Published in final edited form as:
Perspect (Am Probat Parole Assoc). 2008 ; 32(1): 38–46.

Improving Parolees' Participation in Drug Treatment and Other Services through Strengths Case Management

Michael Prendergast and **Jerome J. Cartier**
Integrated Substance Abuse Programs, University of California, Los Angeles

Abstract

In an effort to increase participation in community aftercare treatment for substance-abusing parolees, an intervention based on a transitional case management (TCM) model that focuses mainly on offenders' strengths has been developed and is under testing. This model consists of completion, by the inmate, of a self-assessment of strengths that informs the development of the continuing care plan, a case conference call shortly before release, and strengths case management for three months post-release to promote retention in substance abuse treatment and support the participant's access to designated services in the community. The post-release component consists of a minimum of one weekly client/case manager meeting (in person or by telephone) for 12 weeks. The intervention is intended to improve the transition process from prison to community at both the individual and systems level. Specifically, the intervention is designed to improve outcomes in parolee admission to, and retention in, community-based substance-abuse treatment, parolee access to other needed services, and recidivism rates during the first year of parole. On the systems level, the intervention is intended to improve the communication and collaboration between criminal justice agencies, community-based treatment organizations, and other social and governmental service providers. The TCM model is being tested in a multisite study through the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) research cooperative funded by the National Institute of Drug Abuse.

Keywords

case management; strengths-based; parolees; substance abuse treatment

Introduction and Background

A growing body of research indicates that prison-based substance-abuse treatment needs to be followed by community treatment in order to obtain optimal outcomes. Indeed, some studies have found that the reincarceration rates of prisoners who participate only in prison treatment are not much better than the rates of those who receive no treatment (Knight, Simpson, & Hiller, 1999; Martin, Butzin, Saum, & Inciardi, 1999; Prendergast, Wellisch, & Wong, 1996; Wexler, Melnick, Lowe, & Peters, 1999). The most notable improvement comes from participation in community treatment. As a result, the correctional treatment systems of many states comprise prison-based treatment and a system of contracted community programs that treat parolees coming out of prison programs. To link these two phases of treatment, there is also a planning and transition process between the end of a prison term and the early phase of re-entry to the community. Depending on the correctional

Inquiries about this paper should be directed to Michael Prendergast, Ph.D., UCLA Integrated Substance Abuse Programs, 1640 S. Sepulveda Blvd., Suite 200, Los Angeles, CA 90025; e-mail address: mlp@ucla.edu.

For further information, see the CJ-DATS Web site at www.cjdats.org.

system, referral to community-based treatment consists of either encouraging inmates with drug problems to volunteer for treatment or mandating them to treatment as a condition of parole. Multiple agencies are involved in this process. Too often, however, the transition process breaks down.

The promised improvements in offender behavior from continued treatment in the community are realized only if prison treatment participants follow through on referrals to community treatment and remain in treatment for a minimum period of time, generally considered to be three months, although this will vary by client needs (Simpson, Joe, & Brown, 1997). Failure of parolees to enter post-release aftercare often results in relapse to drug use or reincarceration (Knight, Simpson, & Hiller, 1999; Martin, Butzin, Saum & Inciardi, 1999; Wexler, Melnick, Lowe & Peters. 1999). No-shows and dropouts are particularly a problem in states where participation in community treatment by parolees is voluntary and incentives to enter and remain in treatment are minimal. But even in states where community treatment is mandated, compliance with treatment requirements is lax, often because of high parole caseloads, poor coordination and communication between criminal justice and treatment personnel, and low motivation and accountability on the part of the parolee. Although outcomes tend to be positive for those who complete at least 90 days of community treatment, low treatment participation rates are clearly a barrier to the overall effectiveness cost effectiveness of systems of offender treatment.

Some states with prison treatment programs also fund community treatment for parolees and have procedures in place that refer inmates to treatment before release. However, many parolees with referrals fail to show up for treatment once on parole and of those who do enroll in treatment, many drop out early in treatment. For example, data collected during evaluations of in-prison substance abuse programs in California indicate that 35% of parolees graduating from a prison-based program actually enter treatment upon release and 47% of those who enter treatment drop out within the first 90 days (Prendergast, Farabee, & Cartier, 2005). Thus, there is a need to improve the transition process from prison treatment to community treatment to increase the likelihood that inmates with a referral to community treatment enter their assigned treatment placement and remain engaged in treatment for a reasonable length of time. Participation in treatment is underscored by the growing recognition that substance abuse is a chronic disorder that often requires long-term treatment and management (National Institute on Drug Abuse, 2007).

Successful transition to community treatment is likely to result from several processes: (1) enhancing the motivation of the client during in-prison planning for aftercare treatment, (2) fostering collaboration between treatment and criminal justice personnel during the client's transition process, (3) ensuring continuity of care between treatment services obtained in prison and those obtained in the community, and (4) providing initial post-release support to the client to facilitate admission to treatment and other needed community services. These processes can be addressed at two levels: (1) by improving the coordination and collaboration among correctional and treatment staff in the institution, community correctional and treatment staff, and other health, mental health, and social service providers and (2) by working directly with the client in developing specific goals and plans for transition to the community and assisting him/her during the crucial early months in the community. Of the various options that might be used to achieve these ends, case management is a promising approach because it is specific to care coordination across settings and is widely used to manage chronic conditions. Active case management strategies, in which the case manager begins working with the inmate and others in the institution and continues to do so in the community, may be an effective way to overcome both individual and systematic obstacles in the transition and re-entry process and to foster improved post-release adjustment.

The purpose of this paper is to describe a strengths-based case management model for use with parolees. The model is being evaluated in a multisite study that is part of the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) cooperative, which is funded by the National Institute on Drug Abuse (NIDA; Fletcher & Wexler, 2005). Five CJ-DATS Research Centers are involved in the study: the lead center is Integrated Substance Abuse Programs, University of California, Los Angeles; the participating centers are Center for Drug and Alcohol Studies, University of Delaware; Center on Alcohol and Drug Research, University of Kentucky; Connecticut Department of Mental Health and Addiction Services; and National Development and Research Institutes, Inc.

Strengths Case Management

A variety of case management models exist in social work (e.g., brokerage, assertive case management, clinical case management, intensive case management), but the model that is the focus of this study is “strengths case management” (Hall et al., 1999; SAMHSA/CSAT, 1998; Saleebey, 2002; Siegal et al., 1995). Like most case management models, the strengths model was originally developed for use with people with mental illness, but it has subsequently been adapted for substance-abusing treatment populations.

The effectiveness of strengths case management has been demonstrated in two NIDA-funded longitudinal studies. In two studies (Siegal et al., 1996; Siegal, Li, & Rapp, 2002), substance abuse treatment patients were randomly assigned to primary care plus standard aftercare substance abuse services, or to primary care plus aftercare enhanced with strengths case management. The strengths approach was effective in increasing retention in treatment, which in turn had a positive impact on post-treatment drug use, criminality, and employment (see also Siegal et al., 1997). In another randomized study of strengths case management, Vaughan-Sarrazin, Hall, and Rick (2000) found that substance-abuse clients with case managers reported receiving more treatment aftercare services and medical services than did clients who received standard treatment; there were no differences in the use of mental health services. Siegal and Rapp (1996) note that the strengths model has shown promise among substance abuse clients in two main areas: (1) assisting them in obtaining resources and (2) helping them to view the treatment process more favorably. Although no study (to our knowledge) has assessed the effectiveness of strengths case management with a parole sample, the studies cited above included a large percentage of clients who had been, or were, involved in the criminal justice system.

In addition to the fact that strengths case management has been evaluated positively in previous studies and that manuals and assessment forms are available, this approach has a number of advantages over other case management models for parolees re-entering the community. First, as opposed to the referral function of less intensive forms of case management, the strengths case manager is expected to be active in assisting and advocating for the client, something which is needed during the crucial first months of parole. Second, strengths case management assists clients in becoming their own “case manager” by fostering self-sufficiency in seeking services and resources once case management services end. Third, strengths case management is less dependent on a team approach than more intensive (and expensive) forms of case management. Finally, the focus on strengths, assets, accomplishments, and goal seeking seems particularly appropriate for clients who have experienced the negative influences and stigmatization of prison and who are attempting to maintain recovery and adjust to community living.

Six principles characterize strengths case management, as formulated by Rapp and Wintersteen (1989):

1. The focus is on the strengths of the client, not on his/her pathology or deficits.

2. The primary and essential component of this approach is the relationship between the case manager and the client.
3. Interventions and services are determined by the needs and desires of the client.
4. The preferred mode of intervention for the case manager is aggressive outreach.
5. All people, regardless of their current condition or situation, are able to learn, grow, and change, and the case manager is able to assist in this process.
6. The entire community (including formal and informal resources) is viewed as a source of services, not as an obstacle.

Using the list of case management characteristics presented by Ridgely and Willenbring (1992) and Hall et al. (2002), the strengths case management model can be compared with low intensity and high intensity case management models (Table 1).

Although case management is designed to favorably impact client outcomes, the nature of case management activities may also have systematic effects. Case management is a "boundary spanning" intervention. Boundary spanning is a concept in organization and management theory that refers to a task or series of tasks that requires communication and interaction among people within different agencies or systems who, because of contrasting goals, training, or skills, belong to different language communities (Kerson, 2001). As such, it is expected that a case management intervention has the potential to change the communication and collaboration patterns among the personnel in the different agencies with which the client is involved. One might expect to observe measurable changes in the level and type of collaborative behaviors and the attitudes of key actors, suggesting some level of commitment to maintaining these collaborations.

The Transitional Case Management Model

In the strengths case management model being evaluated, called "Transitional Case Management" (TCM), the goal is to increase the likelihood of successful transition from prison treatment to community treatment and to improve outcomes while on parole. There are three phases to TCM:

1. A "Strengths Inventory" of the client's accomplishments and resources and a plan for post-release goals is completed by the client and the case manager about two months prior to release.
2. A case conference call with the client and significant stakeholders involved in the client's transition to the community occurs about 1 month prior to release.
3. Strengths case management, consisting of weekly and ad hoc meetings between the case manager and the client, occurs when the client re-enters the community.

Phase One: Strengths Inventory (pre-release)

For a given client, the TCM intervention begins with participation in the Strengths Inventory session at about two months prior to release. This inventory lies at the core of the TCM model because it focuses on the positive behaviors and accomplishments of the client and lays the foundation for further work with the case manager. The primary focus here is to identify the client's strengths as well as internal or external resources that he or she will use to facilitate participation in treatment and achieve other goals after release to the community. The objectives of this session include:

1. Introduction of case manager to the client and an overview of the TCM model.

2. Support for, and reinforcement of, the client's motivation for entering and participating in community-based treatment.
3. Identification of the client's personal strengths and assets.
4. Development or review of the client's “Goals Plan” for aftercare services (which may have also been developed by the institutional treatment team).

The case manager introduces the Strengths Inventory to the client as a different way for the client to look at their situation. The case manager explains that, unlike many assessments, the Strengths Inventory focuses on the positive aspects of the client's life. The Strengths Inventory contains nine life areas or domains (General Life Skills, Finance, Leisure, Relationships, Living Arrangements, Employment/Education, Health [physical and mental], Internal Resources, and Recovery/Drug Treatment). When addressing each of the life areas, the case manager allows the client to control the flow of information. The case manager begins the discussion by asking the client to provide an overview of positive aspects within each area before addressing specific strengths or accomplishments at length. The strengths case manager keeps in mind that many offender-clients will not be accustomed to discussing their positive strengths and accomplishments and will often revert to the problems and failures they have experienced. The case manager acknowledges these problems and failures and perhaps makes note of them, but re-directs the client's focus back to positive strengths and accomplishments.

The case manager and client use the information from the Strengths Inventory to develop a Goals Plan that will serve as a foundation for their joint work in the community. The Goals Plan is separate from any institutional transitional plan or conditions of parole but may incorporate some, or all, of the components of those plans as well.

Although the primary focus of the Goals Plan is on the continuation of substance abuse treatment in the community, it also includes additional goals and objectives that the *client* identifies as necessary for successful re-entry into the community. The case manager makes note of all the goals and objectives identified by the client. Since TCM is a client-centered model, the case manager does not offer additional goals or objectives to the client, nor does the case manager make value judgments about the goals and objectives put forward by the client, except to remind the client that all goals and objectives need to be legal and ethical.

This session is also used to identify possible participants in the Case Conference Call (see below). This session ends with the case manager providing the client with contact information, discussing the scheduling of the first post-release meeting, and addressing any remaining questions or concerns the client may have.

Phase Two: Case Conference Call (pre-release)

After completion of the Strengths Inventory and Goals Plan, the case manager works with institutional transitional staff to schedule a Case Conference Call with the client and key people involved in the transition process. The call should occur shortly (two to four weeks) before the client is scheduled to be released from prison. The objectives of the Case Conference Call include:

1. Increase in motivation of the client for entering and participating in community treatment and other services.
2. Confirmation of information about the substance abuse treatment program to which the client has been referred.
3. Review of the expectations of the client.

4. Acknowledgment of responsibilities and commitments of transition team members (including parole/probation), family members, and others to the client.

In addition to the client, participants in the call may include, depending on the setting, the transitional case manager, institutional transition specialist, institutional treatment counselor, parole/probation officer, a representative of the receiving community treatment program, the spouse/significant other or key family member of the client, and a 12-step sponsor. Specific topics for the conference call include:

1. Information about the treatment program to which the client has been referred (program name, address, phone number, directions to the program, contact person, brief description of the program, transportation options, etc.).
2. Verification of reporting instructions to parole/probation and conditions of parole/probation in general.
3. Discussion of the client's Goals Plan and other plans for re-entry. The priority of the client's goals and objectives are presented along with the acknowledgment that the client will be expected to work with the case manager (and others) to set timetables and initiate the necessary behaviors to accomplish stated goals and objectives.
4. Each person makes it clear what he/she expects of the client after release. These expectations should reflect the client-identified post-release goals and objectives.
5. The client, in turn, discusses expectations of key actors, including family members, parole/probation staff, and treatment and staff program.
6. The case manager, treatment staff, and family state their commitment to fulfilling their roles in facilitating and reinforcing the treatment and transition process.

Phase Three: Community Strengths Case Management (post-release)

The community services phase of the strengths case management intervention builds on the work begun in the institution. In the current model being tested (see below), community case management consists of three months of weekly contact between the client and the case manager, followed by three months of monthly contact. The primary persons involved in the post-release, community-based strengths case management are the client and the case manager. Depending on the client's social network and the goals and needs of the client, other persons involved would include community treatment staff, parole/probation staff, family members, 12-step sponsor, and various social service agency staff. From a systems perspective, transitional case management is intended to facilitate collaboration between the client, parole/probation, community treatment, social services, and family. The objectives of community strengths case management include:

1. Increasing the client's motivation for participating in community substance abuse treatment and other services (as needed).
2. Assisting the client in identifying and using their strengths and assets to achieve client-identified goals and objectives.
3. Supporting the client in asserting “self” control over accessing resources.
4. Advocating (when necessary) on behalf of the client.
5. Reducing barriers to the client's access to services.

The case manager's caseload is 15-20 clients (see Table 1). This approximates the expert-recommended individual caseload for a strengths model (Marty, D., Rapp, C. A., & Carlson, L., 2001). Immediately upon the client's release from the institution, the case manager

maintains a minimum of 12 scheduled weekly contacts with the client to monitor access and utilization of services (especially substance abuse treatment). Although most of the contacts will take place in a designated transitional case management office (face-to-face), work on goals and needs may also be done over the phone or at a community substance abuse treatment facility, a social services agency, or other convenient and safe locations.

Table 2 summarizes the main features of the three phases of the TCM model.

Case Management Forms

The TCM model uses several forms for each stage of the intervention to be used as guides to individual behaviors as well as to document the process from initiation to completion. This collection of forms includes the Strengths Inventory and Goals Plan, the Objectives Plans, Barriers to Services, and the Case Manager Checklist. These forms have been adapted from those developed by Hall and colleagues (Hall, Carswell, Walsh, Huber, & Jampoler, 2002) in their studies of strengths case management with substance abuse clients. (Copies of these forms can be obtained from the authors.)

The client's Strengths Inventory and Goals Plan (discussed above) guide the initial activities of the client and case manager in determining needs, establishing goals/objectives, and identifying strengths and resources. The Strengths Inventory is used to remind the client of identified strengths that can be used to overcome barriers to goal achievement and access to services. It is a “living document” that is updated as additional strengths are gained or identified during the case management sessions.

Objectives Plans are developed from the Goals Plan and are used to guide the interaction in each session. The Objectives Plans document the agreed-upon objectives and activities that the client, case manager, or other individuals need to complete in order to achieve the stated goals. Although the stated goal may be broad in nature (e.g., enter treatment, get a job, go back to school), the objectives constitute more specific activities designed to move the client toward the goal (e.g., complete intake at treatment agency, fill out job application, apply for student loans). The intent is to have the client take ownership and responsibility for the objectives and activities.

If barriers to services are identified by the client, the case manager makes note of them on the Barriers to Services Form. The purpose of barrier identification and documentation is to assist the client in prioritizing or revising the activities necessary to achieve the stated goals. Barrier identification also allows the case manager to determine whether the client may benefit from more intensive advocacy efforts.

The Case Manager Checklist and the Individual Services Record are designed to provide the study with the quantitative data needed to measure the dosage and intensity of services received by each client (for the concept of dosage in case management, see Huber, Hall, & Vaughn 2001; Huber, Sarrazin, Vaughn, & Hall, 2003). The study's protocol requires a minimum of 17 client/case manager contacts (i.e., two in the institution, 12 during the first three months post-release, and one for three months thereafter). The Case Manager Checklist is used to record the occurrence of each session. It also provides the case manager with a step-by-step review of the components of each of the 17 scheduled client sessions and documents progress. The Individual Services Record (ISR) is used by the case manager to document all of contacts with and services rendered to, or on behalf of, the client. This form identifies the mode of contact (i.e., in person, by phone, etc.), all of the involved persons, and the amount of time spent by the case manager to provide the service.

Conclusion

Through the Criminal Justice Drug Abuse Treatment Studies, a research cooperative funded by the National Institute on Drug Abuse, the TCM model for assisting in the re-entry process for substance-abusing parolees is being tested in a multisite study using an experimental design. The study will assess whether the TCM model improves parolee outcomes compared with standard parolee processes.

If the TCM model proves to be successful, its wider adoption would increase the likelihood that offenders follow through on referrals to community treatment, engage in treatment for longer periods of time, and receive services that will support successful re-integration. By involving staff from various agencies in the prison-to-community transition process, the TCM intervention may also strengthen collaboration between the criminal justice system, the community treatment system, and other health and social service systems to further enhance the offender's ability to achieve and maintain a successful transition from institution to community.

Acknowledgments

Disclaimer: This study was funded under a cooperative agreement from the U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse (NIH/NIDA). The authors gratefully acknowledge the collaborative contributions by NIDA, the Coordinating Centers (University of Maryland at College Park, Bureau of Governmental Research and Virginia Commonwealth University), and the Research Centers participating in CJ-DATS (Brown University, Lifespan Hospital; Connecticut Department of Mental Health and Addiction Services; National Development and Research Institutes, Inc., Center for Therapeutic Community Research; National Development and Research Institutes, Inc., Center for the Integration of Research and Practice; Texas Christian University, Institute of Behavioral Research; University of Delaware, Center for Drug and Alcohol Studies; University of Kentucky, Center on Drug and Alcohol Research; University of California at Los Angeles, Integrated Substance Abuse Programs; and University of Miami, Center for Treatment Research on Adolescent Drug Abuse). We also wish to thank James Hall for his comments and assistance. The contents are solely the responsibility of the authors and do not necessarily represent the views of the Department of Health and Human Services, NIDA, or other CJ-DATS participants.

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Table 1

Characteristics of Strengths Case Management in Comparison with Low- and High-Intensity Case Management Models

Characteristics	Low-Intensity Case Management	Strengths Case Management	High-Intensity Case Management
Duration	Time limited	Two months in prison; three months in community weekly; three months in community monthly	Indefinite
Frequency of contact	Infrequent (quarterly contact)	Two contacts in prison; weekly for three months, then monthly for three months	Frequent (daily contact)
Staff:Client ratio	High (1:75)	Medium (1:15-20)	Low (1:10)
Focus of services	Narrow; exclusive	Broad: treatment participation, client goals and needs as determined by Strengths Assessment and Goal Plan	Broad: inclusive
Type of service	Management of services provided by others.	Manage and coordinate services provided by other agencies	Provides all services
Availability	Office hours	Mainly office hours, some evenings and weekends	24 hours
Site of case management services	Office only	In office, in the community, and by telephone	In community
Client direction	Professionally directed	Largely client directed, subject to parole and treatment requirements	Client directed
Advocacy	Gatekeeper for systems (finds alternatives to requested services)	Case manager advocates for client to obtain access to services	Advocates for client (to gain access to services)
Training	On-the-job training	Project-provided training, with ongoing supervisory support	Advanced professional degree
Authority	No authority, persuasion only	No authority, use of persuasion only	Broad authority, administrative control
Team structure	Primary case manager with individual caseload	Case manager with individual case load	Full team mode: All case managers share all clients.

Table 2
Phases of Transitional Case Management for Substance-Abusing Parolees

	Phase 1: Strengths Inventory	Phase 2: Case Conference Call	Phase 3: Strengths Case Management
Who	Client and Case Manager	Client, Transitional Case Manager, Prison Treatment Counselor, Transitional Specialist, Parole/Community Corrections Agent, Community Treatment Rep, family members and a 12-step sponsor.	Client and Case Manager; other service agency staff as needed
What	Orientation, strengths inventory, goal plan development, conference call planning.	Case Conference Call	Strengths case management activities in the community
When	Approximately two months prior to release.	Approximately one month prior to release	Weekly contacts for the first three months post release and monthly phone calls for the subsequent three months.
Where	Institution	Institution	Case Manager's office; in community
Why	Sets the foundation for future case management activities; heightens motivation for community treatment	Defines roles and expectations; heightens motivation for community treatment	Promotes client retention in substance abuse treatment and develops client skills to achieve goals.