-government organization that supports the development of a professional prevention and treatment network. It serves as a focal point for information about substance use prevention and treatment.

ISSUP offers basic and advanced training called the Universal Treatment Curricula and the Universal Prevention Curricula. Its website is www.issup.net.



Training instructions: The trainers should direct participant to *Resource Page 8.3* on ISSUP Network and courses on pages 218-220 of the participant manual.



Universal Treatment Curriculum (UTC)

Basic series

- Course 1: Physiology and Pharmacology
- Course 2: Continuum of Care
- Course 3: Co-occurring Disorders Overview
- Course 4: Basic Counselling Skills
- Course 5: Screening Intake, Assessment, Treatment Planning
- Course 6: Case Management
- Course 7: Crisis Intervention
- Course 8: Ethics

Advanced series

- Course 9: Pharmacology and SUD
- Course 10: Managing MAT Programs
- Course 11: Enhancing MI skills
- Course 12: Cognitive Behavioral Therapy
- Course 13: Contingency Management
- Course 14: Working with Families
- Course 15: Skills for Screening Co-occurring Disorders
- Course 16: Intermediate Clinical Skills & Crisis Management
- Course 17: Case Management Skills and Practices
- Course 18: Clinical Supervision for SUD professionals
- Course 19: Enhancing Group Facilitation Skills
- Course 20: Special Population Group
- Course 21: Theories of Counselling
- Course 22: Trauma Informed care
- Course 23: Recovery management, Continuing Care and Wellness

(Source: www.issup.net)



OAS CICAD



8.12

Say

This is an overview of the courses available on the ISSUP website, www.issup.net. There is free material available to download and information on how to request a training or become a trainer. As you can see, many courses have been translated and are taught in local languages to fit the requirements of the countries and communities, thanks to partnerships with local universities and civil society organizations.



Certifications

Certifications and Trainings:

Case Care Manager could obtain a national certification as a Drug Counselor if applicable and in accordance with national law and regulations on the matter



The organization providing Case Care Management services could consider the Commission on Accreditation of Rehabilitation Facilities (CARF International) for behavioral health



OAS/CICAD



8.13

Ask

Why are we interested in certifications?

Say

Certifications are valuable assets both for Case Care Management professionals and for the organization hosting it.

Case Care Managers could apply for national or subnational certification as a Drug Counsellor, if available, or look for national accreditations that can enhance their professional profile.

The organization providing Case Care Management can also consider accreditation services through Commission on Accreditation of Rehabilitation Facilities, or CARF.

CARF provides accreditation services worldwide at the request of health and human service providers. CARF International accreditation provides a visible symbol that assures the public of a provider's commitment to continually enhance the quality of services and programs, with a focus on the satisfaction of the persons served.

Partnership with the Certification authorities will give me the programme impetus and enhance the quality of the Case Care Managers and Case Care Management support professional in the different countries.



Additional Elements to Consider

Re-allocating existing staff/resources:

- Consider pros and cons of reallocation
- Keep the separation between previous functions:
Avoid having the treatment provider performing both functions (treatment and Case Care Management)



OAS



8.14

Say

There are a few additional elements that you might want to consider:

Having understood the key features of the Case Care Manager, reallocating existing staff and training them to be Case Care Managers might be an option.

It is important to evaluate the pros and cons of reallocating existing human resources, and the costs of doing so.

In the case of reallocation, it is suggested to maintain a separation between the previous function and avoid having the treatment provider performing the dual role of treatment provider and case care management. Similarly, if the professionals in question are being asked to perform two jobs, be aware of the workloads that will be involved.

Case Care Manager Profile

**Say**

Before we finish the module, we are going to have a short reflective exercise. I would like you to look through the slides in this chapter and think again about the profile of the Case Care Manager. How has this chapter helped you further understand the professional and personal requirements for Case Care Managers? Is there something missing or that was not clear? What would be the most important aspects for Case Care Managers to do their jobs effectively in your country?

Please take five minutes to think about these questions and write down your answers.



Training instructions: The trainer should direct the participant to page 258 in the Participant Manual and give them five minutes to write down their notes. After the five minutes are up, the trainer should open the floor and ask participants to share their ideas with the group and stimulate discussion.

THE PROFILE OF A CASE CARE MANAGER

Resource page 8.1 Motivational Interviewing (MI) Fundamental Interactive Communication Skills: OARS

Source: Adapted from: The Colombo Plan Asian Centre for Certification and Education of Addiction Professionals Training Series, Enhancing Motivational Interviewing Skills, Participant Manual developed for the U.S. Department of State Bureau for International Narcotics and Law Enforcement Affairs (INL), (Colombo Plan, 2017).

There are four core interviewing and communication skills important in all processes of Motivational Interviewing. These skills can be used in individual, group, and family treatment sessions. These skills are referred to as “OARS.”

The acronym OARS stands for:

- **Open-ended questioning:** Supports dialogue and allows the participant to tell his or her story.
- **Affirming:** Uses supportive statements to verify and acknowledge a participant’s behavior changes and attempts to change.
- **Reflective listening:** Involves listening carefully to a participant and then making a reasonable guess about what they are saying; in other words, it is like forming a hypothesis.
- **Summarizing:** Relates or links what participants have already expressed and moves them on to another topic or has them expand the current discussion further. (Sobell and Sobell, 2008)

Open-ended questioning

When the Case Care Manager uses open-ended questions, it allows for a richer conversation that flows and builds empathy with participants.

- Open-ended questions encourage participants to do most of the talking, while the Case Care Manager listens and responds with a reflection or summary statement.
- The goal is to promote further dialogue that can be reflected back to the participant by the Case Care Manager.
- Open-ended questions allow participants to tell their stories.

Open-ended Questions ask the respondent to think and reflect, showing opinions and feelings and giving control of the conversation to the respondent.

Closed-ended questions give facts, are easy to answer and keep control of the conversation with the person asking the questions. The Case Care Manager might use them at the end of the meeting while summarizing the planning process.

Both closed-ended and open-ended questions are needed. It is important to know when each type should be used and the different ways that each type promotes participant engagement.

Affirming

Affirmations are statements made by the Case Care Managers in response to what participants have said, and are used to recognize participants’ strengths, successes, and efforts to change.

- Affirmative responses or supportive statements verify and acknowledge participants' behavior changes and attempts to change.
- While affirmations help to increase participants' confidence in their ability to change, they also need to sound genuine.

Reflective Listening

Good listening is fundamental to Motivation Interviewing and to Case Care Management. Reflective listening is a basic skill used in all four processes of MI.

- Listening reflectively is the primary way of responding to participants and building empathy.
- The more that Case Care Managers listen, the greater there is for an opportunity for the participant to speak. The more the participant speaks, the greater the chances are for talking oneself into change.
- Behind the discipline of good listening is a trust that helps participants explore their own experiences and perceptions, even those that may be uncomfortable.
- Reflective listening involves listening carefully to participants and then making a reasonable guess about what they are saying; in other words, it is like forming a hypothesis.
- Another goal is to get participants, rather than the Case Care Manager, to state arguments for change.
- Reflections also validate what participants are feeling and are particularly important following open-ended questions. Note that these are called statements rather than questions.
- A question demands a response. Reflective statements place no such demand on the participant yet allow for the participant to feel heard, hear their ideas out loud and choose to correct their ideas.

Summarizing

Summaries should be used judiciously to relate or link what participants have already expressed, especially in terms of reflecting ambivalence, and to move them on to another topic or have them expand the current discussion further.

- Summaries require the Case Care Managers to listen carefully to what participants have said throughout the session.
- Summaries are also a good way to either end a session (i.e., offer a summary of the entire session), or to transition a talkative participant to the next topic.

Resource page 8.2 OARS Techniques facilitating Case Care Management Planning

Source: Adapted from: The Colombo Plan Asian Centre for Certification and Education of Addiction Professionals Training Series, Enhancing Motivational Interviewing Skills, Participant Manual developed for the U.S. Department of State Bureau for International Narcotics and Law Enforcement Affairs (INL) 2018, (Colombo Plan, 2017).

Case Care Managers can apply OARS technique in the planning phase to engage with participants and explore goals and values, stimulating talk of change, letting desire for change emerge from the conversation, or examining the down-side of the status quo.

Exploring in Case Care Management

- Understanding the participant's values and goals helps promote engagement and create a rapport between the participant and the Case Care Manager.
- Recognizing where there are discrepancies between a participant's values and behaviors is a potential source of motivation for change.
- Motivational Interviewing experiences demonstrate that when participants are invited to

reflect on their values and actions in a nonjudgmental atmosphere they are usually well aware of discrepancies.

- Helping participants recognize the discrepancy between present behavior and important stated goals is a constructive way to look at planning and to create achievable steps that reflect participant's personal and program goals.

Focusing and Service Plan Creation

- Focusing is the term used in MI to describe the ongoing process of finding and maintaining direction, and within this direction outlining more specific and attainable goals.
- Sometimes the participant's focus is clear, but not always. The Case Care Manager can help guide the participant to maintain focus on a goal, finding the direction that participant intends to move and determining the kind of information or advice that the participant might need to achieve that particular goal.
- The Case Care Managers help the participant create their agenda, specifically the treatment and service plan.
- The participant's agenda is more than a list of goals. A participant's agenda may also involve hopes, fears, expectations, and concerns. The Case Care Managers will help the participant establish a proper pace as well as concrete and achievable steps that would work best for each individual.

Resource page 8.3 ISSUP network: UTC and UPC courses

ISSUP

The International Society of Substance Use Prevention and Treatment Professionals (ISSUP) is a global, non-profitable, non-government organization that supports the development of a professional prevention and treatment network. It serves as a focal point for information about substance use prevention and treatment.

ISSUP is a membership organization, developing a professional workforce with the competencies and skills required to deliver high quality, evidence-based, ethical prevention and treatment services.

ISSUP aims to:

- Represent the international and national communities of substance use prevention, treatment and recovery support professionals;
- Develop and deliver knowledge systems for evidence-based prevention, treatment and recovery support;
- Provide opportunities for and access to training, education, and credentials; and,
- Offer communication and networking opportunities taking place online and at ISSUP events.

Universal Treatment Curriculum (UTC)

The Universal Treatment Curriculum (UTC) has been developed by several teams of curriculum developers, with overall coordination by the International Centre for Credentialing and Education of Addiction Professionals (ICCE). **It provides a series of training materials for knowledge and skill development of treatment professionals. The aim of the training series is to reduce the significant health, social and economic problems associated with substance use disorders by building international treatment capacity through training,** thus expanding the professional global treatment workforce (ISSUP, 2019).

UTC is available through the basic and advanced series as well as with several specialist series that focus on populations with special needs such as women, children, and persons in recovery.

Basic series

- Course 1: Physiology and Pharmacology
- Course 2: Continuum of Care
- Course 3: Co-occurring Disorders Overview
- Course 4: Basic Counselling Skills
- Course 5: Screening Intake, Assessment, Treatment Planning
- Course 6: Case Management
- Course 7: Crisis Intervention
- Course 8: Ethics

Advanced series

The Advanced Level UTC offers a specialized training provision that aims to provide an in-depth continuing education with the latest information and skills-based activities to further enhance the capacity of the treatment workforce and standardize the quality of care and services they provide for their participants.

- Course 9: Pharmacology and SUD
- Course 10: Managing MAT Programs
- Course 11: Enhancing MI Skills
- Course 12: Cognitive Behavioral Therapy
- Course 13: Contingency Management
- Course 14: Working with Families
- Course 15: Skills for Screening Co-occurring Disorders
- Course 16: Intermediate Clinical Skills & Crisis Management
- Course 17: Case Management Skills and Practices
- Course 18: Clinical Supervision for SUD Professionals
- Course 19: Enhancing Group Facilitation Skills
- Course 20: Special Population Group
- Course 21: Theories of Counselling
- Course 22: Trauma Informed Care
- Course 23: Recovery Management, Continuing Care and Wellness

Universal Prevention Curriculum (UPC)

The Universal Prevention Curriculum for Substance Use comprises two training series, each addressing the needs of different target groups (ISSUP, 2019).

- **UPC Coordinators Series** is designed for those wishing to undertake a significant in-depth study of prevention. It is designed for coordinators, managers and practitioners, or for those who wish to undertake a major program of study (288 hours) in prevention.
- **UPC Implementers Series** is written for implementers or practitioners who work with families, in schools, in the workplace, and in the community

UPC is informed by the International Standards on Drug Use Prevention developed by the United Nations Office on Drugs and Crime (UNODC) in 2013.

A major role in the development of UPC has been undertaken by Applied Prevention Science International (APSI) led by Dr. Zili Sloboda, working with international experts in prevention from

around the world. The underlying principles of UPC are to provide a way forward for prevention that is based on scientific research and evidence, sound quality standards, and an ethical stance in how prevention should be undertaken. UPC was designed to meet the current demand for a comprehensive training package in the field of drug use prevention, based on evidence-based principles.

UPC Coordinator Series

The UPC Coordinators Series provides a 288-hour training program for prevention coordinators, managers, and students/trainees whose role includes, or will include, coordination and supervision of the implementation of prevention interventions and/or policies. The content is organized into the following nine courses:

Course 1: Introduction to Prevention Science

Course 2: Physiology and Pharmacology for Prevention Specialists

Course 3: Monitoring and Evaluation of Prevention Interventions and Policies

Course 4: Family-based Prevention Interventions

Course 5: School-based Prevention Interventions

Course 6: Workplace-based Prevention Interventions

Course 7: Environment-based Prevention Interventions

Course 8: Media-based Prevention Interventions

Course 9: Community Based Prevention Implementation Systems

UPC Implementers Series

The UPC Implementers Series is currently under development. The goal of this series is to ensure effective delivery of prevention interventions. Aims include providing knowledge about prevention science and its application to the effective delivery of prevention interventions, and equipping prevention practitioners with the requisite skills to implement effective evidence-based prevention programs in their respective settings. The content will be organized into the following 8 tracks:

Core: Introduction to the Universal Prevention Curriculum Series for Implementers

Track 1: Monitoring and Evaluation of Prevention Interventions and Policies

Track 2: Family-based Prevention

Track 3: School-based Prevention

Track 4: Workplace-based Prevention

Track 5: Environment-based Prevention

Track 6: Media-based Prevention

Track 7: Community Prevention Implementation System

MODULE 9



Case Care Management Implementation Roadmap

Preparation checklist

Content and timeline

Training goals and learning objectives

PowerPoint slides

Resource pages

MODULE 9

Module 9 Preparation Checklist

- Review the “Getting Started” section for general preparation information on page 13 of this manual.
- Preview Module 9.
- Prepare for the interactive exercise: assemble the following:
 - A stack of letter-sized (or A4-sized) paper for each table.
 - Pads of Post-it notes for each table.
 - Place colored markers and a stack of colored paper on each table.
- Bring copies of the daily evaluation form - Day 2.

Module 9 Content and Duration

Activity	Time
Module 9- Case Care Management Implementation Roadmap	60 Minutes
Presentation: Step 1- Program Design	10 minutes
Presentation: Step 2- Resource Planning	10 minutes
Group Exercise: Monitoring and Evaluation Planning	20 minutes
Presentation: Step 3- Program Creation	10 minutes
Presentation: Step 4- Pilot Project Implementation	10 minutes
Evaluation and End of Day 2	5 minutes

Module 9 Goals and Objectives

Training Goals

- Understand the Case Care Management implementation steps.
- Prepare for the Case Care Management action plan.
- Provide an overview of the following steps.

Learning Objectives

Participants who complete Module 9 will be able to:

- Describe the Case Care Management implementation steps.
- Understand how to prepare the Case Care Management action plan.
- Describe the follow up action needed to establish Case Care Management programs in their country.



MODULE 9

CASE CARE MANAGEMENT SYSTEM IMPLEMENTATION



9.1

Say

Let's go ahead and look at the steps involved in implementing Case Care Management, and review the important aspects of the implementation phase.

Module 9 constitutes the basis for the next and final module, where learning will be integrated into practice via group activities and the action plan exercise.

It also provides insights on further follow-up actions that go beyond the scope of this training, but will be necessary to kick-start Case Care Management implementation.



MODULE 9

Objectives

Understanding the Case Care Management implementation steps

Prepare for the Case Care Management action plan

Provide an overview of the following steps



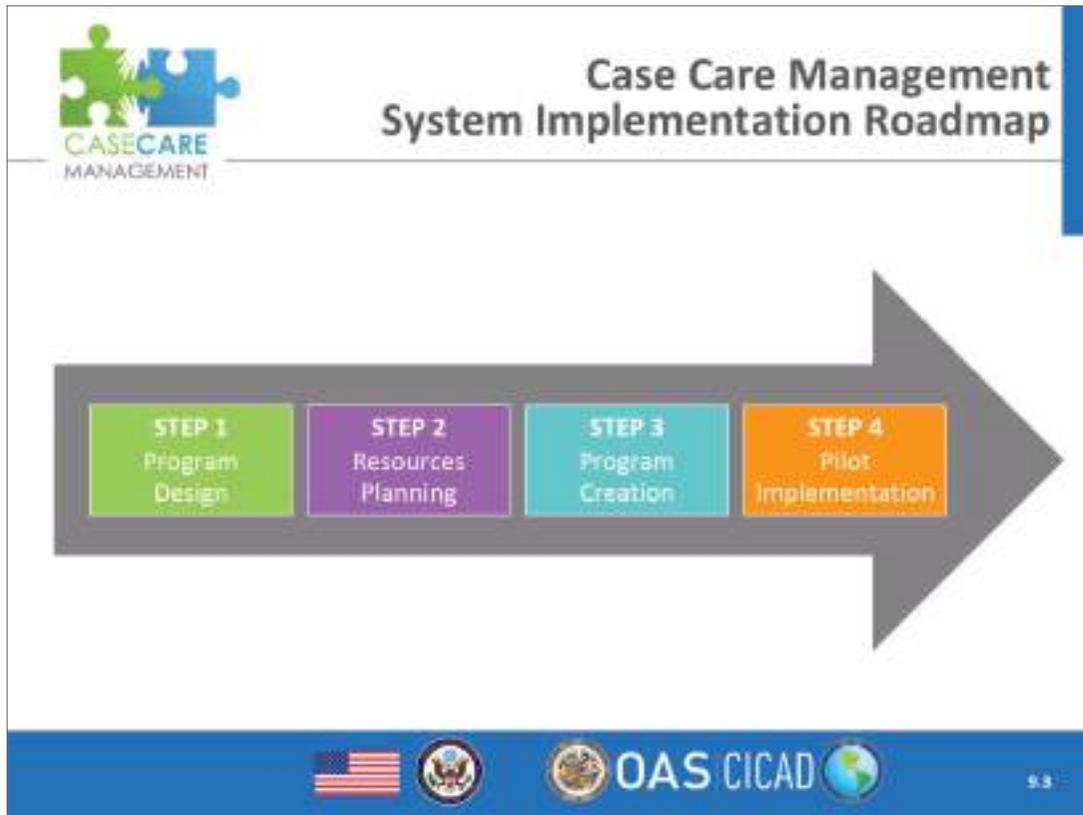
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9.2

Say

Upon completion of the module, I expect you to understand the Case Care Management building blocks and implementation steps to move forward.



Let's look at an overview of the Case Care Management implementation steps.

Step 1 is Program Design: Provides a definition of a Case Care Management pilot program, model, and leadership.

Step 2 is Resource Planning: Addresses mapping, budgeting, monitoring and evaluation, and minimum standards.

Step 3 is Program Creation: Elaborates on the creation of a team and office, and establishing relations with relevant stakeholders.

Step 4 is a Kick-Start: Discusses how to start implementation of a pilot program.



Step 1: Case Care Management Program Design

1.1 Identify the programs in the justice system continuum that will be served by Case Care Management

1.2 Define the Case Care Management operational model

1.3 Create the Case Care Management Steering Committee and define leadership



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Say

In Step 1, countries work on:

- 1.1 Defining the Case Care Management Program in the Justice System Continuum.
- 1.2 Defining the Case Care Management Operating Model.
- 1.3 Creating the Case Care Management Steering Committee and defining the Case Care Management Leadership.



Understand the Features of the Justice Programs

Location of existing interventions or those in development that could benefit from Case Care Management



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9.5

Say

Of particular importance in the program design is understanding the justice system and the alternatives to incarceration that are already in place. The following aspects need to be clarified:

- Justice program and justice intercepts: Which current ATI or preventive initiatives will have a Case Care Management program?
- Participant profile: Define who will be the participant.
- Program Eligibility and expectations: Define legal and clinical eligibility to enter the program.
- Program details: Elaborate on program length, graduation requirements, etc.



Clarifying Program Expectations

Overall Program Transparency

- Criteria from admission to completion for the participant
- Participant's obligations and consequences of non-compliance
- Communication protocols with stakeholders
- Sign Memoranda of Understanding for Case Care Management implementation



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9.6

Say

It is important to be clear on the expectations for the Case Care Management program. Well-defined expectations ensure that all of the stakeholders involved are on the same page and have a clear vision on what to expect.

Program transparency means providing a clear explanation of the steps or functions of the Case Care Management program. All aspects of program criteria, from participant admission to completion of the program, should be clearly defined. Clear explanations about participants' obligations should be provided, as well as the consequences of non-compliance and circumstances that would lead to program termination.

Training instructions: The trainer might want to remind participants that relapse should not be considered a cause of program termination. Relapse can occur during recovery and should not be stigmatized. The trainer should also mention that lying about relapse or hiding important information is a signal that something is wrong, or that the participant does not trust the Case Care Manager. In such cases, a conversation between the treatment provider, the participant, and the Case Care Manager is needed to better understand and assess the situation.

Trainer might want to underline that the participant entering the Case Care Management Program should be briefed on expectations as well as on the confidentiality and ethical aspects. The institution responsible for Case Care Management might think about creating an information package or hand-



book compiling all the relevant information for the participants. As we already discussed in Module 4, there are several elements constituting the Case Care Management model (Embedded vs. Independent, Centralized vs. Decentralized, Public vs. Private Funding) that need to be addressed to determine the best variant for a Case Care Management program in your country.

Based on the information you already know there are three key questions that you should address:

- Where should the Case Care Management program be placed: Embedded in an existing ministry/agency or independent?
- At the operational level: Should Case Care Management functions be centralized or decentralized?
- Funding: Is the best option public or private funding, or is a hybrid model preferable?

In Module 6, we discussed the creation of the Case Care Management model and its three levels: System, Operation, and Funding.

Please consult this information and the notes that you wrote down in your book, because these will be used tomorrow while discussing the implementation plan.

Training instructions: The trainer should remind participants they can use the SWOT analysis as they did in Module 6 to consider the pros and cons of each



Case Care Management Steering Committee and Leadership

WHO should be on the Steering Committee?

WHO should chair the Steering Committee?



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9.9

Say

model, before elaborating on the final model suggestion.

You also might recall the Stakeholder Exercise we did in Module 3, and the results should be in your notes in the Participant Manual on pages 253 and 254.

Based on the conclusion of the previous activity, where the leading organ of Case Care Management will be revealed, the next action would be to define the Case Care Management Steering Committee composition. The ideal members of the Steering Committee are those who can promote action and support the creation and development of Case Care Management.

The stakeholder chart created in Module 3 constitutes the starting point for brainstorming about the membership of the Steering Committee. During that discussion, it will also become clear which member is the natural leader for the process: the one with the capacity to make others accountable and transform plans into action.

Please also recall the exercise we did on the stakeholders and the key questions, including:
WHO should be on the Steering Committee?
WHO should lead the Steering Committee?

During tomorrow's implementation plan exercise, participants will be asked to discuss and come up with more details about each stakeholder, including whether they should sit on the Case Care Management Steering Committee.

Trainer might want to underline that the name Steering committee is just a suggestion. The country could rename the committee as they deem appropriate. The country could decide to create a working group or additional committee/es as needed. What is considered essential in the Case Care Management model is to establish a mechanism that secure commit-



Step 2: Resource Planning



2.1 Mapping of services and resources

2.2 Budgeting and funding for Case Care Management

2.3 Monitoring and Evaluation planning

2.4 Minimum standard compliance



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2.9

Say

ment, cooperation and information sharing with all the stakeholders. Step 2 is Resource Planning and includes the following:

- 2.1 Mapping of Services and Resources
- 2.2 Budgeting and Funding for Case Care Management
- 2.3 Monitoring and Evaluation Planning (Evaluation Exercise)
- 2.4 Minimum Standard Compliance



Mapping Treatment Resources

Assessing and mapping the existing treatment and service providers is a necessary pre-requisite for starting up Case Care Management

Highlight the gap between treatment and service needs and available options

Starting point for the referral resources



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9.10

Say

Assessing and mapping the existing treatment and service resources is a prerequisite for starting a Case Care Management program. The first activity in resource planning is mapping the existing resources that Case Care Management can count on in terms of treatment and services that are available to the participant. It is also an opportunity to conduct a gap analysis and collect information on what is needed but is not available and advocating for the creation of new services.



Resource page 9.1 in the Participant Manual on pages 239 to 241 provides a template for the mapping exercise. The following additional questions might be useful during the mapping phase:

What are the services available?

Where are they located?

Are the services available able to cover the Case Care Management workload? Consider the possibility of expanding existing treatment capacity.

Are new services needed that are not available? Consider what resources are needed, how to set them up, and how to get funding and train the professionals.

The information gathered from the mapping exercise will be the starting point for the Case Care Manager for the creation of the Referral Registry.

Training instructions: The trainer should refer participants to *Resource page 9.1 Mapping Resources for Case Care Management* at pages 239 to 241 of the participant manual.



Budgeting and funding are the next aspects that we need to look into.
 What is a budget used for?

STAFF COSTS: As we have already mentioned in the training, it is suggested you budget for a team of at least two people. The ideal timeframe for a pilot program is two years, in order to establish the Case Care Management functions and evaluate progress and results.

OFFICE COSTS: You should consider a location that is convenient both for the participant and for the justice authority. Ideally, you could partner with the judicial authority to tie Case Care Management in with existing services. Remember that accessibility is key.

OPERATIONAL COSTS: Assessment, toxicology performance, transportation. All of these activities might have an economic impact to consider and should be included in the budget.

STAFF TRAINING: You should consider initial training and at least one additional training per year in diverse areas according to the country's needs. Life-long training is one of the key elements to ensure Case Care Management's success in the long run, and to support professionals to do their job as best as they can.

EVALUATION: Specifically earmarked funds could be allocated to conduct an independent study on the results of the pilot project. On-going efforts are made to strengthen the capacity to collect data at the national level according to a common evaluation framework. INL is supporting the creation of a database model to facilitate data collection and analysis, and collect evidence on the effectiveness of Alternative to Incarceration and Case Care Management programs and their outcomes.



Training instructions: The trainer should refer participants to *Resource page 9.2 Budgeting for Case Care Management* on pages 241 and 242 of the participant



Funding for Case Care Management

Funding opportunities to consider

- National grants
- International grants/international cooperation
- Justice funds
- Treatment funds
- Reallocation of existing resources
- Developing crucial partnerships with university/academia to get trainees and for evaluation (grants for training and technical assistance, grants for evaluation)
- Philanthropy



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9.12

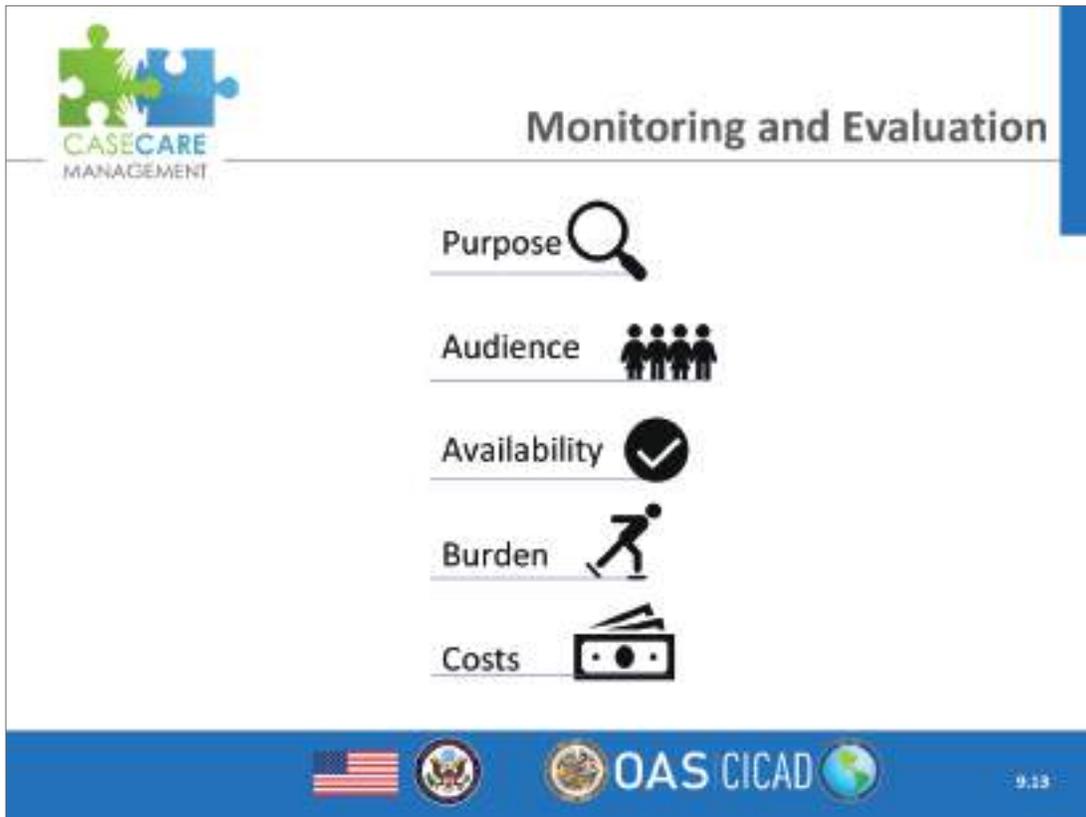
Say

manual.

There are several options to consider when applying for funding. Let's have a look at them:

- **National grants** - Mainly operational. Be aware of what is available and when it is available.
- **International grants/international cooperation** - There might be options for international grants for specific purposes, such as evaluation. Look for them and plan ahead to familiarize yourself with the application process and deadlines.
- **Justice sector funds** - Keep in close contact with the judicial authority and be aware of what is available.
- The same applies for **treatment funds**.
- Another option you might want to consider if funding is scarce is the **reallocation of existing resources** (you might need to invest in training).
- Developing partnerships with university/academia is critical to get trainees and for evaluation purposes (grants for training and technical assistance, grants for evaluation purposes).
- Philanthropy at large.

On a general note, writing grant applications is a time-consuming job. Plan ahead and if possible, consider having a grant writer or someone specifically



Say

devoted to that task. Monitoring and evaluation is another building block that deserves our attention. The more planning that is devoted to monitoring and evaluation, and better the embedded data collection systems are, the easier it will be to have quality data accessible when needed. Continual, system-wide self-monitoring means measuring adherence to benchmarks on a consistent basis, reviewing findings as a team, and modifying policies and procedures accordingly.

What should we consider when planning for the evaluation? Let's have a look at the key aspects.

The **Purpose**: What do we need the evaluation for? What are we going to assess? Why are we doing the evaluation?

The **Audience** is the ultimate recipient of the evaluation: Who is going to read the evaluation? Who are the stakeholders we want to have an impact on?

Availability of data: Consider what data is available, and the **time and costs** required to collect this data.

An additional option is hiring an independent evaluator, who can help identify strengths and areas for improvement by interviewing all stakeholders. The independent evaluator could also help define Case Care Management performance, by identifying a comparison group to measure impact and developing a research model for measuring outcomes.

Source: Carey, S.M., Macklin, J.R., and Finigan, M.W., 2012. "What works? The ten Kay components of Drug Court: Research best practices>" Drug court review 8:1: 6-42

Once all of these aspects have been addressed, you should have more clarity and can:

- Define the goals and the indicators to measure them.
- Clearly define outcomes and performance to be measured.
- Create indicators for measuring outcomes.
- Develop a participant file (physical or electronic) that can be accessed by all professionals working in a CCM team.
- Collect accurate data regularly and in a timely fashion, and organize it in an acces-

Planning Monitoring and Evaluation



sible data management system.

Training instructions: The trainer should prepare and read the exercise description in the manual and refer to pages 258 and 259 of the participant manual. The trainer asks the questions below to the participants, and the co-trainer writes down the participants' ideas on the flip chart.

Say

At this point, let's do a group exercise and apply some of the knowledge into practice.

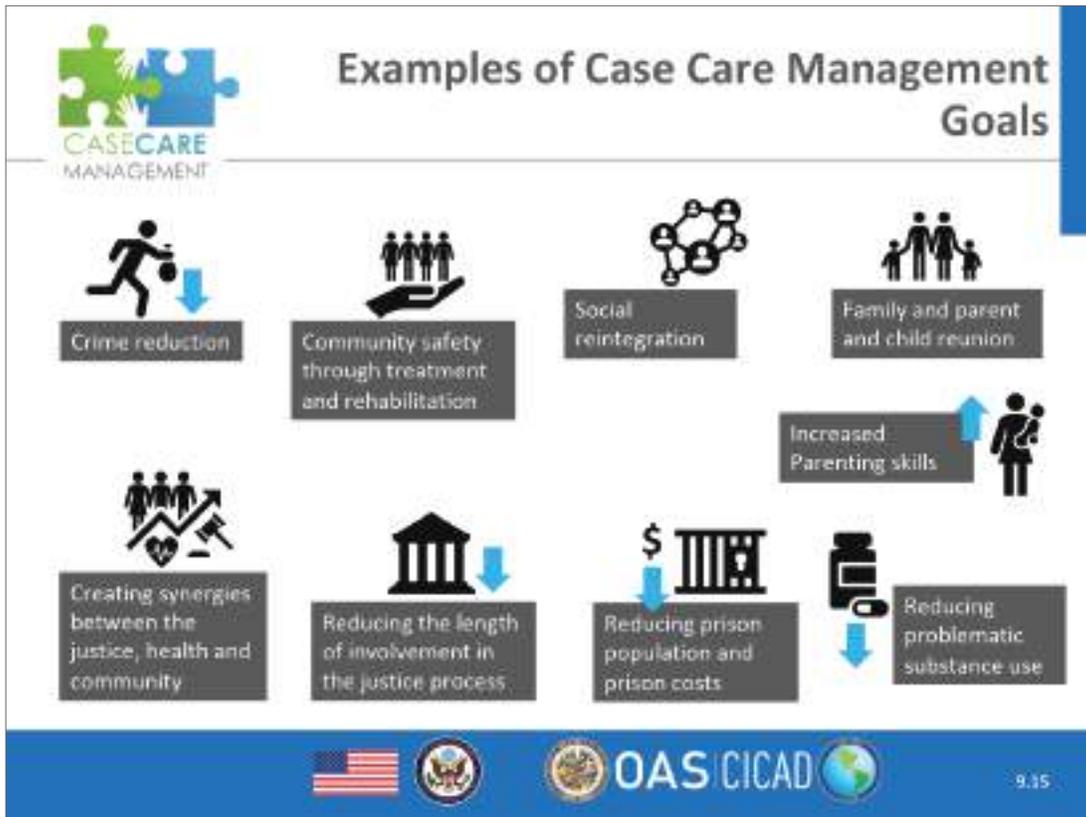


Please form three or four groups and discuss the following:

- What goals of Case Care Management are most relevant?*
- How would you measure them? What are the possible indicators?*
- How would you plan to collect them?*
- How would you consolidate them into the evaluation?*



After working on the big picture and identifying at least two major goals, the trainer will lead a discussion to identify some indicators. The co-trainer writes the group's conclusions on the flip chart, reproducing the table provided in



the participant manual on pages 258 and 259.

Based on the results of the group exercise, go through the list to check that all of the following elements are included:

Reducing crime, via reducing the vulnerabilities that lead to recidivism in crime and problematic drug use.

Promoting **community safety** through treatment and rehabilitation.

Reducing problematic substance use.

Promoting **social reintegration** for individuals with SUDs in the criminal justice system.

Creating opportunities for family and parent and child reunion, thanks to recovery, the increased health and welfare of the participant and the ability to assume responsibilities for the family.

Thanks to the support received in recovery and the increased parenting skills, the participant is able to take better care of the child.

Creating synergies between the justice, health, and social services systems.

Reducing the length of involvement in the justice process.



Suggestions for Case Care Management Core Data Collection



Program Goals

- ✓ Retention in the program
- ✓ Sobriety
- ✓ Low Recidivism
- ✓ Stable Housing
- ✓ Employment
- ✓ Successful Program Completion
- ✓ Completion across demographics
(gender, age range, ethnicity, etc.)





9.18



Reducing prison population and prison costs when not needed to preserve community safety.

What about the data? Which indicators have been established? Once again, let's see if we have already mentioned some of these indicators. We could have (A) program goals or (B) service data.

Regarding program goals, we can look at:

Retention: The number of participants who stayed in the Case Care Management program divided by the number of participants who entered the program.

Sobriety: Based on the toxicology results, the number of negative drug tests divided by the total number of tests performed.

Recidivism: The number of new charges divided by the number of participants in the program; the number of new technical violations divided by the total number of participants.

Stable Housing: The number of participants reported to have stable housing divided by the total number of participants.

Employment: The number of participants studying, looking for, or having secured employment divided by the total number of all participants.

Successful Program Completion: The number of participants successfully

CASECARE MANAGEMENT

Case Care Management Service Data

- Time for referral and assessment
- Number of contacts per month with participant
- Number of Case Care Management program completion
- Number of participants handled

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completing the program divided by the number of participants that entered the program. (This information could also include demographic information to allow cross-tabulation).

Service data helps to determine the quality of the Case Care Management program. Suggestions of the type of data to collect include:

Time for referral and assessment: Indicating the time required to respond to participant needs.

Number of contacts per month: Indicating the intensity of Case Care Management required by participants.

Number of CCM program completion: Indicating program success rate.

Number of participants handled: Indicating the average number of participants per Case Care Manager.

Training instructions: The trainer might want to underline the importance of



Case Care Management Minimum Standards

Integrating Case Care Management in a multisystem framework

Having (formal or informal) agreements in place, protection for confidentiality and communication protocol with stakeholders

Being identifiable with one of the existing Case Care Management models or hybrid

Respecting the Case Care Management value system

Following the basic Functions of the Case Care Management

Building up Case Care Management team (minimum of two professionals)



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9.18

Say

participant understanding and commitment to the process. An informed consent should be presented to the participant who signs it at the beginning of the program. The informed consent is periodically revised and signed, as appropriate.

Using minimum standards allows you to create a benchmark for a Case Care Management program and provide a checklist for Case Care Management activities. If what you are doing covers all aspects mentioned in the minimum standards, then the program can be labeled as Case Care Management.

The minimum standards are a useful tool when planning activities, as well as during implementation to secure coherence and consistency. Let's have a look at them.

First, Case Care Management should be working in a **multisystem framework**, as we mentioned in Module 3. Working with multiple stakeholders, creating synergies, and holding everyone accountable is a key feature of Case Care Management.

Case Care Management should have either a formal or informal agreement in place with such stakeholders. Establishing **confidentiality and communication protocols** with stakeholders is essential for the work of Case Care Management.

Ensuring that all stakeholders are on the same page, and knowing what to expect and when to expect it, will make work easier for all of the involved parties.

Case Care Management should reflect one of the **existing models—or a hybrid of more than one of these models**—based on the system. These include the operational and funding building blocks we discussed in the training.

Case Care Management should respect and implement the **value system** and operate according to the **functions** we described.

Case Care Management should have a **team** (of at least two professionals) to ensure constant coverage and continuity of services.

 CASECARE MANAGEMENT	Obtaining national and international credentials both for the organization and staff
	Determining the maximum case load that can be handled by a Case Care Manager to secure adequate attention and care
	Being committed to conducting initial and on-going staff training
	Keeping an accurate and protected record system for Case Care Management
	Being connected with communities and promoting social reintegration throughout the program
	On-going monitoring and evaluation
	



Training instructions: The trainer should refer participants to *Resource Page 9.3 Case Care Management Minimum Standards Check List* at page 242 of the Participant Manual.

We recommend that Case Care Management programs obtain **national (and eventually international) credentials** to certify both the organization(s) and staff involved. Being certified will generate respect for the program and increase the reputation of the professionals and the organization(s) involved.

The caseload for Case Care Management is another important concern. Determining the maximum number of cases that can be efficiently handled in terms of time and quality of services and care might be difficult, especially at the beginning. Thus, when starting a Case Care Management program, the **caseload** should be light, with a maximum of around 10-15 cases for each Case Care Manager. This is because participants often require more frequent meetings and more attention at the outset of the program. Frequency of meetings and intensity of care then decreases over time, which will allow the Case Care Manager to take on more participants. Be aware of the time and effort that participants need so that you create a manageable caseload and prevent burnout among the Case Care Managers.

Initial staff training and regular trainings are helpful for staff to improve their work, acquire new skills, and increase their professionalism.

Case Care Managers should have a **record-keeping system** in place. They should ensure that the records are secure and that the confidentiality of the participant is protected, while still keeping the information easily accessible for the Case Care Management team.

A Case Care Manager should create **connections with communities**, being aware of the op-



Step 3: Case Care Management Program Creation



3.1 Case Care Management Team Creation

3.2 Office Creation

3.3 Relationship with Justice Authorities

3.4 Relationship with Treatment and Service Providers and Communities



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opportunities and the social reintegration options for the participants.

Ongoing monitoring and evaluation should be included in the Case Care Manager's work. Monitoring and evaluation is an asset that provides evidence on what works and what does not work in the program to guide the program's development and continuous improvement.

What about the initial setup and creation of the Case Care Management program?

The steps include:

Say

- 3.1 Case Care Management Team Creation
- 3.2 Office Setup
- 3.3 Relationship with Judicial Authorities
- 3.4 Relationship with Treatment, Service Providers, and Communities

Now it is time **to build the team**. Remember that at least two professional staff is recommended, to ensure program continuity and to maintain coverage in case a staffer becomes sick, takes another job, or is otherwise unavailable.

This includes hiring the Case Care Manager (you could use Module 8 as a reference for drafting the job profile and announcement and as guidance for starting and completing the selection process). Once you have filled the open positions, you may want to have an initial training to ensure they are up-to-date on the Case Care Management core competencies. If you are unable to

provide such training, you might consider creating an information packet so that new hires can train themselves.

The next step is to set up the Case Care Management **office**. While deciding on the place and subject to availability, keep accessibility in mind. Secure a suitable location, preferably close to the judicial authority and easily accessible for your participants.

Establish cooperation with the judicial authority. If appropriate, sign a Memorandum of Understanding and/or create a communication protocol with the judicial authority to clarify expectations and needs.

Establish cooperation with treatment and service providers as well as with surrounding communities. You could use Module 8 as a reference: How Case Care Manager Interacts with Treatment Services and Social Services.

Some other suggestions that you might want to consider are:

- Create synergies and regular communication with treatment and service providers.
- Explore and reach out to new services as needed, to respond to participant needs and to include them in the referral registry.
- Reach out to NGOs, local businesses, spiritual leaders, and support



Step 4: Pilot Program Implementation



- 4.1 Ensure MOUs are in place
- 4.2 Secure funding for at least 2 years
- 4.3 Ensure program visibility
- 4.4 Ensure monitoring and evaluation mechanisms are in place
- 4.5 Plan for program extension and sustainability



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9.21

Say

- groups to find additional resources for participant social integration.
- Remember that the referral registry is the key tool in the daily work of the Case Care Manager, and make sure to update it regularly with information about the service providers.

The last step is the implementation of the pilot project. This might vary significantly in each country. Nonetheless, you may want to consider the following before officially launching the Case Care Management program and starting the pilot:

- 4.1 Ensure Memorandums of Understanding (MOUs) are in place as appropriate.
- 4.2 Secure funding for at least two years. Consider reallocation of available resources and start the pilot project for a minimum of two years
- 4.3 Secure program visibility.
- 4.4 Ensure monitoring and evaluation mechanisms are in place.
- 4.5 Plan for program extension and sustainability.

Say

ES-CICAD is available to provide technical assistance and assist countries in the creation of the Case Care Management system and implementation.

Make sure that **MOUs are signed with relevant stakeholders** and that all of the actors are briefed on the advantages of collaborating with the Case Care

Management initiative. The Steering Committee should be the lead actor and the lead supervisor of the Case Care Management program and should ensure that the MOUs or informal agreements with the various participating organizations are in place as appropriate.

Before launching the program, **funding for at least one year should be secured**, to make sure that Case Care Management has the time to yield results.

Liaise with the primary source of funding and secure financing for at least one year, with the option of another year of financing based on the initial results.

Because it will be a new concept in your jurisdiction, the new Case Care Management program also needs to be publicized.

Some suggested actions in this regard are:

- Ensure that judicial authorities are briefed about the new program, and organize high-level briefings to secure buy-in.
- Obtain visibility in the media and press to raise awareness about CCM and Alternatives to Incarceration among potential participants, their families, and communities.

Monitoring and evaluation is an important part of Case Care Management, as well. Being able to provide up-to-date results on the program is crucial for obtaining funding, making the program sustainable, understanding how it performs, resolving problems as they arise, and ensuring positive outcomes.

We strongly advise you to create an embedded mechanism for data collection and evaluation that systematically collects the information needed for the evaluation.

In order to ensure that the Case Care Management program will endure, it is important to keep thinking about the future. Constantly raising funds to sustain the program is a demanding but necessary job to ensure its continued operation.

You might want to:

- Create and strengthen partnerships with public authorities, as well as national and international donors, and keep them briefed on program results and achievements to stimulate interest and buy-in.
- Consider maintaining links with counterparts and similar agencies to build networks and share best practices
- Engage with local academic institutions and academics to identify



Wrap up and questions



OAS CICAD



9.22

Say

shared areas of interest or collaboratively work to identify funding streams to support evaluation.

- As appropriate, consider scaling up the program and offer Case Care Management in additional locations.

In this module, we learned about the steps involved in implementing Case Care Management programs. In the next session, we will start by examining the Action Plan and completing group exercises that transform learning into practice.

CASE CARE MANAGEMENT IMPLEMENTATION ROADMAP

Resource Page 9.1 Example of Mapping Services for Case Care Management

Source: Adapted from The Kenyan Certification and Educational Manual for Addiction Professionals. U.S. Department of State, Bureau for International Narcotics & Law Enforcement Affairs (INL). 2010 Series (Colombo Plan, 2017).

SUD Services	Used	Needed
Crisis services		
Acute care programs, detoxification at general or psychiatric hospitals or other inpatient care facilities		
Alcohol or SUD primary care or detoxification programs in non-hospital, outpatient settings		
Ambulatory detoxification services		
SUD crisis centers		
Acute care programs, detoxification at general or psychiatric hospitals or other inpatient care facilities		
Outpatient services		
SUD outpatient agencies		
Medically supervised ambulatory SUD programs		
SUD outpatient clinics certified to provide intensive treatment		
SUD outpatient clinics certified to provide rehabilitation services		
Day services provided by medically supervised ambulatory SUD programs		
Methadone/Buprenorphine maintenance treatment programs		
Methadone/Buprenorphine maintenance programs		
Methadone/Buprenorphine to abstinence programs		
Inpatient services		
Inpatient SUD treatment programs		
Inpatient SUD treatment and rehabilitation programs		
Residential services		
Drug-free residential programs		
Recovery homes		
Half-way houses		
Supportive living facilities		
SUD program for adolescents		
School and community-based prevention programs		
Acupuncture as an adjunct to treatment		
Twelve-step and other self-help groups		
Healthcare Services	Used	Needed
Medical/nursing services		
Health maintenance/prevention		
Treatment		

Nutritional Services	Used	Needed
Health maintenance/prevention		
Treatment		
Food distribution programs		

Ophthalmic (Eye and Vision) Services	Used	Needed
Health maintenance/prevention		
Treatment		

Dental Services	Used	Needed
Health maintenance/prevention		
Treatment		

Childcare Services	Used	Needed
Daycare		
Nursery school		
Babysitting		
Neighborhood parks		
Parenting classes/groups		
Family planning		
Voluntary foster care/child placement services		

Mental Health Services	Used	Needed
Crisis intervention		
Peer support		
Support groups		
Individual/couple/family counseling		
Psychotherapy		
Psychiatric care		

Residential Services	Used	Needed
Independent		
Homemaker services		
Home support for daily living		
Home skilled nursing care		
Hospice care		
Supervised living		
Day treatment services		
Homeless shelters		
Halfway houses		
Group homes		
Long-term care facilities		
Other housing programs with services		
Institutionalized living		
Nursing home		
Hospital		
Psychiatric facility		

Benefits/Entitlement Services	Used	Needed
Private insurance benefits		
Programs administered by the government's social services		

Transportation	Used	Needed
Public transportation		
Buddy programs		
Medical transport systems		
Government-provided service		
Transport by counselor (case manager)		

Legal Services	Used	Needed
Legal aid services		
Public defenders		
Private attorneys		

Spiritual Services	Used	Needed
Denominational		
Non-denominational		
Alternative		

Leisure Activities	Used	Needed
Sports and exercise programs		
Special interest programs		
Service clubs		

Educational/Vocational Services	Used	Needed
Literacy, language skills		
School classes		
Vocational/educational assessment and/or services		
Employability skills training		
Vocational training		

Educational/Vocational Services	Used	Needed
Direct placement		
Referrals		
Other relevant community programs		

Additional Resources	Used	Needed

Resource Page 9.2 Budgeting Elements for Case Care Management

The following table is presenting an example for creating a preliminary budget file with the basic requirements for a Case Care Management Program, according to the content presented in Module 9 of the curriculum.

While filling in the table, the Case Care Manager might want to keep in mind the following questions: *How many Case Care Managers are needed?* According to the knowledge from the training, the smallest group should be constituted by 2 professionals. *What about the model with a two person professional team (La Dupla)? Would it be applicable/feasible?*

Regarding funding opportunities, the Case Care Manager might recall the information presented in Module 9 and undertake personal research and list the available options and calls for current international and national grants highlighting the deadline for application and information on the process.

The Case Care Manager can also add possible in-kind contributions from the justice system (one example could be having office premises for free or to be rented at a preferred rate).

BUGDET TABLE		
Explanation	Amount	Possible source of funding
Staff salary (how many people, how many hours per week)		
Office costs		
Operational costs		
Staff training		
Evaluation		
Other?		

Resource Page 9.3 Case Care Management Minimum Standards Check list

The Case Care Management Minimum Standards are a tool to be used as a check list to determine whether a program can be considered Case Care Management. Revising the description and assessing the elements which are not yet included and the actions that need to be taken provides an opportunity for gap analysis and for improvement of the program.

MINIMUM STANDARDS CHECKLIST		
Minimum standards	Applied: Yes/No	Action needed
Case Care Management embedded in multisystem		
MOU and protocols for Confidentiality and communication		
Adherence to the Case Care Management models		
Respect to the value system		
Performing the Case Care Management functions		
Case Care Management has a team (minimum 2 staff)		
National/international accreditations		
Maximum caseload for Case Care Management established		
Staff training		
Connection with communities		
Monitoring and evaluation mechanism in place		

MODULE 10



Case Care Management Implementation Exercise and Report Out

Preparation checklist

Content and timeline

Training goals and learning objectives

PowerPoint slides

Resource page

MODULE 10

Module 10 Preparation Checklist

- Review the “Getting Started” section for general preparation information on page 13 of this manual.
- Preview Module 10.
- Prepare for the interactive exercise: assemble the following:
 - A stack of letter-sized (or A4-sized) paper for each table.
 - Pads of Post-it notes for each table.
 - Place colored markers and a stack of colored .
- Bring copies of the overall training evaluation form.

Module 10 Content and Duration

Activity	Time
Module 10- Case Care Management Implementation Exercise: developing the system- Part 1	90 minutes
Group Exercise: Implementation Plan Part 1	90 minutes
Break	15 minutes
Module 10- Case Care Management Implementation Exercise: developing the system- Part 2	90 minutes
Group Exercise: Implementation Plan Part 2	45 minutes
Reporting out	45 minutes
Course Wrap Up and Evaluation	30 minutes
Closing Ceremony	30 minutes
Course wrap up and evaluation	30 minutes
Closing ceremony	5 minutes
Evaluation and End of Day 2	

Module 10 Goals and Objectives

Training Goals

- Familiarize with the Case Care Management implementation roadmap.
- Prepare presentation for the executives on Case Care Management and reporting to the group.
- Determine follow up action.

Learning Objectives

Participants who complete Module 10 will be able to:

- Understand and describe the Case Care Management implementation roadmap.
- Understand and describe the follow up actions.



MODULE 10

CASE CARE MANAGEMENT IMPLEMENTATION EXERCISE AND REPORT OUT



OAS/CICAD 

10.1

Say

The task in Module 10 is the Case Care Management implementation exercise.

Training instructions: Trainers should prepare for this module in advance. At the end of second day, they should sit together and revise the PowerPoint presentation and the outline for Module 10. They should also edit the **Case Care Management Action Planning Outline** to reflect the contributions from previous training sessions and define the programs they will propose during the exercise.



MODULE 10

Objectives

Integrate learning on Case Care Management in to practice

Prepare a presentation for executives on the Case Care Management program and reporting to the group

Determine follow up actions



OAS



10.2

Say

The objective of Module 10 is to integrate learning on Case Care Management into practice. It is a very interactive module, with hands-on exercises aimed at preparing of a presentation for high-level authorities with concrete suggestions on the Case Care Management program that the participants think should be added.

Suggestions concerning follow-up actions are also included in the exercise.

Creating the groups



- Group 1
- Group 2
- Group 3



Note: Slide to be edited by the Trainers!

Training instructions: The trainers will edit the Module 10 slides, customizing them with content that reflects the input from the participants so far. The trainers should make the customized outline available for participants prior to (if possible) or during the session. Trainers should make sure that the distribution of participants into groups is even and attempt to represent the stakeholders in each group equally (e.g., at least one probation officer, one judge, one civil society representative, one treatment provider, etc.).

Suggestions for creating the groups.

A) The trainer could create a list that divides the participants into groups before the session begins, making sure that the groups are of the same size and represent a diversity of participants and views. The trainer will give each group a name to distinguish it from the others.

B) The trainer then reads the list aloud and helps the participants gather in their respective groups.

Say

For the purpose of Module 10's interactive exercises, we have created two or three [or the appropriate number of] groups, each of them focused on Case Care Management for a specific program. The groups are:

- Group 1 (group name)
- Group 2 (group name)
- Group 3 (group name)

In order to facilitate your groups' work, we have prepared an outline for the exercise that is based on the template on pages 259-262 in the Participant Manual. The outline has been adapted to include your input from all of the previous sessions.





Implementation Plan Exercise

Part 1: Case Care Management Framework – 60 minutes

- Justice Program Case Care Management Elements
- Case Care Management Model and Leadership
- Case Care Management Steering Committee Creation



10.4

Training instructions: The trainer should introduce the exercise and direct the participants to the outline. The trainer should remind the participants in each group to be mindful about the time allocated to the exercise and to strategize

The trainer should allow the participants to have a look at the outline and ask questions before the groups begin their work. The trainers will also circulate among the groups and be available to help and facilitate if needed.

Say

The first part of the interactive exercise addresses the Case Care Management Framework. Each group is expected to discuss the following three topics and write down the results of the discussion, filling in the Action Plan outline provided.

Justice Program Case Care Management Elements: This focuses on which ATI or justice programs intersect Case Care Management (Pre-sentencing, Sentencing, Post-sentencing). Each group will also discuss the participant profile, the program eligibility requirements, when the Case Care Manager will initiate contact with the participant, how the program will operate, and the expected results.

Case Care Management Model and Leadership: Following the same example of the SWOT analysis we saw in Module 4, the groups will choose the Case Care Management model they would recommend for implementing the program they serve, as well as providing suggestions on the leadership of their Case Care Management program, including which agency should have the lead role.

Case Care Management Steering Committee Creation: This addresses which stakeholders should sit on the Steering Committee and provide an overview of the key actors that will launch and then monitor Case Care Management implementation in the country.

Training instructions: The trainer could encourage the participants to follow the outline provided, using information from their group discussions.



Implementation Plan Exercise

Part 2: Follow Up Action– 45 minutes

- Three main follow up actions needed
- Description
- Timeframe



OAS CICAD



18.5

Say

Welcome back to the plenary session! How was the experience?

The second part of the exercise focus on the follow-up actions. Each group will identify and propose three main follow-up actions that they deem relevant for Case Care Management implementation, describing them and indicating a timeframe for each. The time allocated for this exercise is 45 minutes. As before, we are around to help and keep track of time.

Have a great session!

Training instructions: Part 2 of the exercise follows the same dynamic of Part 1, with the groups working on the outline. In case a group did not finish Part 1 in the allotted time, it will be allowed to continue working on that and then move on to Part 2. After the exercise, each group will have 15 minutes to report back, following by a debriefing with all participants present.



Implementation Plan Exercise

Reporting Out - 45 minutes

- Group 1
- Group 2
- Group 3



OAS CICAD



10.6

Say

Welcome back! Now we are ready for to report back. All of you have worked hard in your groups to prepare your presentations. Thank you for your commitment to this training. Let's go through how each group will report back. Just to recap, we have three [or however many groups you have created] groups:

- Group 1 (group name)
- Group 2 (group name)
- Group 3 (group name)

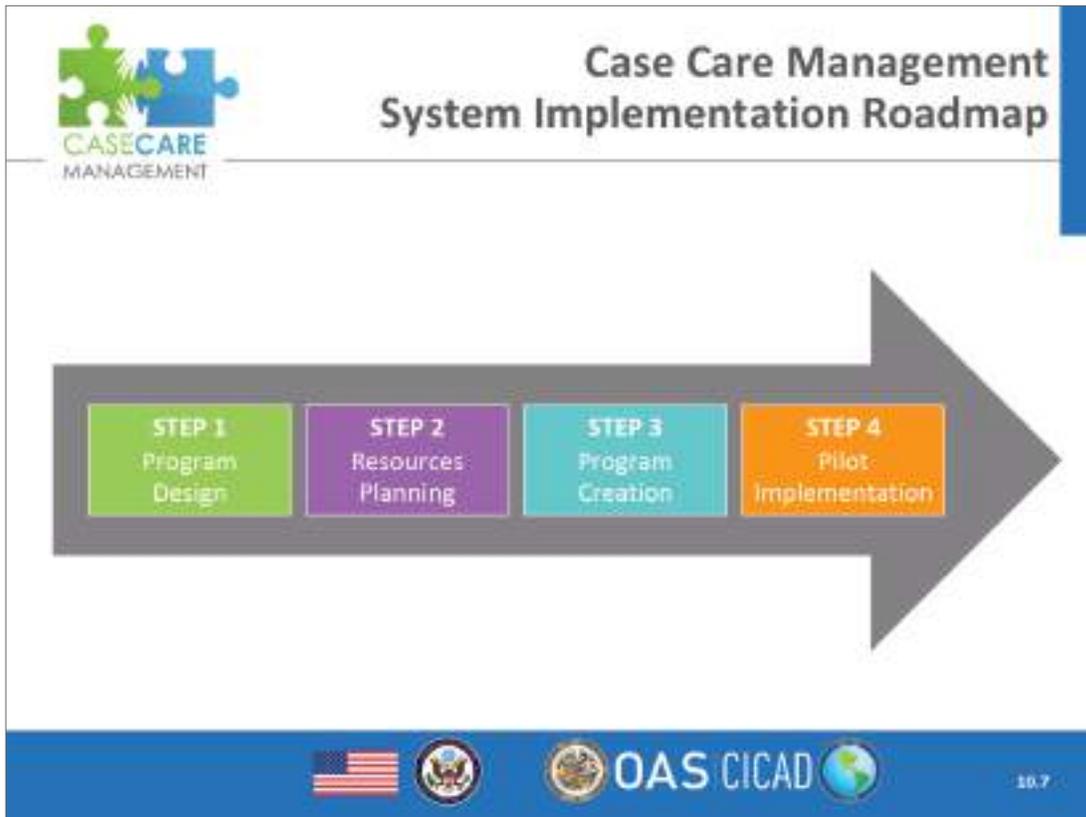
Each group will have two presenters, who will have 15 minutes to give a presentation for their group that addresses the key points of the action plan that you have been working on, namely:

- Justice Program Case Care Management Elements
- Case Care Management Model and Leadership
- Case Care Management Steering Committee Composition
- Three Follow-Up Actions for Consideration

Ask

Which group would like to go first?

Training instructions: Trainers will note down the order of the groups. The trainer should allow enough time for the speakers to report back. After each presentation, the trainer debriefs with all of the participants in the training present, making comments and asking questions. At the end of the debriefing, the trainer should ask everyone present to express appreciation for the group that just presented.



Our training is coming to an end. In these few final slides, I would like to review the steps for the Case Care Management system implementation that we already mentioned during Module 9. I hope that this content will help those of you here who will be following up on the creation of a CCM pilot project:

- Step 1 (Program design): Defining which Case Care Management model you will use, who will lead its development, and how it will intersect with the judicial system.
- Step 2 (Resource planning): Mapping your resources, analyzing your strengths, and making a list of what you already have and what is missing
- Step 3 (Program creation): Obtaining the green light from the stakeholders and putting together all of the necessary pieces, from creating the team creation and setting up the office, to establishing the Referral Service Registry.
- Finally, Step 4 (Pilot implementation): Launching the program and inviting participants to start participating.



Case Care Management Implementation Checklist

- ✓ Definition of the operating model
- ✓ Steering committee creation
- ✓ Definition of the budget
- ✓ Funding opportunities secured
- ✓ Definition of monitoring and evaluation
- ✓ Minimum standards checked



OAS CICAD



10.8

Say

Finally, let's review a checklist of the essential issues to be addressed before launching a Case Care Management program:

- Define the operating model: Selecting which model you are going to follow and who will lead it.
- Create the steering committee: Choosing the organizations that will supervise the Case Care Management program and secure accountability and commitment from its stakeholders.
- Establish the budget: Understanding how much the Case Care Management program will cost, reallocating existing resources to start the pilot, and identifying what additional funds will be required to support the program's long-term sustainability
- Secure funding: Explore options for funding that will support Case Care Management implementation and development (national, international, and ad hoc funding).
- Define monitoring and evaluation parameters: Be clear about what you need to measure, for what purpose, and how to measure it (indicators).
- Ensure minimum standards are present: Make sure that the minimum standards for Case Care Management programs presented in Module 9 are being fulfilled, both in the pilot project and beyond.



Say

Thank you! This training has been an amazing experience. Thank you for your time and commitment that you have dedicated to the course. I truly wish you all the best in the implementation of a Case Care Management program in your country.

Say

Before starting the Closing Ceremony, we would like to ask you to complete the overall training evaluation for the course. We truly appreciate your feedback and the time you will dedicate to answering the questions. Your feedback makes sure we can maintain and improve the quality of this course.

Closing Ceremony

We recommend that you organize a short session with closing remarks from key people in the Case Care Management project, including:

- ES-CICAD officials;
- National stakeholders that contributed to the project;
- INL (as the sponsor of the Case Care Management curriculum); and
- Representatives of other countries that have received the training in the past and have implemented Case Care Management (if appropriate).

CASE CARE MANAGEMENT IMPLEMENTATION EXERCISE - ACTION PLANNING M10 OUTLINE

Resource Page 10.1 Trainer Outline for the Interactive Exercise

Note: The current outlines should be used for training purposes only. Trainers should customize them to reflect the content and results of the specific training session they are organizing. Therefore, the following outlines should be considered a working document that is subject to change during the training.

Overall description of the implementation planning exercise

Module 10 is an interactive exercise to be completed in groups. Its goal is for participants to create a draft implementation plan and a 15-minute presentation for high-level authorities that includes all of the elements of Case Care Management discussed in the training. This implementation plan could serve as a starting point for the implementation of a Case Care Management program in the participants' jurisdiction.

Training instructions: The trainers need to prepare in advance for Module 10 and create a customized version of the exercises presented below. Based on the work from Days One and Two, trainers should consolidate the input received by the participants and:

1. Update the proposed outline of the Module 10 exercise, paying particular attention to section C (below) that contains the stakeholder chart discussed with the participants in Module 3. It is possible to group some of the inputs together to avoid repetition, but do not exclude anything that could be relevant to the group discussion.
2. Create two or three groups to work on a specific proposal based on the feedback gathered from previous sessions of the online training.

Participants will be divided into two or three groups and will be assigned a Case Care Management intervention to work on.

The groups will work together in two sessions. The first session will last one hour and the second session will last 45 minutes. During this time, the participants will discuss and draft their proposal using the outlines and instructions below as a guide. During the exercise, trainers will monitor the process and make themselves available to answer questions and provide further guidance if needed.

PART 1: CASE CARE MANAGEMENT FRAMEWORK - 60 minutes

PART 2: DETERMINE THREE FOLLOW UP ACTIONS - 45 minutes

PART 3: REPORTING BACK

PART 1: CASE CARE MANAGEMENT FRAMEWORK - 60 minutes

- a) Justice Program Case Care Management Elements
- b) Case Care Management Model and Leadership
- c) Case Care Management Steering Committee Composition

- a) Justice Program Case Care Management Elements (suggested time to be allocated: 15 minutes)



Exercise Instruction:

The group should review the exercise in Module 3 on the justice system in your country. Fill in the table below after discussing options with your group.

JUSTICE PROGRAM ELEMENTS FOR Case Care Management	
Intersections between the Case Care Management program and existing ATI programs and the judicial system (Use as Reference: Module 3, Slide 3.8-3.10)	
Participant profile (Use as Reference Module 4 and Module 7)	
Program eligibility (e.g., legal, clinical, other) (Use as Reference Module 9)	
When does the Case Care Manager interact with the participant? (Use as Reference Module 3 and 7)	
Program details (e.g., length, graduation requirements, completion) (Use as Reference Module 9)	
Expected Case Care Management deliverables and results (Use as Reference Module 3, slides 3.22-3.24 and Module 9, slides 9.13-19)	

- b) Defining Case Care Management Model and Leadership (suggested time to be allocated: 15 minutes)



Exercise Instruction:

The groups should review the results of the discussions on stakeholders in Module 3 and the elements of the Case Care Management model presented in Module 4. It is strongly suggested to use a SWOT analysis similar to the presentation in Module 4 and identify at least one viable model of Case Care Management for their jurisdiction. If the groups decide on more than one model, it would be an excellent opportunity to have a look at

their SWOT analysis and start a discussion.

CASE CARE MANAGEMENT MODEL AND LEADERSHIP			
Case Care Management Model	Suggestions	Possible Obstacles	Reasoning
Embedded/Independent			
Centralized/Decentralized			
Publicly funded/Private funded/Hybrid			
Case Care Management Leadership	Suggestions	Possible Obstacles	Reasoning
Agency in charge			
Existing agency			
New agency to be created			

c) Case Care Management Steering Committee Exercise (suggested time to be allocated: 30 minutes)

Note for the trainer for the preparation of this exercise. Trainers should look at the inputs gathered on Day 1 in Module 3 and prepare an updated version of the stakeholder table below that reflects the results of the exercise in Module 3 for the participants to work with.



Exercise Instruction:

The group should work with the list of stakeholders provided below and determine the key stakeholders that should be included in the Case Care Management Steering Committee, and the reasons for their participation.

STAKEHOLDER CHART			
Justice Authority	Health Services	Social Services	Communities
Magistrates/Judges	Treatment services	Social welfare agencies (social, financial, housing, food, etc.)	NGO/Civil society
Judges	Drug treatment	Religious organizations	Spiritual leaders and faith-based organizations
Forensic officials	Rehab	Family services	
Police	Counselling	Hotlines	
Protective services	SUD treatment providers	Vocational programs	



PART 2: DETERMINE THREE FOLLOW-UP ACTIONS – 45 minutes

Exercise Instruction: The groups will identify three follow-up actions to be included in the presentation for high-level authorities. They should include a detailed description and timeframe for each action.

FOLLOW UP ACTIONS		
Follow Up Actions	Description	Timeframe
Action 1		
Action 2		
Action 3		

PART 3: REPORTING BACK



Reporting back to the group – 45 minutes (for three groups)

Exercise Instruction:

The groups will decide on one or two spokespeople to give a 15-minute presentation on Parts 1 and 2 of this exercise, covering the following topics:

- Justice Program Case Care Management Elements
- Case Care Management Model and Leadership
- Case Care Management Steering Committee Composition
- Three Follow-Up Actions for Consideration

APPENDICES

APPENDIX A- Training Exercise Instructions

All the exercises in this training are meant to collect information and encourage reflective thinking on the material of the course. This will be used at the end of the training in the Implementation Exercise and will provide guidance for the participant during the implementation phase of Case Care Management programs.

For this reason, the exercises are organized in a logical and consequential way, building on each other and providing reliable reference sources for the training and beyond.

Module 10 is entirely based on the Case Care Management implementation exercise and final report. The instruction for Module 10 will be provided separately following the description of the exercises of the other modules at the end of this annex.

List of the Case Care Management Exercises in the training:

1. Partner Exercise: Introduction (M1)
2. Reflective Exercise: Course Expectations (M1)
3. Embedded Reflective Exercise: Stakeholders (M3)
4. Group Discussion: The Justice System in Your Country (M3)
5. Interactive Exercise: What Does C Stand For? (M4)
6. Reflective Exercise: Case Care Management Definition (M4)
7. Group Exercise: Case Care Management Success (M5)
8. Embedded Interactive Exercise: Embedded vs Independent Case Care Management Models (M6)
9. Embedded Interactive Exercise: Centralized vs Decentralized Case Care Management Models (M6)
10. Embedded Interactive Exercise: Public Funding vs Private Funding (M6)
11. Reflective Exercise: Case Care Management Models (M6)
12. Reflective Exercise: Case Care Management Profile (M8)
13. Group Exercise: Planning Monitoring and Evaluation (M9)

Module 10 Case Care Management Implementation Exercise and Reporting out:

- Part 1: Case Care Management Framework
- Part 2: Follow Up Action
- Reporting Out

Module 1 Exercises

[Slide 1. 3 Partner Exercise: Introduction](#)

The objective of this exercise is to allow participants to introduce themselves and connect with each other.

Participants are asked to answer to the questions presented on the slide:

What is your name?

Where do you live and work?

What is your interest in Case Care Management?

JUSTICE PROGRAM ELEMENTS FOR Case Care Management

Alternative to Incarceration Program and Justice intercept	
Option 1	
Option 2	
Option 3	
Option 4	
Option 5	

[Slide 3.13 Interactive Exercise: Who is the participant?](#)

The objective of this exercise is to make participants think about the participants and have them appreciate the difficulties, barriers and stigma that participants face. This exercise proposes two role playing activities to familiarize participants with the profile of the participant.

The first role playing activity is based on the following case study:

Johnny is a 24-year old male who is currently incarcerated for robbery. Johnny has been using drugs since he was 18. He has a partner Mary and a young daughter named Jill. Although he has been in prison for 6 months, Johnny is not currently involved in a re-entry program, and does not attend treatment regularly. He is preparing for a job interview to become a bartender. He is quite nervous because he needs the job to support his family. He knows that the interviewer might have prejudices related to his criminal records and substance use history.

How do you think Johnny should address the issue if asked? How would you react if you were the job interviewer?

The trainer will ask for two volunteers to role play as characters from the scene: Johnny and the interviewer.

After the role playing activity the trainer will debrief with the group.

The second role playing activity will involve 4 volunteers: the participant, the justice authority, the treatment provider and the probation officer. Each one of the role players will be provided with instructions by the trainer. The volunteers will have 5 minutes to prepare before beginning.

At the end of the exercise, participants will have an overview of some challenges that the participants face. Trainers will help the group summarize the key challenges.

M4 Exercises

[Slide 4.4: Interactive Exercise: What Does C Stand For?](#)

The objective of the exercise is to warm up participants and engage their thinking. The trainer will ask them: *What do you think this big C stands for?* The co-trainer will help write the answers on the flip chart.

At the end of the exercise the trainers will provide a summary of the key aspects.

[Slide 4.21: Reflective Exercise: Case Care Management Definition](#)

The objective of this exercise is to engage participants in a discussion on the definition of Case Care Management and to increase their understanding of it.

The trainer will ask the participants to revise the material of the module and write down their first thoughts for five minutes.

After that they will divide in groups and discuss their definitions, finally coming up with a group definition. They will have 15 minutes to work in groups.

The groups will then report back and share their definitions with all the participants.

M5 Exercise

[Slide 5.21: Group Exercise: How to Measure Case Care Management Success](#)

The objective of this exercise is to discuss the definition of success for the participant and for the Case Care Management program.

The trainer will divide participants into groups and ask them to answer the following questions:

1. *What is the main goal of Case Care Management?*
2. *Who is the audience? What is the institution or figure Case Care Management should report?*
3. *Which indicators are needed to prove the success of the program?*
4. *How can these indicators be collected? (Embedded data collection? Regular updates? Other ideas?)*

The groups will have 20 minutes to discuss and 5 minutes each to report back.

Objectives	Indicators	Accessibility	Costs
1.	1.1 1.2		
2.	2.1 2.2		

M10 Exercise

[Module 10 Case Care Management Implementation Exercise and Reporting Out](#)

Module 10 is an interactive exercise to be conducted as a group exercise. Its goal is to create a draft implementation plan and a 15 minute presentation for the executives, including all the elements of Case Care Management discussed in the training that could be a starting point for the implementation of a Case Care Management program in the country.

Participants will be divided into 2 or 3 groups and will be assigned a Case Care Management intervention to work on.

The groups will work together in 2 sessions: the first session will be 1 hour and the second session will be 45 minutes, discussing and writing their proposal using the outlines and indications below as a guide in preparing their presentation. Trainers will monitor the process and be available to answer questions and provide further guidance if needed during the exercise.

Part 1 CASE CARE MANAGEMENT FRAMEWORK – 60 minutes

- a) Justice Program Case Care Management Elements
- b) Case Care Management Model and Leadership
- c) Case Care Management Steering Committee Composition

a) Justice Program Case Care Management Elements

Each group will work individually. After having a group discussion, the members will use the exercise in Module 3 on the justice system to fill out the table below:

JUSTICE PROGRAM ELEMENTS FOR CASE CARE MANAGEMENT	
ATI Program and Justice Intercept	
Participant Profile	
Program Eligibility: Legal/Clinical/Other	
At which point(s) does the Case Care Management interact with the participant?	
Program Details: Length, Graduation Requirement, Level of Completion	
Expected Case Care Management Deliverables and Results	

b) Case Care Management Model and Leadership

Each group will review the elements of the Case Care Management models presented in Module 6 working with a similar SWOT analysis to identify one viable Case Care Management model applicable in the country.

CASE CARE MANAGEMENT MODEL AND LEADERSHIP			
Case Care Management Model	Suggestions	Possible Barriers	Reasoning
Embedded/Independent			
Centralized/Decentralized			
Publicly/Private funded/Hybrid			
Case Care Management Leadership	Suggestions	Possible Barriers	Reasoning
Agency to be in charge			
Existing agency			
New agency to be created			

APPENDIX B- Glossary

Adaptive Change	Requires new knowledge, skills and abilities
Addiction	A chronic, relapsing disorder characterized by compulsive drug seeking and drug use despite adverse consequences. It is considered a brain disorder, because it involves functional changes to brain circuits involved in reward, stress, and self-control, and those changes may last a long time after a person has stopped taking drugs.
Advocacy	The act of speaking out on behalf of participants
Alternatives to Incarceration (ATI)	Refers to an innovative treatment model that focuses on the effectiveness of reducing the risk of criminal recidivism, providing effective treatment of problematic drug use and assuring adequate social integration
Assessment	A process for defining the nature of the problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis
Benchmark	A standard or reference by which others can be measured
Best Practice	Consensus of key expert opinions on approaches or elements of Case Care Management that appear to result in the most successful outcomes
Case Care Management	A form of specialized participant-oriented Case Management embedded in a multisystem approach with the overall purpose to support participants in their social integration
Cognitive Behavioral Therapy (CBT)	A form of short-term, goal-oriented psychotherapy treatment that takes practical approaches to problem-solving. Its goal is to change patterns of thinking or behavior that are behind people’s difficulties, and so change the way they feel supporting their path towards recovery and independence
Confidentiality	Principles and procedures that protect a participant’s privacy by not allowing Case Care Managers to reveal, even indirectly, participant information that could potentially be used against the participant
Contingency Management	A type of behavioral therapy that provides rewards for the desired behaviors, such as clean drug tests, enforcing positive patterns. Contingency management is also called motivational incentives
Coordinated Services	Uninterrupted activities that are integrated among service providers
Counselling	The process of assisting and guiding participants, especially by a trained professional, to identify, address and eventually resolve problems and difficulties of a personal, social, or psychological nature
Criminal Thinking	A consistent pattern of distorted thinking errors that result in irresponsible and arrestable behavior
Criminogenic Need	Provide services that address risk factors (needs) for arrest (including drug treatment)
Criminogenic Responsivity	Provide services in key areas to enhance engagement in drug treatment
Criminogenic Risk	Focus resources for drug treatment on moderate-high risk offenders (risk for arrest)
Dopamine	A neurotransmitter—a chemical released by neurons (nerve cells) to send signals to other nerve cells – which plays a major role in the motivational component of reward-motivated behavior

Drug Treatment	Intended to help addicted individuals stop compulsive drug seeking and use. Treatment can occur in a variety of settings, take many different forms, and last for different lengths of time using a variety of behavioral and pharmacological approaches
Evidence-Based Practice	Treatment practices that are well implemented and well evaluated and have accumulated evidence of effectiveness over the years
Fragmented Services	Separate activities that do not support access for the participant
Inpatient Or Residential Treatment	Treatment for those with more severe SUD problems (including co-occurring disorders). Licensed residential treatment facilities offer 24-hour structured and intensive care, including safe housing and medical attention. Residential treatment facilities may use a variety of therapeutic approaches, and they are generally aimed at helping the patient live a drug-free, crime-free lifestyle after treatment
Integrated Services	The organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money
Management	A process of working with others to achieve organizational objectives in an efficient, legal and ethical manner
Medication-Assisted Treatment	The use of medications to help re-establish normal brain function and decrease cravings. Medications are available for treatment of opioid (heroin, prescription pain relievers), tobacco (nicotine), and alcohol addiction.
Motivational Interviewing (Mi)	Model designed to help people increase their motivation to make changes in their life
Outpatient Behavioral Treatment	Includes a wide variety of programs for patients who visit a behavioral health counselor on a regular schedule. Most of the programs involve individual or group drug counseling, or both. These programs typically offer various forms of behavioral therapy
People with Substance Use Disorder	People whose use of drugs is harmful to the point where they may experience drug dependence and or require treatment
Post Treatment / Continuum of Care	Once called aftercare, this is the period when the participant transitions into life in the community
Pre-Arrest Diversion	Diversion initiatives conducted by law enforcement aimed at keeping low risk individuals out of the justice system often through direct referral to community-based treatment services
Pre-Trial Diversion	A voluntary option which provides alternative criminal case processing for a defendant charged with a crime that ideally, upon successful completion of an individualized program plan, results in a dismissal of the charge(s)
Proportionality	The balance between the seriousness of the offense and the severity of the punishment
Recidivism	A person's relapse into criminal behavior, often after the person receives sanctions or undergoes intervention for a previous crime
Recovery Oriented System of Care	A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential
Referral	A process of facilitating the participant's utilization of available support systems and community resources to meet needs identified in clinical evaluation and or/ treatment planning

Relapse	A prolonged episode of substance use during which the participant is not open to therapeutic intervention or learning. Often a relapse can lead to dropout and indicates a continuing struggle by the participant with his or her disease
Screening	A process for evaluating the possible presence of a particular problem. The outcome is normally a simple yes or no
Service Coordination	This is the administrative, clinical, and evaluative activities that bring the participant, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan
Service Plan	A document that is based on clinical and Case Care Management assessments, and outlines goals and objectives to realize a participant's need for community resources. The findings from the assessment, including specific skill deficits, basic support needs, level of functioning and risk status, define the scope and focus of the service plan
Specialty Courts	Specialized court sessions that offer an intensive probation program for people with mental health and/or substance use disorders. Specialty courts aim to address the underlying problems that can cause criminal behavior
Specialized Case Management	Includes clinical assessment, placement into community-based services, participant advocacy, and ongoing monitoring and support to increase participants' success
Substance Use Disorder	The recurrent use of alcohol and/or drugs which causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. Measured along a continuum of mild to severe using DSM criteria
Supervision	Supervision is the purposeful and systematic sharing of knowledge, skills and attitudes by a senior member professional to a junior member or members through a defined relationship
Stakeholder	A person with an interest or concern in something or one who is involved in, or affected by, a course of action
Technical Change	Requires only existing knowledge, skills and abilities
Therapeutic Alliance	A working relationship between the participant and clinician in which the participant has the capacity to progress in treatment based on his or her emotional bond with the therapist, the therapist's empathic understanding of the participant, and the agreement between participant and therapist on the goals and tasks of treatment
Transformative Change	Not related to knowledge, skills and abilities but rather changing the culture, context and environment of the system within which you work
Trauma	An emotional wound or shock that creates substantial, lasting damage to the psychological development of a person, often leading to neurosis. Also, it is an event or situation that causes great distress or disruption.
Treatment Plan	A clinical plan designed mutually by the clinician and participant that is complete with goals and objectives focused on the addiction, achieving and maintaining long term abstinence.
Treatment/Primary Care	This is a broad term that can be understood as the phase of treatment when substance users examine how substances impact their lives

APPENDIX C- Resources

Global Drug Use Statistics

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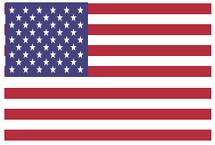
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APPENDIX D- Special Acknowledgement

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