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Using Intensive Case Management to Reduce Violence by Mentally Ill Persons in the Community

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Aggressive and intensive case management and a comprehensive array of community support services are the keys to reducing the risk of violence by people with serious mental illness in the community. The authors describe the elements of intensive case management for potentially violent clients, including use of individual case managers responsible for small caseloads, 24-hour availability of case managers, and strong linkages to agencies providing mental health services, substance abuse treatment, and social services as well as to the criminal justice system. They summarize the results of three recent studies of intensive case management programs suggesting that this intervention is effective in reducing clients' dangerousness in the community. They discuss cultural and human resource issues that affect planning of intensive case management services. Intensive case managers need to be "boundary spanners" with the training, experience, and personality to bridge the often-broad gap between human service and criminal justice systems.

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On December 13, 1992, nearly one-third of the television program *60 Minutes* was devoted to the case of Larry Hogue, a 48-year-old African-American man living in New York City. According to the press (1–3), he annually received $36,000 in disability payments from the Department of Veterans Affairs, but he did not use the benefits to gain housing or other basic necessities. Instead, he spent his income on alcohol, marijuana, and crack cocaine, and he was chronically homeless.

It was reported that when he was under the influence of these substances, his behavior terrorized the entire Upper West Side of Manhattan. He was reported to throw garbage and feces at passers-by, destroy property, and light fires under automobiles or stuff rags in their gas tanks. He was once convicted in a jury trial of reckless endangerment for pushing a young girl in front of an oncoming truck, which barely managed to stop without hitting her. Yet, when he was civilly committed to inpatient psychiatric treatment and was away from street drugs, it was reported that his behavior became peaceful and even docile, and hospital administrators concluded that he should be released.

If there are treatments available that will reduce violence associated with mental disorder, how can they be delivered most effectively? How can the Larry Hogues across the U.S. be managed while both their rights to liberty, due process, and least restrictive setting and the public's right to be safe are properly balanced? This paper examines these questions and proposes that intensive case management is an effective intervention to reduce the risk of violent behavior by mentally ill persons in the community. Case manage-

ment can be an appropriate strategy for risk management if individual case managers are responsible for small caseloads and if a comprehensive array of services are available in the community.

Case managers as risk managers

Many mental health systems in the U.S. are not able to offer truly comprehensive services and thus have difficulty providing the continuous care that is needed by mentally ill people in the community, including those who sometimes engage in violent behavior. However, effective intensive case management that coordinates the services of a wide variety of community agencies can facilitate their living safely in the community. The case manager, with appropriate caseloads, works to manage both the risks faced by the client and the risk the client could possibly pose to the community. The organizing theme of all case management services is the management of a wide variety of risks. We concentrate here on only one of those risks, the risk of violence associated with mental illness in the community.

People with mental illness, especially those with histories of violent behavior, most often require continuous rather than episodic care. The medical paradigm that treatment is provided only when symptoms are evident is inconsistent with effective community supervision and support of persons with mental illness who have a history of violent behavior. Such persons need regular monitoring, especially when symptoms are absent or at a low ebb, to contain the individual and situational factors that may result in violence.

One of the most important roles of the case manager as risk manager is teaching clients to recognize and respond to high-risk situations, the nature of which varies from client to client. Case managers can help clients to gain insight into the kinds of situations that have led to violence in the past and to develop strategies for avoiding such situations and ways of resolving them if they cannot be avoided.

Definitions of case management abound and include many different processes and responsibilities (4–6). However, all models of case management involve the case manager as "a vehicle for implementing continuity in the care of mentally ill persons" (4). Our purpose here is not to assess the value of various models, which has been addressed in a useful review by Solomon (5). Rather, we will discuss case management as it relates to issues of violence, as both a service modality and an operating system that seeks to organize and synthesize elements of the mental health, social services, and criminal justice systems.

Case managers help clients to gain insight into the kinds of situations that have led to violence in the past and to develop strategies for avoiding such situations and ways of resolving them if they cannot be avoided.

During the last 15 years, case management has evolved as a service modality that usually targets persons with serious mental illness who have been ill served by or unwilling to participate in the generic mental health system. In New York State, for example, the State Office of Mental Health recently began a major intensive case management program for persons with mental illness who are frequent users of expensive psychiatric services such as emergency rooms and inpatient care.

Surles and colleagues (7) have identified eight characteristics of this initiative. First, the client (as opposed to a particular treatment program) is the central focus for the case manager. Second, persons are "nominated" locally for participation in the program by those responsible for treatment. Third, persons cannot be removed from the program roster for "failure to improve." Fourth, caseloads are limited to ten persons per case manager. Fifth, activities are expected to occur in the client's community. Sixth, case managers are expected to be accessible. Seventh, case managers serve as advocates and develop support for clients, who are encouraged to express their own goals and concerns. Eighth, services are not time limited.

So far we have been discussing case management as a system of services. However, there is debate in the field about the optimum way of delivering services. In this paper, the primary mode of service delivery we describe relies on each client's being assigned an individual case manager. Stein (8) recently proposed an alternative service delivery model involving continuous care teams—interdisciplinary teams with low patient-to-staff ratios that operate seven days a week. Stein recommended that these teams should not be thought of as treatment, rehabilitation, or case management teams but as vehicles for providing whatever service or practical assistance a patient requires. He suggested that because the continuous care team provides most services itself and brokers for only a few, services are integrated and responsive to the client's current needs.

We suggest that continuous care teams, as proposed by Stein, constitute a comprehensive outpatient treatment program. Although we agree with Stein that a full array of integrated and responsive services could remove the need for an individual case manager, such ideal systems exists in few places in the United States. In the absence of such systems, we remain convinced of the necessity for individual case managers who integrate services through creative brokering and advocacy. Whether some version of the proposed continuous care team is ultimately preferable awaits future research. In the meantime, intensive case management programs that rely on individual case managers constitute the most practical method of managing violence associated with mental illness in the community.

Specific clients must be identified

and assigned by name to individual case managers. Such assignments are perhaps the most important facet of case management and its greatest value because they prevent case managers from disavowing responsibility for clients who may engage in violent, criminal, psychotic, embarrassing, or threatening behavior. Although case managers may occasionally need to rely on the resources of the criminal justice system or on emergency psychiatric services to respond to clients in potentially violent situations, they continue to be responsible for providing the person with case management and support services, even if the person goes to jail.

Many persons with mental illness who frequently interact with the criminal justice system have been disenfranchised for a variety of reasons. Many are from lower social classes, either because their family of origin was poor or because their mental illness has forestalled employment necessary to maintain social status. Many are unmarried, young, and homeless and may view the mental health and social services systems as their enemy.

Obviously, engaging such a group in treatment is difficult. Mental health systems have traditionally attempted to do so by developing a finite variety of treatment modalities and attempting to fit clients into those services. Such an approach may be suitable for clients who are passive, dependent, and compliant. However, persons with mental illness who have recently come into contact with the criminal justice system because they have been violent are likely to be active, independent, and unwilling to obey orders. Furthermore, many of these people have not had the long hospital stays that characterized an earlier generation of people with serious mental illness. Patients with long hospital stays often learned compliant behaviors that prepared them to accept traditional community mental health services. People with mental illness who are at risk for violent behavior not only may lack these compliant behaviors but may actively antagonize providers in community mental health programs (9).

As in New York's intensive case management program, case managers in effective programs for potentially violent clients must have extremely low caseloads and must be available to clients 24 hours a day, either individually or via teams. Many violent acts and arrests occur in the evening or during the night, when traditional programs are closed. The case management program must have the ability to respond quickly when violence is part of a psychiatric crisis that occurs during these off hours.

One important reason for having low caseloads for intensive case managers is that developing a personal relationship with a client takes a great deal of time and individualized attention. Furthermore, most of this work does not take place in offices, but on the streets and other locations where the clients live and hang out. The importance of this relationship cannot be overstated. One of the simple ways violence can be avoided is to talk about anger. For someone who is socially isolated or whose entire peer support group is made up of people who repetitively act out violent thoughts and feelings, this modulating and inhibiting does not exist. Often, the ability simply to express anger verbally to someone who is perceived as being interested can allow a person an alternative to violent behavior that may not otherwise exist.

Another advantage of a personal relationship with a case manager is that it offers clients an appropriate way to seek more intense treatment services. Tragically, some clients who feel they need to be hospitalized may believe that the only way to receive such help is to commit a violent act. Clients who can go to their case manager for help may no longer feel the need to be violent.

Sometimes, of course, a poor personal match between an individual client and a case manager may occur. Case managers should meet as teams to flexibly address the needs of clients who might be better off with a case manager from a different gender, race, culture, or generation.

Before accepting case management and other services, clients first ask themselves "What's in it for me?" Clients who perceive the case manager as an agent of the state whose sole intention is to make the client "toe the line" will be unlikely to invest any effort in forming a relationship with a case manager. The case manager must thus be seen as an advocate for the client even if other agencies such as the criminal justice system are at the same time dealing with the client in more coercive or authoritarian ways.

What form should this advocacy take? Certainly, case managers should not suggest to clients that they need not be held accountable for criminal or violent acts. However, other forms of advocacy are both necessary and appropriate. For example, as Massaro (10) and others have pointed out, health care for people with serious mental illness is often quite deficient. Case managers could advocate for clients in this area by helping them apply for Medicaid and gain access to a physician or other health care professional. The case manager could assist the client in obtaining other human services and entitlements, such as Social Security Disability Insurance, Supplemental Security Income, or food stamps, and in enrolling in and seeking resources to fund training in their desired vocation.

Case managers may have additional options, depending on the particular provisions of the case management program in which they work. For example, New York's intensive case management program provides service dollars that are intended to be used to meet a range of clients' needs, not only those related to traditional clinical concerns. A case manager may help a client use this money to make a rent payment and thus make a tenuous housing situation more permanent.

Linkages to other systems

To assist severely mentally ill clients in gaining access to the services they need, a case manager must be familiar with the services offered by de-

partments of social services, mental health agencies, medical or health providers, and criminal justice agencies. The case manager may be the client's only social and constructive link to these systems, which have very different goals and practices and use very different terms. Case managers must be able to facilitate communication and cooperation among these agencies. The case manager must have the authority to convene meetings of appropriate staff from each service agency when necessary. Agencies' support for such meetings can be confirmed through interagency agreements or memoranda of understanding.

For clients who are at high risk of becoming violent, convenient access to services is especially important. For a client who is known to respond to homelessness with violent or criminal behavior, being put on a two-year waiting list for subsidized housing is of little help. Although one may debate the moral propriety of giving someone high-priority access to services simply because of violent or criminal behavior, some spots in community support programs should be reserved for clients who present the highest risk to both their own and the community's safety. Such alternatives are especially necessary for clients whose behavior has not escalated to the level at which other coercive measures such as involuntary civil commitment or incarceration are legally justified.

For the client, linkages to the criminal justice system are as important as linkages to the mental health and human service delivery systems. The importance of case managers' working cooperatively with police and criminal justice agencies cannot be overstated. Case managers for high-risk clients must be able to converse fluently in the sometimes idiosyncratic language of the criminal justice system. They must be seen by police and officials in other criminal justice agencies not as helping people with mental illness avoid responsibility for crime, but rather as partners whose main vocational goal is to help make the community safer.

Case managers with links to the criminal justice system may be able to use criminal justice sanctions to facilitate potentially violent clients' adherence to treatment. Judges may release a defendant with mental illness before trial through a variety of mechanisms, including conditional probation, release on one's own recognizance, and adjudication in contemplation of dismissal, on the condition that the person is actively participating in mental health programming. Many judges have expressed to us their frustration over not being able to use these mechanisms for release more frequently because they feel there is no one to accept responsibility for organizing such programming. Judges are often as uncomfortable with the nomenclature and organization of the mental health system as mental health professionals are with that of the legal and criminal justice systems.

Probation and parole officers are important treatment allies. In addition to having the role of oversight and enforcement, parole officers provide important social supports for many of their clients. Most probation and parole officers view engaging a client in education or vocational training as important as monitoring their adherence to the conditions of their release.

However, parole and probation officers typically have caseloads that are far too large for them to adequately address the needs of mentally ill clients at high risk for violence. In addition, parole and probation officers are not likely to be able to negotiate the mental health service delivery system and are usually very grateful for the assistance of case managers. On the other hand, parole and probation officers can provide an external structure that may increase the chances that a client will adhere to an agreed-on treatment plan.

Outcome research

To date, little research has focused specifically on violence reduction as an outcome of case management. However, one study of New York State's intensive case management program (11) and two reports on forensic clients (12,13) strongly suggest that intensive case management services are effective in safely serving potentially violent clients in the community.

In an evaluation of New York's statewide intensive case management program (11), follow-up data on a variety of community functioning variables were gathered on 5,121 adult clients who received services through the program between 1989 and 1992. Some clients were followed for as long as 18 months. Results on measures of harmful behavior, antisocial behavior, and alcohol and drug abuse suggest that the program was effective in reducing clients' dangerousness in the community. Overall scores on the three measures decreased significantly for patients followed for 18 months. In addition, scores on the measures of harmful behavior and alcohol and drug abuse decreased significantly between entry and six months in the program.

The two studies of forensic populations used rearrest as a proxy measure for violent or harmful behavior. The first study assessed the effectiveness of an assertive case management program for mentally ill offenders on probation from a provincial correctional center in Vancouver, British Columbia (12). Case managers in the program each had caseloads of about ten clients, and clients received a minimum of 24 months of intensive case management. The study included a comparison group of offenders who were eligible for the program but who could not be fit into available program slots, declined to participate, or resided outside the Vancouver area. The comparison group was followed through agency records for 36 months.

During the first six months of the study, the clients who received case management averaged eight days in jail, compared with 51 days for the comparison group. At 12 months, the case management group averaged 40 days in jail, compared with 137 days for the comparison group. For the full 18 months of the study, the case management group averaged 80 jail days, while the comparison group averaged nearly three

times that number (214 days). All of these differences were statistically significant, indicating the effectiveness of intensive case management in substantially reducing jail days.

A similar finding emerged from the recent evaluation of Project Action in Texas (13). From 1990 to 1992, six case managers coordinated services for 229 adult offenders released from the Harris County criminal justice system. Most of the data on the project do not relate specifically to the issues of violence. However, the evaluation showed that 75 percent of the program participants had no arrests within one year of entry into the program, 92 percent did not return to state prison, and 80 percent of the program participants who were on parole had no parole violations.

These studies are far from definitive, but they do provide preliminary empirical support for an association between intensive case management and reduced violent behavior by high-risk clients in the community.

Service planning

The case manager for a potentially violent client must be viewed as a member of any treatment team that interacts with the client. The team should assess both individual clients' strengths and their weaknesses. For example, it is quite common for a client's above-average intelligence to be viewed as an impediment to treatment. Phrases such as "too smart for his own good" and "manipulative" often appear in the records of such clients. It is ironic and unfortunate that what for most people would be deemed a strength has been considered a weakness by the mental health care providers who claim to help such clients. The presence of the case manager on the treatment team can encourage mental health care providers to enlist the client's street survival skills as important strengths that can foster rather than impede the person's recovery.

Substance abuse treatment. A full discussion of substance abuse treatment is well beyond the scope of this paper. However, in some jurisdictions, as many as 80 percent of people arrested are reported to have illegal drugs or alcohol in their systems at the time of the arrest (14). Moreover, awareness that substance abuse disorders often co-occur with major psychiatric disorders is growing. Abrams and Teplin (15) found that 59 percent of the inmates in the Cook County jail who had a diagnosis of schizophrenia also had a current alcohol abuse disorder, and 42 percent had a current drug dependence disorder.

The best intensive case managers for clients at high risk of becoming violent are those who have prior experience in a variety of service locations in both the mental health and the criminal justice systems.

Case managers for potentially violent clients with substance abuse problems should actively and aggressively pursue substance abuse treatment for their clients. In addition, as case managers develop trusting relationships with clients, case managers should reinforce that staying away from alcohol and illegal drugs will increase clients' chances of remaining in the community.

Cultural issues. Traditional mental health programs are staffed by credentialed mental health professionals who are typically white and middle-class. However, clients who are likely to be arrested generally do not share this demographic profile and may have opted not to use traditional mental health services because they feel disenfranchised. Many variables that influence the development of violence and crime among people with mental illness in the community may also contribute to their poverty, low levels of education, and underemployment.

To increase the relevance of case management services to these clients, mental health systems should try to employ case managers who are culturally similar to the clients they serve. In our opinion, cultural similarity may be more important than an advanced degree in one of the mental health professions in preparing the case manager to serve high-risk clients.

Cultural issues may include a variety of factors in addition to race and ethnicity. For example, clients with a hearing impairment typically grow up in a subculture quite different from that of persons without such impairments. Clients who are homosexual may need a different array of social supports than heterosexual clients. Persons who are arrested while passing through an area will require linkages with different types of services than will lifelong residents.

Human resources. Intensive case managers tend to have particular characteristics that distinguish them from staff of typical mental health programs. They should be creative, self-directed, independent people with little need for formal structure. Clearly, this work is not for everyone. In our experience, the most crucial element is experience, not formal education.

The best intensive case managers for clients at high risk of becoming violent are those who have prior experience in a variety of service locations in both the mental health and criminal justice systems. Former police officers may be particularly appropriate candidates for this job. Many police officers and others who work in the criminal justice system view themselves primarily as human service professionals. Their work involves supervising and supporting individuals, besides enforcing the law. Many police officers have a college degree when they begin police work or obtain a degree during their police career. They typically retire after 20 or 25 years of police service and thus constitute a potential cadre of experienced, yet young, service professionals with strong linkages with the criminal justice system.

Another group of potential intensive case managers are people who have succeeded in gaining control of their life circumstances despite their

own serious mental illnesses (16). In addition to having developed networks of peer support, knowledge of responsive treatment providers, and strategies for meeting various needs, people who have been treated for mental illness may also be perceived as more credible sources of information by their prospective clients. More generally, case managers of every background can benefit from the insights and support of the emerging self-help movement of mental health service recipients (17).

Case management is a stressful business. Clients who are not cooperative can be frightening and a source of frustration to case managers. Yet if such clients form a bond with a case manager, the relationship may become intensely dependent and leave the case manager feeling drained. Case managers' salaries are typically low, and case managers are unlikely to receive benefits enjoyed by law enforcement officials, such as retirement after 20 years.

Further, case managers may feel that they are in personal danger, especially if they work with clients who have been violent in the past or if their work includes visiting the high-crime areas where many people with serious mental illness live. Case managers must frequently provide coverage after usual working hours, which can put a strain on their health as well as on their relationships. Finally, case managers may not have the prospect of upward career mobility. All of these factors lead to job stress and a high turnover rate. Administrators should thus pay attention to the need for ongoing training and support of case managers.

Conclusions

The keys to reducing the risk of violence by persons with mental disorder in the community are aggressive case management and a comprehensive array of support services. Although some specialized clinical services aimed at reducing violence per se may be needed, most of the services required by this client population are those that any person with serious mental disorder needs. The crucial difference is the increased intensity of case management for potentially violent clients.

Intensive case management for potentially violent clients requires case managers with special skills and low caseloads. The case managers must truly be "boundary spanners" (18) who understand and are able to negotiate the medical care, social service, housing assistance, and criminal justice systems as well as the mental health system.

This special kind of case manager does exist. We have seen them in many intensive case management and jail diversion programs throughout the U.S. They know what kinds of services are available and how to help their clients gain access to them. If clients drop out of a treatment program, intensive case managers attempt to find them and reconnect them to the services they need. If clients are arrested, intensive case managers do not drop them from their caseloads but continue working for them.

Intensive case management is not a panacea. It will fail if appropriate treatment and human services are not available in the community. As Goldman and colleagues (19) observed, the brokering and linkage roles of case management mean little if services are not available in the community to be brokered or linked. Case management may be but one piece of a comprehensive mental health care system, but it is the key to managing the risk of violence in the community among people with mental illness.

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