U.S. Department of Justice
Office of Justice Programs
National Institute of Justice

National Institute of Justice

Research in Action

Jeremy Travis, Director

February 1999

Highlights

Jurisdictions across the country have adopted case management techniques to combat recidivism, homelessness, and joblessness. Case management is being used for arrestees, probationers, and parolees who need services such as batterer intervention, drug treatment, mental health treatment, or to provide help for mentally retarded offenders. This Research in Action examines different criminal justice case management models and critical issues regarding existing case management programs.

The case management of offenders is most likely to be supervised by probation and parole officers. Based on the social service models of the late 1960s and early 1970s, today's criminal justice case management models link inmates returning to the community with drug treatment programs, mental health services, and social service agencies prior to their release.

The fundamental activities of criminal justice case management include engaging the client in the treatment process, assessing the client's needs, developing a service plan, linking the client with appropriate services, monitoring client progress, intervening with sanctions when necessary, and advocating for the client as needed. Case management within a criminal justice context requires the case manager to take on additional tasks beyond those assumed by traditional social service case workers.

In the original social work setting, the case manager served exclusively as a broker of services but did not become involved in counseling the client. In the criminal justice setting, case managers broker services but also are likely to provide informal guidance to their clients. Case managers interviewed for this report consider informal counseling to be a vital component in their rela-

continued...

Case Management in the Criminal Justice System

by Kerry Murphy Healey

Jurisdictions across the country are adapting case management techniques, a service delivery approach developed by mental health and social services workers in the late 1960s and early 1970s, to suit the needs of a wide variety of criminal justice populations. These jurisdictions use case management strategies to reduce recidivism and address mental disorders, developmental disabilities, joblessness, homelessness, HIV/AIDS and other serious medical conditions, and such offenses as domestic violence and substance abuse among adult and juvenile arrestees, probationers, and parolees.

Diverse programs and agencies use a variety of case management techniques with criminal justice populations. Most employ a holistic service approach that addresses conditions within the offender's life that could contribute to recidivism, joblessness, homelessness, or substance abuse relapse. Maintaining service continuity as the client moves through the criminal justice system and returns to the community is critical. Today's criminal justice professionals who provide pretrial services, corrections programming, transitional services for incarcerated offenders, and probation and parole supervision require expertise in case management techniques.

The case management of offenders is most likely to be supervised by probation and parole officers. In a few systems across the Nation, every probationer and parolee receives some form of case management. Increasingly, these agencies employ case management strategies to link inmates returning to the community with drug treatment programs, mental health services, and social service agencies prior to their release. Pretrial service agencies frequently apply case management techniques to assure an arrestee's appearance at trial, tailoring the pretrial supervision of the arrestee to reduce risk to the community.

What is case management?

While strategies and practice vary from one setting to another, traditional case management consists of a social or mental health worker who secures and coordinates continued social, mental health, medical, and other services for a client. The roots of the case management approach can be found in early 20th century social work, but most researchers attribute its development as a distinct service delivery method to the social reform movement of the late 1960s and early 1970s.[1] In particular, the deinstitutionalization of the mentally ill during that period required mental health social workers to develop new ways to connect clients to community social service agencies and to monitor clients' use of services.[2] Similarly, as the numbers of offenders sentenced to community corrections supervision (in lieu of incarceration) and former inmates returning to their communities grew, criminal justice workers began to adapt case management techniques to meet the needs of these populations. Case management reduces recidivism or relapse, encourages social reintegration, and enhances public safety.[3]

Highlights *continued...*

tionship with their clients. A number of correctional case management programs consciously blur the broker and treatment roles and emphasize the need for cross-training between case managers and mental health providers, substance abuse counselors, domestic violence program counselors, and other social service providers.

Practitioners consider effective offender monitoring and the use of graduated sanctions for offenders who fail to comply with service plans to be the keys to successful case management. Because two or more case managers may be employed to supervise an inmate's probation and progress through treatment, practitioners interviewed for this report said it is critical that philosophical differences are ironed out prior to the intervention. Expectations between, say, probation officials and drug treatment or mental health counselors must be fully aligned to ensure uninterrupted and successful treatment for the client.

The case management of offenders raises a number of challenges, including how to provide continuous service to inmates returning to the community, how to best use sanctions to maximize service participation while avoiding unnecessary incarceration, and how to measure program effectiveness. Uniquely in criminal justice case management, case managers must develop employment resources for offenders reentering the community; prepare offenders to find, qualify for, and retain employment; and help resolve difficult family problems.

While support for case management as a tool for use with criminal justice populations is strong among experts, administrators, program directors, and case managers themselves, several interviewed for this report said that poorly designed programs and overburdened case managers can severely undermine such a program's performance. Case management programs require clear lines of communication and cooperation between probation/parole and treatment staff. Failure to develop this rapport can result in increased paperwork, lack of managerial control of cases, and poor supervision of client progress through treatment and court-ordered sanctions.

Case management models

Most current literature on mental health or social work case management has distilled the fundamental functions of the case manager into five sequential activities: (1) assessing the client's needs; (2) developing a service plan; (3) linking the client to appropriate services; (4) monitoring client progress; and (5) advocating for the client as needed.[4] The original social work case management model cast the case manager exclusively as a broker of services and precluded his or her involvement with the client as a counselor or treatment provider.

Two common models are "strength-based" and "assertive" case management. Strength-based case management assesses the client's strengths and talents (with special emphasis on those strengths identified by the client) and builds on them in the treatment and service plan. This model emphasizes the case manager's unconditional positive regard for the client and assumes that clients "possess a psychological self-wisdom that can cause them to discover for themselves their inner strengths and resources" and "act on normative or socially acceptable choices."[5] In a criminal justice setting, the supportive, positive regard displayed by case managers for their clients must be balanced with disapproval of the client's antisocial attitudes or behaviors.

Assertive case management involves delivering services aggressively to the client, rather than passively offering services in a centralized office setting.[6] Assertive case management may require case managers to seek out the client in his or her home, job, or community for meetings and counseling or to locate branch offices that provide services in the communities where clients reside.

Many programs combine or mix both case management models to maximize the impact on clients. Today, the "mixed model" of case management, where the case manager serves in a therapeutic capacity and brokers services, is more common than the pure "service broker" model.[7] Case managers interviewed for this report regard informal counseling to be a necessary component in their relationship with the client. A number of correctional case management programs recognize the need to blur the broker and treatment provider roles and emphasize the importance of cross-training between case managers and mental health providers, substance abuse counselors, batterer treatment program counselors, and other social service providers whose work they formally or informally augment.

The criminal justice case manager may function as a member of a team that creates and implements a service plan for an offender or as one of several case managers independently creating service plans for an offender. For example, a juvenile offender who is in the legal custody of a State department of social services may receive case management services from that department, as well as from a probation officer or a counselor in a correctional facility.

A team of case managers, each with a different responsibility, often coordinates service delivery and achievement of criminal justice goals for batterers on probation. A probation officer commonly acts as the batterer's primary services broker, court liaison, and monitor, while secondary case managers in domestic violence intervention and substance abuse programs provide counseling and treatment, as well as referrals to other social services. Case managers in intervention and treatment programs may also advocate on the batterer's behalf before the courts if their assessment of the client's progress or compliance differs from that of the probation officer.

The in-house sharing of clients is another common case management approach. Probation officers often share responsibilities to ensure that a client's case management services will continue uninterrupted if one officer must attend to other cases or is otherwise unavailable—on vacation, ill, on maternity leave, and so forth. Two or more officers must be familiar with the client to guarantee continuity of services if the primary case manager is absent.

Criminal justice case management requires the case manager to take on additional tasks that go beyond the traditional "service broker" model. Enos and Southern have proposed a criminal justice model that incorporates seven stages: intake, assessment, classification, referral, intervention, evaluation, and advocacy.[8] The case management tasks described below frequently overlap, as opposed to being discrete and sequential.

Intake. This may involve crisis intervention, establishing a rapport with the client, providing orientation (such as information about how to comply with a treatment plan and to communicate with case managers and treatment providers), and a discussion about sanctions for failure to comply. Intake is best performed face-to-face, but may include printed or videotaped information.

Assessment. This phase usually involves interviews and history-taking and may include substance abuse evaluation or specialized psychological evaluation, home visits, and contacts with family members, employers, and other agencies with which the offender has been involved. When specialized assessments are needed, the case manager arranges for or approves the provider. In general, violent offenders (especially sex offenders and domestic batterers) require more careful evaluation than offenders who commit property crimes.[9]

Classification. Traditionally, offenders were classified by their amenability to treatment; those judged to be poor candidates for rehabilitation were incarcerated and received no services. In some jurisdictions, 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. Classifications may be based on risk assessments derived from the offender's criminal history. More complicated cases may include the written assessments of mental health experts, social workers, or addiction specialists; the results of standard psychological evaluation tools, such as the Minnesota Multiphasic Personality Inventory; or empirically based prediction models. Based on classification, offenders may be assigned to particular units within institutional settings or offered specialized services.

Referral. This may take many forms, depending on the status and needs of the offender. Arrestees awaiting trial may be referred to halfway houses that provide more stable community ties, substance abuse treatment, behavior modification programs, and employment training and placement assistance. Inmates may be referred to in-house educational, job-training, or mental health programs. Inmates due for release may be referred to transitional service providers or linked with community-based services, such as substance abuse treatment or mental health counseling, to ensure continuity of services. Case managers refer offenders on probation or parole to community and government agencies that can assist with substance abuse or domestic violence problems and to obtain health care, housing, public assistance, mental health counseling, and assistance with developmental disabilities, HIV/AIDS, or other serious health problems.

Intervention. The case manager matches available resources and services to the offender's identified needs. The offender is responsible for cooperating with program requirements and changing his or her behavior.

Monitoring. Practitioners have identified the keys to successful case management as effective offender monitoring and graduated sanctions for offenders who fail to comply with service plans. Monitoring may incorporate graduated, court-ordered sanctions, such as more frequent court reviews, use of electronic surveillance devices, or short incarcerations to encourage offender cooperation with case management goals. Intensive monitoring may include frequent drug or alcohol testing, weekly (or even daily) phone or personal contact between the case manager and the offender, and frequent communication with service providers to track the offender's compliance with court-ordered conditions or program requirements. The need for intensive offender monitoring should decrease over time—shifting from a highly structured intervention with extensive external controls on relapse or reoffense 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.

Evaluation. The case manager must determine if the client has received the services outlined in the case management plan and whether that client has benefited from those services. The most significant indicator of successful case management for criminal justice clients is recidivism. Case managers also may use other measures of behavioral change to gauge response to the intervention: data provided by the offender; urine drug screening; program attendance and compliance reports; and information from victims, family members, employers, or other agencies. Evaluations of case management programs should consider such factors as overall efficiency of service delivery, cost effectiveness, and any systemic obstacles to service delivery. While case managers are unlikely to evaluate programs, they may assist with data collection. Administrators should share evaluation results with staff and adjust procedures as needed.

Advocacy. Several types of advocacy are required of case managers in a criminal justice setting. The case manager may testify or make recommendations in court on the client's behalf, negotiate pro bono services for clients, or secure priority placements at programs with waiting lists. The case manager also may mediate difficult situations for the offender, such as arranging visitation with children who are no longer in the client's custody. The case manager must review obstructive bureaucratic practices and community conditions. For example,

case managers and their supervisors interpret individual and program outcomes and use the information to advocate change and refinement within the criminal justice system. Criminal justice case managers may propose solutions, such as interagency working groups or task forces that work outside their departmental jurisdiction, to address systemic obstacles. Finally, case managers may identify community conditions or parole or probation procedures that contribute to crime or recidivism. They may advocate for changes in law or policy that support their work with offenders. For example, one probation official noted that the majority of drunk drivers under his department's supervision were arrested after attending evening "happy hours" at bars. This officer successfully lobbied the State legislature for legislation banning happy hours, a law that subsequently reduced drunken driving arrests.

Criminal justice case management in action

Because criminal justice populations are so diverse, case management programs must be diverse. One author and evaluator observed the following:

> As might be expected with any new practice form, the nature of case management is unclear. . . . A comparison of settings that [claim] to use case management reveals diversity rather than uniformity. Patterns of case management that are similar, however, seem to be associated with settings that serve similar client populations (mental health, child welfare, physical disabilities).[10]

Research shows that similarities between programs develop to reflect the specific population they serve: drug-addicted offenders, mentally ill offenders, offenders with mental disabilities, and so forth.

One offender, many case managers. Differences in practice are revealed when coordinating the efforts of two or more case managers. As mentioned above, a number of programs described in this report use two case managers—or, more likely, a team of case managers—for each client. One case manager, housed at a substance abuse treatment facility, might coordinate all aspects of drug treatment, education, and social services, while another case manager might be a transitional services worker from the corrections department or a probation officer who helps the offender secure transitional housing, employment, or health care insurance and monitors client compliance with the terms of probation or parole. One program director observed that in his jurisdiction it was useful to have a mental health/mental retardation counselor and a probation officer—whose roles as case managers were "fluid"—provide case management to mentally ill and retarded offenders. According to the director, "Both provide services. There can be no division in the ranks, no separation of roles. A division upsets the clients. The probation officer cannot always be the 'bad' guy."[11]

By contrast, a formal division of roles between supervision and rehabilitation services is maintained in a Quincy (Massachusetts) District Court program that provides intensive case management to batterers. Probation officers closely monitor probationers' attendance at a domestic violence program and often require that the probationers make daily phone or face-to-face contact with the supervising officer, undergo weekly random drug or alcohol screening, and attend substance abuse programs where indicated. They also advocate for victims. Counselors in the batterers' and substance abuse programs provide rehabilitative services to offenders.

Where should the case manager be located? Case management services are largely defined by the setting in which they are delivered. In Pima County, Arizona, probation officers and drug treatment counselors shared office space at a drug treatment facility (see sidebar "The Pima County, Arizona, experiment"). Don Stiles, chief adult probation officer for the Superior Court in Pima County, praises the cooperation that developed between his officers and the treatment staff due to the increased personal contact. "Communication worked 10 times better with people in the same building. Probation officers knew immediately if someone missed treatment. We had better attendance and better results."

Other program administrators were similarly enthusiastic about case management programs that operate within the communities where the clients live.[12] Assertive case management is easier for both the case manager and the client when the program is based in a client's neighborhood, rather than at the probation or social services department's location.

One advocate for the victims of batterers on probation emphasizes the importance of service location. Although she considers victim outreach and advocacy to be a critical component of the case management of batterers on probation, she declines to provide services to victims if secure office space remote from the probation office is not available. "It is not responsible to ask victims to come in for services if they might meet their batterer in the hall or elevator," said the advocate.

Other criminal justice case managers are being trained to assist mental health and substance abuse counselors with onsite treatment and therapy in institutional settings. In the Alexandria (Virginia) jail, case management teams composed of jail officials and representatives of the local mental health authority coordinate treatment for inmates in an onsite unit administered primarily by jail employees (see sidebar "Linking inmates with local resources: Alexandria jail's Critical Care Mental Health and Sober Living Units").

The Federal Bureau of Prisons (BOP) organized a pilot program to provide substance abuse treatment at six BOP halfway houses around the country. This arrangement removes the need for

dual case managers for offenders in treatment.

Automated case management systems. A number of software developers now offer systems designed to assist pretrial service providers, courts, and probation and parole officers with case management recordkeeping. Discipline-specific features offered by software systems include tracking basic case management information (including workload analysis and scheduling); managing fines or restitution; managing warrants; maintaining drug-testing, juvenile, and adult records; managing electronic surveillance; collecting data for research and statistics; and generating notification letters.[13]

System costs vary widely according to the sophistication of the services offered. One basic automated system that helps coordinate the case manager's workload by tracking offenders' obligations, victims, comments, aliases, actions, special good time, and payments—and also generates automatic reports that tell the case managers what specific actions must be taken when—costs as little as $700. Another system that provides "an integrated, comprehensive solution to the information needs" of sheriffs, clerks, judges, court administrators, prosecutors, and probation officers ranges in price from $7,500 to $150,000.[14]

Issues in criminal justice case management

The case management of offenders raises a number of difficult issues, including how to provide continuous services to inmates returning to the community, how to use sanctions to maximize service participation while avoiding unnecessary incarceration, and how to measure program effectiveness. Aside from these structural issues, criminal justice case managers face a number of unique challenges, such as sustaining consistent levels of service while the offender passes through the criminal justice system and back to the community; developing employment resources for offenders reentering the community; preparing offenders to find, qualify for, and retain employment; and helping to resolve such thorny problems as family reunification and the substance abuse problems of other family members.[15]

Providing continuity of services. While the challenge of maintaining service and staff levels as an offender moves through the criminal justice system and back into the community is similar to that facing other social service providers who must track clients moving through hospitals, schools, and jobs, criminal justice case managers must not only track but also anticipate and prepare for each client move to minimize the likelihood of recidivism and the risk to society. The BOP and some local correctional systems piggyback inmate and community corrections treatment contracts onto those already held by the local probation authority, providing offenders with access to the same services upon their release from prison. When it is impossible to use the same service provider, some parole officers seek to create a sense of continuity by referring offenders to a treatment program that is philosophically similar to the one in which the offender participated while incarcerated. Other institutions offer transitional services for soon-to-be released inmates that link them with service providers in the community before release, including scheduling intake appointments as soon after release as possible.

Successfully reintegrating mentally disordered inmates and probationers into the community is very challenging. In 1989, the New York State Office of Mental Health (OMH) first funded private mental health contractors who helped parolees with mental disorders qualify for supplementary security income (SSI), social security disability income (SSDI), food stamps, and Medicaid. The funding was to assure that the parolee—with the assistance of the private contractor—would qualify for income and services from other State and Federal agencies

The Pima County, Arizona, experiment[a]

The Amity Project, a collaboration between Amity, Inc., and the Pima County Department of Probation, was funded in 1990 by the Center for Substance Abuse Treatment of the U.S. Department of Health and Human Services to target offenders who were at high risk of probation revocation due to substance abuse. Racial and ethnic minorities, as well as younger offenders, were included in the program, which incorporated key elements of a therapeutic community into a day-and-evening program.

The program design incorporated escalating sanctions, including urine screens and varying supervision levels, case management (assessment and support), educational or vocational training, family support and counseling, health services coordination, intensive aftercare, and a community-based site housing both probation officers and treatment staff.

After 2 years, drug use relapses were reduced and probationer employment increased. Across the program, positive urine tests decreased by more than 50 percent in the first year, and the employment component was so successful that the project developed night and weekend services to accommodate employed offenders. Despite these promising results, the program was terminated due to lack of funding.

a. Information in this section is from the following sources: a January 1996 telephone interview with Don Stiles, chief adult probation officer for the Superior Court in Pima County, Arizona; Stiles, Don R., and Rod Mullen, "Smart Sanctions: Treatment Center, Probation Collaborate to Improve Treatment and Supervision Results," *Executive Exchange,* National Association of Probation Executives, Fall 1993: 1–8; Adult Probation Department, Arizona Superior Court, Pima County, *Annual Report,* 1994; and Adult Probation Department, Arizona Superior Court, Pima County, *Annual Report,* 1995.

Linking inmates with local resources: Alexandria jail's Critical Care Mental Health and Sober Living Units[a]

Since 1983, the city jail in Alexandria, Virginia, has partnered with the Alexandria Department of Mental Health, Mental Retardation, and Substance Abuse (hereafter, the department) to provide services to inmates. The idea behind the cooperative effort is that jail presents an opportunity to link inmates with treatment and social services before they return to the community. The collaboration, which began with a part-time health worker assigned to work inside the jail, has grown to include two in-house programs—one for mentally ill inmates and another for substance abusers. Both programs use case management techniques that replicate community-based, intensive residential programs.

The Critical Care Mental Health Unit and the Sober Living Units (which have 10 beds for female inmates and 29 for male inmates) are staffed jointly. The department contributes 7.5 full-time staff members to the effort, and the jail adds 4 trained intake staff; a full-time, special management sergeant; and 2 case managers who specialize in aftercare placement for the Sober Living Units. The department provides case management services for the inmates, as well as any necessary training and research support. Of the department employees, five are assigned to the Critical Care Mental Health Unit (two clinical social workers and three psychological counselors), and five are assigned to the Sober Living Units (one for female inmates and one for male inmates). Trained jail staff, designated as "special management deputies" and "unit counselors," augment the work of the mental health counselors. Trained jail staff are responsible for initial treatment, and only the most serious cases are referred to the mental health department counselors.

Case management for mentally ill offenders includes regular case review by a behavior management team, which includes security personnel (the sergeant), classification personnel, and clinicians (both mental health and medical) who develop a treatment plan integrating the needs of the inmate and the institution. Approximately 20 percent of the jail's inmates receive some form of mental health services from the unit.

The Sober Living Units were established in 1987 in response to the increasing number of drug offenders among the jail population. The units provide 90-day intensive residential substance abuse treatment in preparation for return to the community. Treatment includes educational programs and both individual and group therapy. The Sober Living Units and the Critical Mental Health Unit link inmates to community social and health services while they are in jail. Inmates are expected to continue the relationship with their case manager upon release from jail.

Staff research indicated that 85 percent of mental health referrals also had substance abuse problems. Therefore, in 1990, a full-time substance abuse counselor was added to the mental health unit to assist with dually diagnosed inmates.

---

a. The information for this section is from the following sources: a January 1996 telephone interview with Bob Gimblette, Alexandria (Virginia) Department of Mental Health, Mental Retardation, and Substance Abuse; Fortin, Connie, "Jail Provides Mental Health and Substance Abuse Services," *Corrections Today*, 55 (6) (1993): 104–107; Office of the Sheriff, *Treating the Community's Mentally Ill: A Collaborative Approach to Jail Mental Health Services*, City of Alexandria, Virginia, Department of Mental Health, Mental Retardation, and Substance Abuse, July 1994, unpublished manual; and Office of the Sheriff, *Jail Mental Health Services: A Training Manual for Deputy Sheriffs and Correctional Staff,* City of Alexandria, Virginia, Department of Mental Health, Mental Retardation, and Substance Abuse, February 1994, unpublished manual.

by the time OMH support payments ceased.[16] The Maricopa County (Arizona) Adult Probation Department uses the Transitional Living Center (TLC), a probation-operated residential psychiatric program for offenders with serious mental illness, to bridge the critical span between release from custody and independent living in the community. The length of stay is determined by the time it takes to link clients to community-based mental health and support services; the average stay at TLC is 60 days.[17]

Sanctions as a case management tool. Case management with criminal justice populations is also different from case management in other contexts because compliance with substance abuse treatment or other provisions of the offender's service plan may be a condition of probation/parole or part of a court-ordered diversion program for mentally disordered, developmentally disabled, or pregnant drug-abusing offenders. Some commentators have suggested that, at the very least, compulsory substance abuse treatment generally results in higher rates of retention in treatment and is associated with better outcomes.[18] Some of the programs described in this report make aggressive use of sanctions and intensive supervision to promote the goals of the service plan; others operate without legal coercion. Literature concerning the use of sanctions as a case management tool emphasizes the need for graduated sanctions and less rigid enforcement with mentally disordered or developmentally disabled offenders, who are more likely to have difficulty complying with treatment goals or the conditions of their release.

Probation and parole officers and service providers must be frank concerning the criminal justice case manager's enforcement policy. Service providers and case managers interviewed for this report expressed frustration over the use of sanctions. Some probation and parole officers suspect that substance abuse treatment program staff are lax in reporting violations because they either may be tolerant of some degree

of relapse or have no desire to report client failure and thus risk losing program income. Conversely, therapists and substance abuse treatment providers expressed concerns that probation policies often are relatively inflexible concerning relapse, which is unrealistic. By contrast, batterer treatment program counselors in some jurisdictions expressed concern that probation violations concerning domestic violence are not taken seriously by the courts, and, as a result, sanctions are rare or inadequate.

In other jurisdictions, sanctions are used successfully as a case management tool. For example, in jurisdictions where batterer treatment program providers and probation officers meet regularly to discuss case management issues, a clear policy concerning the use of sanctions has developed and no conflict arises about the overusage or underusage of sanctions. The drug court model, which is employed in a number of jurisdictions nationally, positions the judge as case manager and uses strict, court-based monitoring and an array of graduated sanctions to motivate the offender to comply with court-ordered treatment goals.[19]

Case management evaluations. Questions concerning the case manager's expectations and attitudes and even the "tone" of the program setting and how these factors affect outcomes resonate throughout case management evaluation literature and were a focus of several interviews for this report. In his evaluation of the Assertive Community Treatment Program, James Inciardi writes the following:

> To a large extent, research on case management is research on case managers, since it is often difficult to separate the two. Although there are different philosophies and techniques to case management, most agencies appear to expect a fair amount of conformity among managers. Therefore, the role of the case manager may be crucial to understanding the varied impact of treatment programs on clients. How do staff members facilitate the therapeutic process? Does staff effectiveness vary by training, philosophy, personality, case load, or charisma? Although impact and outcome analysis will answer some of these questions, it is also necessary to probe their qualitative aspects as well.[20]

Shelli Rossman of the Urban Institute observes that evaluations of pilot programs are inevitably affected by the quality of case management being provided—not just by the type and number of service linkages offered—and that there is "an extraordinary variation in what masquerades as case management."[21] She points to the fact that some case managers have backgrounds in social work, others in mental health, and others have no special qualifications whatsoever. Clinical psychologist Matthew Ferrara calls for the creation of an academic specialty to train criminal justice case managers working in the field of mental health.[22] Another evaluator echoes Rossman's concerns, predicting that one program would be likely to produce better results than its structurally identical sister programs because "the staff got their act together earlier and better than at the other sites."[23]

Which offenders need case management?

Enos and Southern identify six classes of offenders whom they consider best suited for case management focusing on behavioral change: juvenile delinquents; offenders with impulse control disorders (kleptomania, pyromania); offenders with specific personality disorders (especially antisocial); substance abusers; all sex offenders; and offenders who experience problems in personal relationships that affect their ability to function at work, as parents, in the family, or in society.[24]

These broad classifications cover virtually all offenders. At present, the criminal justice populations who most commonly receive case management services are substance abusers, mentally disordered or developmentally disabled offenders, probationers, and inmates and parolees needing transitional services to help them reintegrate with their community.

Substance-abusing offenders. The majority of the criminal justice populations discussed here receive case management services related to substance abuse treatment. 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.[25] Many factors contribute to the tentative tone struck by researchers in the early studies; probably the most important of these was the widely varying quality of case management services provided to offenders and the evaluators' inability to gauge the long-term impact. Nonetheless, individual programs report significant cost savings compared with incarceration, less recidivism, and longer time until rearrest. South Carolina's "Stayin' Straight" program, a day reporting center with an intensive substance abuse treatment component, cost $3.65 per day per probationer to administer (versus $32 per day for incarceration), reduced rearrest by 20 percent after 22 months, and delayed the average time until rearrest by 137 days compared with program dropouts.

Mentally disordered and developmentally disabled offenders. Some of the most promising programs work with mentally disordered or developmentally disabled offenders—the type of client for whom case management has a proven track record in other settings (see sidebar "Case management of mentally disordered or developmentally disabled offenders"). These programs generally use trained personnel and follow traditional mental health case management models. Project Action,[26] an intensive case management program for mentally ill offenders in Houston, Texas, boasted a 5 percent

recidivism rate for program participants versus a 64 percent rate for offenders on regular release.[27] Project CHANCE[28] (Case management/Habilitation/Advocacy/Networking/Coordinating council/Education and training), a program run by the Association of Retarded Citizens and funded by the Texas Council on Offenders with Mental Impairments, reported equally promising results. The program aimed to reduce recidivism rates through intensive case management. Project CHANCE served both adult and juvenile offenders and accepted referrals from both pretrial services and correctional institutions. The project, which operated for 7 years, helped developmentally disabled offenders understand their legal rights and responsibilities, make informed decisions, set goals (such as ceasing substance abuse or achieving independent living), and identify the resources necessary to achieve those goals. Project CHANCE also coordinated the transfer of services for developmentally disabled offenders to the local mental health or mental retardation authority and ensured that services were not discontinued or duplicated. The program boasted an 11 percent recidivism rate for participants, compared with nearly 60 percent for comparable groups. The program was cost effective: Services for incarcerated mentally retarded offenders cost the local authorities between $30,000 and $45,000 per person annually, versus $9,000 for Project CHANCE case management. Even if special services for develop-

Case management of mentally disordered or developmentally disabled offenders: Lancaster County, Pennsylvania, Office of Special Offender Services[a]

The Lancaster County, Pennsylvania, Office of Special Offender Services directs four programs that use case management to target mentally retarded offenders, nonviolent mentally disordered offenders, mentally retarded juvenile offenders, and at-risk juveniles in special education. Two factors contribute to the success of the programs, says Director Wayne Geltz. First, the Office of Special Offender Services is the bureaucratic equal of both the local social services and probation departments. As an equal, it is better able to command cooperation from those agencies and to request funding from the county. Second, criminal justice sanctions encourage offenders to use services offered by his department. "You need the enforcement package to go along with the social services," he says.

Established in 1981 jointly by the Lancaster County Court of Common Pleas (Probation/Parole) and the Lancaster County Office of Mental Health and Retardation, the Office of Special Offenders Services provides intensive probation/parole and case management services to mentally retarded adults. In the Adult Offenders with Mental Retardation Program, probation officers and case managers work together to define client functional levels and case management goals. Intensive supervision and counseling (provided by the case manager) help the offender develop self-esteem and confidence; build decisionmaking, social, and independent living skills; and obtain employment. After successfully completing probation, offenders in the program are linked with the county's main mental health/mental retardation department for continued case management. Contact between offenders and case managers may continue as needed.

Mentally disordered probationers who have committed nonviolent crimes and have been diagnosed with certain psychological conditions (schizophrenia, bipolar disorder, delusional [paranoid] disorders, major depression, and anxiety disorders) are eligible to participate in the Offenders with Mental Illness Program. Case management services vary in intensity (depending on the needs of the client) but may include daily or weekly monitoring, medication monitoring, day programming, employment counseling, vocational testing, job placement, and family and personal counseling. The program attempts to limit incarceration and hospitalization for nonviolent offenders, to assist in the successful completion of probation, and to reduce recidivism.

The Juvenile Division of the Office of Special Offender Services addresses the needs of developmentally disabled juvenile offenders who might otherwise fall through the cracks of the juvenile justice system. A specially trained team of probation officers and case workers assists this population. The program, which is partially funded by the Pennsylvania Juvenile Court Judges, works to reduce recidivism and the cost of placement by providing the juveniles with the skills necessary to live independently or with their family, obey the law, and function in the community. Case management for juveniles includes intensive supervision (daily meetings until they are stabilized, then several meetings a week); meetings with the family, school officials, and employer; and an intensive educational program that covers drug and alcohol issues, legal rights and responsibilities, money management, social skills, recreational activities (as a reward for program compliance), and other training related to daily living skills. Juveniles spend an average of 9 to 12 months in the program.

Office of Special Offender Services case managers and a probation officer teach a school truancy prevention program targeted at mainstreamed developmentally disabled juveniles who may not adequately understand the law or the criminal justice system. The 3-hour program focuses on community behavioral standards, personal responsibility, decision-making, and the consequences of breaking the law. The educational program is presented two mornings and two afternoons per week.

a. Information in this section is from a January 1996 telephone interview with Wayne Geltz, Director, Office of Special Offender Services, Lancaster County, Pennsylvania, and printed program information provided by that office.

mentally disabled inmates were not included, Project CHANCE case management costs $32 per day per inmate, compared with $56 per day for county jail incarceration.

Probationers. Both Federal and local probation directors contacted for this report were enthusiastic about probationers receiving case management services and praised the effectiveness of such services with high-risk clients. Don Stiles, chief adult probation officer for the Superior Court in Pima County, when asked for a definition of case management, stated, "That is it. That is what we do here every day. You have just described our probation department."[29] According to Stiles, the Pima County Probation Department currently uses its Specialized Offenders Case Loads Division to provide case management targeting mentally ill, mentally retarded, and substance-abusing offenders and sex offenders.

Loren Buddress, Federal chief probation officer for the Northern District of California, reports that he has 70 officers "doing case management" and 15 providing specialized case management services, such as mental health counseling, drug treatment, housing and employment assistance, treatment for batterers, and a cognitive-behavior course for female embezzlers.[30] 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.[31]

Inmates due for release. The provision of transitional services to incarcerated offenders is another area of criminal justice well-suited to the case management approach. In its broadest sense, case management for soon-to-be-released offenders could begin with the provision of prerelease services, including substance abuse treatment, and follow the offender to community corrections and community-based substance abuse treatment. (The Federal Bureau of Prisons has a number of programs working on this model; see sidebar "Case management of addicted inmates: The Federal Bureau of Prisons' Drug Abuse Treatment Initiative.") In New York City, the Women's Prison Association draws on public and private funding to provide transitional services, including individual counseling, discharge planning, outreach workshops, and transitional housing.[32]

Case management of addicted inmates: The Federal Bureau of Prisons' Drug Abuse Treatment Initiative[a]

The Federal Bureau of Prisons (BOP) has undertaken a number of case management initiatives related to substance abuse treatment and transitional services for inmates. Beth Wyman, national drug abuse program coordinator, emphasizes that BOP drug treatment approaches are designed to take a holistic or comprehensive approach to inmates' needs. While inmates are incarcerated, treatment is provided by BOP staff; the key case management challenge involves transferring information between agencies as the inmate is released to community corrections, supervised release, and finally, the community.

According to Jerry Vroegh, transitional services coordinator, case managers start tracking inmates who are completing residential drug treatment provided by BOP before they are transferred to community corrections. In preparation for the transfer, treatment statements are examined, and referrals to treatment programs are made before the inmates are released to the halfway house. Once an inmate is at the halfway house, contact is made with the treatment program within 2 weeks. Transitional services piggybacks its treatment contracts onto those already held by local probation officials (the U.S. Probation Office oversees supervised release for Federal offenders) so that offenders moving through the system experience as few changes in treatment services and case managers as possible.

a. Information in this section is from the following sources: a January 1996 telephone interview with Beth Wyman, National Drug Abuse Program Coordinator, Federal Bureau of Prisons (BOP); an interview with Jerry Vroegh, transitional services coordinator, BOP; an interview with Bernadette Pelissier, project director/evaluator, Pilot Drug Abuse Treatment Programs, Federal Correctional Institution (FCI) Tallahassee, Florida; FCI Butner, North Carolina; and FCI Lexington, Kentucky; Murray, Donald, *Drug Abuse Treatment Programs in the Federal Bureau of Prisons: Initiatives for the 1990s*, National Institute on Drug Abuse Monograph: 62–83; Murray, D., "New Initiatives in Drug Treatment in the Federal Bureau of Prisons," *Federal Probation,* 55, 1991: 35–41; Hayes, Thomas J., and Dennis J. Schimmel, "Residential Drug Abuse Treatment in the Federal Bureau of Prisons," *Journal of Drug Issues*, 23 (1) (1993): 61–73.

Commonly cited obstacles to case management

While the majority of experts, administrators, program directors, and case managers contacted for this report were positive about case management as a tool for use with criminal justice populations, a few raised concerns about the structure of programs and the overburdening of case managers.

One proponent of case management made the following observation:

> [A] poorly designed case management system will result in increased paperwork, poor compliance by line staff, and failure to help manage your agency. However, a good case management system will help you articulate your priorities to your public policy leaders, give clear direction to line staff on cases that should receive the most attention, help identify time and resources required to maintain minimal standards, provide information to evaluate the effectiveness of programs, and help defend in civil liability [cases].[33]

The most serious challenge for criminal justice case managers is to establish open and positive working relationships with the service providers of choice. Because criminal justice programs may involve more than one case manager, communication and cooperation between key professionals is essential. As discussed in a previous section ("Sanctions as a case management tool"), disagreement between the correctional case manager and program or treatment staff over the use of sanctions for probation or parole violations can create a tense working environment.

There are several possible causes for friction between correctional and treatment case managers. Criminal justice case managers consider some treatment providers to be too tolerant of the cycle of relapse and recovery; often, both sides differ philosophically over the use of incarceration as punishment for drug abuse, and case managers have a self-interest to maintain program participation and perceptions of program success. Some evaluators also questioned the impact of the strict enforcement of sanctions on program outcomes. In interviews, several evaluators suggested that program outcomes measuring client success in absolute terms—no relapses to drug abuse, no further arrests, no further criminal activity—were likely to obscure more subtle successes of case management with difficult populations, such as longer drug-free periods, lower levels of criminal activity, longer time to rearrest, and fewer arrests.

Frequent interagency contact, cross-training, and clear communication concerning criminal justice expectations should reduce these barriers. One director of transitional services emphasized the power that community corrections agencies possess to choose their own service providers should these efforts fail. "If a treatment program staff is uncooperative, the probation department can just not renew their contract," he said.

Overburdened case managers. Case managers in some programs must manage too many cases with too few resources to provide comprehensive service, says Dr. James Swartz, project coordinator for the National Consortium of Treatment Alternatives to Street Crime (TASC) programs, generally well-regarded as one of the earliest and largest case management experiments.[34] A personnel shortage has forced his Chicago case managers to restrict their assistance to substance-abusing probationers to the most basic linking and monitoring activities, instead of expanding case management services to include educational and vocational training, psychological services, medical services, and housing and job placement. Furthermore, as available resources shrink, fewer services are targeted to high-risk treatment candidates—those whom he feels are most likely to benefit from the services.[35]

Transfer of offender treatment information. Another challenge for case managers is passing basic offender information, treatment plans, and psychological assessments along to the next agency or case manager as the offender travels through the criminal justice system. The Federal Bureau of Prisons Office of Transitional Services is working on ways to ensure that basic information gathering and assessment is done only once and that relevant case-planning documents arrive at the receiving agency before the offender. Information must also flow back to criminal justice case managers from service providers and treatment programs. Management structures—such as formal coordinating committees or policy teams composed of representatives from key criminal justice and service agencies—are needed to ensure that offender information is exchanged in a confidential, timely, and efficient manner.

Conclusion

While offenders are under the supervision of the criminal justice system, a unique opportunity exists to intervene in the offender's lifestyle to reduce future criminal behavior. Case management for criminal justice populations connects offenders with the specific services and counseling they need to resist substance abuse relapse and to break the cycle of criminal behavior.

Various models of case management are being used in a variety of criminal justice settings. Case management's greatest contribution to date has been to reduce recidivism and supervision costs for mentally disordered or developmentally disabled offenders. Case management will also reduce the enormous social, economic, and bureaucratic barriers that contribute to recidivism or substance abuse relapse among inmates returning to the community and offenders sentenced to probation.

While the majority of criminal justice case management programs focus on substance-abusing offenders, existing evaluations do not present a consistent pattern of success with this population.[36] Nonetheless, the impressive reductions in recidivism, time to reoffense, and cost reported by some programs using day-reporting for substance-abusing probationers and parolees suggest that intensive case management can have a significant impact on these high-risk populations and that further research is needed to define the key program and case management elements contributing to these successes.[37] In the meantime, developing case management approaches for those offenders who are part of populations that have traditionally responded well to case management—for example, the mentally disordered or developmentally disabled—should be a priority.

Notes

1. Martin, Steve S., and James A. Inciardi, "Case Management Approaches for the Criminal Justice Client," in *Drug Treatment and Criminal Justice*, ed. James A. Inciardi, Thousand Oaks, California: Sage Publications, 1993: 84–86; and Falck, Russell S., Harvey A. Seigal, and Robert G. Carlson, "Case Management to Enhance AIDS Risk Reduction for Injection Drug Users and Crack Cocaine Users: Practical and Philosophical Considerations," in *Progress and Issues in Case Management*, Research Monograph 127, Rockville, Maryland: National Institute on Drug Abuse, 1992: 167–180.

2. One early study of the use of case management techniques by social service workers provides the following definition: "The concept of case management drew on two historically different emphases in provision of service delivery to the multi-need client. . . . The 'liaison resource' and 'client monitor' aspects of service

delivery both became incorporated over time into a 'case managing' role for service workers, which was inclusive of planning, coordinating, advocating, and monitoring of client services across a variety of settings and client groups." Caragana, Penelope, and David M. Austin, "Final Report: A Comparative Study of the Functions of the Case Manager in Multi-Purpose, Comprehensive and in Categorical Programs," Austin, Texas: University of Texas, School of Social Work, July 1983. Unpublished report submitted to the Office of Human Development Services, Department of Health and Human Services, Washington, D.C.

3. Enos, Richard, and Steven Southern, *Correctional Case Management*, Cincinnati, Ohio: Anderson Publishing Co., 1996: 2.

4. Martin and Inciardi, "Case Management Approaches for the Criminal Justice Client," 83; Falck et al., "Case Management to Enhance AIDS Risk Reduction," 167; and Roberts-DeGennaro, Maria, "Developing Case Management as a Practice Model," *Social Casework: The Journal of Contemporary Social Work* (October 1987): 466–470.

5. Enos and Southern, *Correctional Case Management*, 44–45.

6. Telephone interview with James Inciardi, January 1996.

7. Falck et al., "Case Management to Enhance AIDS Risk Reduction," 167; Peters, Roger H., "Drug Treatment in Jails and Detention Settings," in *Drug Treatment and Criminal Justice*, ed. James Inciardi, Newbury Park, California: Sage Publications, 1993: 44–80.

8. Enos and Southern, *Correctional Case Management*, 2–20. These stages, which refer to the case management of individual offenders, may take place in the broader context of a "differentiated case management" court system in which specific types of cases—civil, criminal, drug, property, sexual assault, domestic violence—receive individualized routing, scheduling, or disposition to maximize court resources and efficiency. See Bureau of Justice Assistance, *Differentiated Case Management*, Fact Sheet, Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, November 1995: FS000117.

9. Enos and Southern, *Correctional Case Management*, 8–9.

10. O'Conner, Gerald G., "Case Management: Systems and Practice," *Social Casework: The Journal of Contemporary Social Work* (February 1988): 97–106.

11. Bruce Horvath, lead case manager and senior officer, Project Action, Houston, Texas. Funding for Project Action was not renewed by the State of Texas in August 1998, due to Federal policies prohibiting reimbursement of criminal justice agencies for case management services. Federal funds are available to reimburse case management services to the mentally ill through the Texas Council on Mental Health. The program's services have been replaced with a mental health-based program, New Start, supported by the Harris County, Texas, Mental Health/Mental Retardation Agency, Ethel Perry, director, (281) 863–8170.

12. Several of the Opportunity to Succeed sites (Kansas City and St. Louis, Missouri, and Tampa, Florida) experimented with this approach. Interview with Shelli Rossman, program evaluator, the Urban Institute.

13. Office of Justice Programs, *Directory of Automated Criminal Justice Information Systems, 1993, Vol II: Corrections, Courts, Probation/Parole, Prosecution*, Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics, 1993: 449–459.

14. Ibid, 445–446.

15. The U.S. Department of Justice, National Institute of Justice (Washington, D.C.), under its Program Focus series, has published five reports on offender reintegration and education programs across the country by Peter Finn. They are as follows: *The Delaware Department of Correction Life Skills Program* (1998) (NCJ 169589), *Texas' Project RIO (Re-Integration of Offenders)* (1998) (NCJ 168637), *Chicago's Safer Foundation: A Road Back for Ex-Offenders* (1998) (NCJ 167575), *Successful Job Placement for Ex-Offenders: The Center for Development Opportunities* (1998) (NCJ 168102), and *The Orange County, Florida, Jail Education and Vocational Programs* (1997) (NCJ 166820). Other NIJ publications about case management programs include: *Women Offenders: Programming Needs and Promising Approaches,* Research in Brief, 1998 (NCJ 171668); *Work Release: Recidivism and Corrections Costs in Washington State,* Research in Brief, 1996 (NCJ 163706); *Project Re-Enterprise: A Texas Program,* Program Focus, 1996 (NCJ 161448); *Drug-Abusing Women Offenders: Results of a National Survey,* Research in Brief, 1994 (NCJ 149261); *Managing Mentally Ill Offenders in the Community: Milwaukee's Community Support Program,* Program Focus, 1994 (NCJ 145330); *Police Response to Special Populations: Handling the Mentally Ill, Public Inebriate, and the Homeless,* Research in Action, 1988 (NCJ 107273); and *Police Response to Special Populations,* Issues and Practices, 1987 (NCJ 105193).

16. Dvoskin, Joel A., C. Terence McCormick, and Judith Cox, "Mentally Ill Offenders in the Community: Services for Parolees with Serious Mental Illness," in *Topics in Community Corrections, Annual Issue*, Washington, D.C.: U.S. Department of Justice, National Institute of Corrections, 1994: 14–20.

17. Mickel, Kyle, "Mentally Ill Offenders in the Community: A Little 'TLC': Maricopa County's Transitional Living Center," in *Topics in Corrections, Annual Issue*, Washington, D.C.: U.S. Department of Justice, National Institute of Corrections, 1994: 30–32. Also see Conly, Catherine H., *Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program,* Program Focus, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, forthcoming.

18. See De Leon, George, "Legal Pressure in Therapeutic Communities," *Journal of Drug Issues*, 18 (4) (1988): 625–640; and Cook, Foster, "TASC: Case Management Models Linking Criminal Justice and Treatment," in *Progress and Issues in Case Management,* Research Monograph 127, Rockville, Maryland: National Institute on Drug Abuse, 1992: 368–382.

19. For example, Dade County, Florida, or the statewide drug court program in New Hampshire. For information concerning drug courts, contact the U.S. Department of Justice, Office of Justice Programs, Drug Courts Program Office, (202) 616–5001.

20. Inciardi, James A., Howard Isenberg, Dorothy Lockwood et al, "Assertive Community Treatment with a Parolee Population: An Extension of Case Management," in *Progress and Issues in Case Management,* Research Monograph 127, Rockville, Maryland: National Institute on Drug Abuse, 1992: 361–362.

21. Telephone interview with Shelli Rossman, February 1996.

22. Telephone interview with Matthew Ferrara, Ph.D., clinical psychologist, Austin, Texas, January 1996. Ferrara, Matthew, and Sandra Ferrara, "The Evolution of Prison Mental Health Services," *Corrections Today*, 53 (5) (August 1991): 198–203.

23. For a discussion of staffing see Rhodes, William, and Michael Gross, *Case Management with Drug-Involved Arrestees,* Research Preview, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, January 1996; and Inciardi et al., "Assertive Community Treatment with a Parolee Population," 350–366; for an exception to concerns about case management training, see Falck et al. in relation to the Dayton-Columbus model.

24. Enos and Southern, *Correctional Case Management*, 2. It should be noted that Enos and Southern argue that while it might be more efficient to provide services only to perpetrators of incest or other offenders thought to be most amenable to treatment, the rehabilitation of only one high-risk sex offender could spare multiple victims, making the effort worthwhile. They also point to the cost efficiency of community-based treatment versus incarceration.

25. Mackinem, Mitchell, Karen Goodale, and Sally Caughman, "Modest Program, Modest Gains: An Outcome Study of a Day Reporting Program/Stayin' Straight: South Carolina's Experiment with Day Reporting," South Carolina Department of Probation, Parole, and Pardon Services, undated manuscript. Also see Rhodes and Gross, *Case Management with Drug-Involved Arrestees.*

26. Information in this section is from a telephone interview with Bruce Horvath, lead case manager and senior officer, Project Action, Houston, Texas, and an undated program brochure titled, "ACTION: A Special Project of Harris County Community Supervision and Corrections Department." Project CHANCE and Project Action were evaluated by the Criminal Justice Policy Council in Austin, Texas, (512) 463–1810. See the newsletter article, "Mentally Retarded and Mentally Ill Criminal Offenders: Effectiveness of Community Intervention Programs," *Criminal Justice Policy Council Research Analysis*, March 1993, No. 17: 1–4. This publication is available from the National Institute of Corrections Information Center.

27. Telephone interview with Bruce Horvath, January 1996.

28. Information in this section is from printed program materials provided by the Association for Retarded Citizens and Donna Cole, the interim lead case manager of Project CHANCE, Austin, Texas. Two programs are continuing Project CHANCE's work: Victim and Offender Services, Irene Huq, program director, and Dennis Chapman, project leader, (512) 476–7044, and Anew-Champ, Don Johnson, executive director, (512) 459–7637. Funding for Victim and Offender Services is received through the Austin County Health and Human Services Agency. Victim and Offender Services currently serves mentally retarded or developmentally disabled juveniles but seeks grants to extend services to adult offenders. Anew-Champ works with both mentally ill and mentally retarded offenders to provide case management, discharge planning, individualized training (rehabilitation, independent living skills, and anger management), and psychiatric support services. Anew-Champ had served Project CHANCE's clients on a subcontract basis until August 31, 1998. Anew-Champ is funded in part by the Texas Department of Parole.

29. Telephone interview with Donald Stiles, January 1996.

30. Telephone interview with Loren Buddress, January 1996.

31. Hall, Frank A., "Oregon Tackles a Tough Issue: Department of Corrections Strategies to Reduce Recidivism," *Alternatives to Incarceration,* Spring 1995: 26–27; Finigan, Michael, "Evaluation of Oregon Parole Transition Projects, Executive Report," prepared for Community Programs Division, Oregon Department of Corrections, October 15, 1993.

32. See Conly, Catherine, *The Women's Prison Association: Helping Women Offenders and Their Families,* Program Focus, Washington, D.C.: U.S. Department of Justice, National Institute of Justice, 1998 (NCJ 172858).

33. Bemus, Brian J., "Implementation of a Case Management System in Washington State Misdemeanor Courts: An Example of Cooperation and a Guide for the Future," Misdemeanant Corrections Association, unpublished manuscript, December 1993: 18.

34. TASC is supported by the National Institute of Justice, the Bureau of Justice Assistance, Office of Juvenile Justice and Delinquency Prevention, the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and State and local agencies. There are approximately 150 programs in 20 States. Contact number: National TASC, Melody Heaps, president, (312) 787–0208.

35. Telephone interview with Dr. James Swartz, January 1996.

36. See, for example, Inciardi et al., "Assertive Community Treatment with a Parolee Population,"; Rhodes and Gross, *Case Management with Drug-Involved Arrestees*; and Falck, R., R. Carlson, S. Price, and J. Turner, "Case Management to Enhance HIV-Risk Reduction Among Users of Injection Drugs and Crack Cocaine," *Journal of Case Management,* 3 (4) (1994): 162–167.

37. Mackinem, Goodale, and Caughman, "Modest Program, Modest Gains": 1ff.

This research was conducted by Kerry Murphy Healey, Ph.D., a consultant to Abt Associates Inc., Cambridge, Massachusetts.

Prepared under contract OJP–94–C–007 (Research Applications Contract) to Abt Associates Inc. from the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. Findings and conclusions of the research reported here are those of the author and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

The National Institute of Justice is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, the Bureau of Justice Statistics, the Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime.

This and other NIJ publications can be found at and downloaded from the NIJ Web site (http://www.ojp.usdoj.gov/nij).

NCJ 173409

U.S. Department of Justice
Office of Justice Programs
National Institute of Justice

Washington, DC 20531

Official Business
Penalty for Private Use $300

PRESORTED STANDARD
POSTAGE & FEES PAID
DOJ/NIJ
PERMIT NO. G–91