

CASE MANAGEMENT FOR INDIVIDUALS WITH CO-OCCURRING PSYCHIATRIC AND SUBSTANCE DISORDERS (ICOPSD)

Case management refers to interventions provided to assist the ICOPSD in accessing the full range of services needed, including social, medical, educational, spiritual, recreational, and any other services which may increase the likelihood of the ICOPSD maintaining long-term mental stability & sobriety.

Case management includes the goal of coordinating services whereby the client/consumer experiences a seamless system of care. By decreasing the fragmentation of treatment and increasing the convenience of uninterrupted case management services, the consumer's chance of long-term mental recovery and substance recovery is greatly increased.

The initial goal of integrated case management is assisting clients/consumers and the caregivers and/or concerned significant others in making informed decisions based on needs, abilities, resources, and preventative measures, minimizing unnecessary hospitalizations and inappropriate placement or institutionalization.

Effective integrated case management focuses on correctly identifying the level of care and assistance needed by consumers to enhance their quality of life. While encouraging healthy functioning, consumers are continually guided toward the ultimate goal of autonomy.

Description of Case Management Function

Case management function requires two main components:

Information and Referral

Information and support about existing resources available to persons served is essential in order to maximize these services. Staff not only would need to know what services are available, but also need to know the eligibility requirements and application procedures so that they can give accurate instructions to clients trying to obtain services. Staff assists the client in following through with referrals and applying for services.

Ongoing Coordination, Monitoring

Monitoring refers to the periodic follow-up with the client. Monitoring may be contact by telephone or in person and should be documented with dates and the nature of the contact. Support persons and service providers contacted should also be documented. A reassessment should occur whenever a change in the client's status occurs which significantly affects his/her care needs. The events would include but not be limited to serious illness, hospitalization, loss of income, or loss of stable housing.

Priority Case Management Activities

Housing: Permanent, transitional, low-income, & group housing alternatives.

- Assess current adequacy of current living arrangement
- Assess need for emergency shelter or specialized housing
- Assist in securing & maintaining a suitable living environment

Transportation: Practical support for ability to maintain independence

- Assist in providing access to and ability to use public and private transportation

Employment/Education: Financial assistance and entitlement programs, such as Ryan White Care Act, Social Security, GPA, FITAP, food stamps, fuel assistance

- Assess source and level of income
- Assess ability to gain employment and remained employed
- Assess Health Insurance coverage
- Assist in applying for entitlement programs
- Assist with money management

Childcare: Foster care, adoption, guardianship

- Assess need for childcare services

Medical: Primary care, hospital services, specialty services, dental care, HIV counseling, testing, referral, and other healthcare related services

- Assess medical history and current symptoms
- Assess current medical treatments, use and understanding of prescribed medications
- Assist with medication monitoring
- Coordinate with primary care physician
- Educate on nutrition and other health education

Criminal Justice/ Legal

- Coordination with judges, probation officers, and attorneys

RECOMMENDATION: Charge each Local System of Care to develop a Resource Manual and make available to all AD and MH facilities.