Foundations in Human Services Practice explores theories, models, and practices by human services practitioners. This text will provide you with a base of information that can be built upon to assist you with practice essentials for working with clients, agencies, and communities.

As a distinct academic field of study, human services focuses on social technologies (such as models and methods of practice) as well as service technologies (such as programs and delivery systems) that are designed to provide human benefits. As an introduction, a history about human services is included. The history of human services will set the stage by providing a concrete explanation of how the human services profession differs from other helping fields, providing students with a better sense of professional identity and appreciation of the progressive history behind human services.

When developing this text, I endeavored to write it in such a way that captures the human services ideology of helping the whole person by providing content that focuses on theories and practices with clients, agencies, and communities that are important to human services practice. I designed this text to help students realize that helping the whole person entails work in many different spheres:

- **Direct Service**—case management theory, case management process, and interviewing
- **Organizational Structure**—management, supervision, and fundraising
- **Community**—organizing, advocating, and lobbying

**Features**

Many features have been included in this text to enhance your experience; however, they are only as useful as you make them. By engaging with this text and its resources, you’ll gain an understanding and mastery of:

- **Human Service History**—covers the history of social welfare from the colonial period to the modern day so that students understand the sources of current practices and institutions.
- **A Multidisciplinary View of Human Services Practice**—examines practices in the context of social, economic, and political factors at all levels of society focused on alleviating human problems.
- **Micro, Mezzo, and Macro Approaches to Practice**—covers the theories and models of case management, interviewing, nonprofit structure and operations, fundraising, grassroots organizing, and more.
Learning Outcomes

Students will be able to achieve a variety of learning outcomes by using this text and its resources, including:

- **Critical Thinking Skills**—students can develop their critical thinking skills by reviewing the standards boxes (indicated by the National Standards series band) and engaging with the multimedia resources highlighted in boxes throughout the chapter.

- **Oral Communication Skills**—students can develop their oral communication skills by engaging with others in and out of class to discuss their comprehension of the chapter based on the chapter’s learning objectives.

- **Assessment and Writing Skills**—students can develop their assessment and writing skills in preparation for future certification exams by completing topic-based and chapter review assessments for each chapter.

- **CSHSE National Standards**—students can develop their understanding and mastery of CSHSE’s national standards by discussing the standards box critical thinking questions.

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Finally, I dedicate this book to all the human services students I have taught and met over the past two decades because they were my inspiration for creating this textbook.

*This text is available in a variety of formats—digital and print. To learn more about our programs, pricing options, and customization, visit [http://www.pearsonhighered.com](http://www.pearsonhighered.com).*
Human services practice—at the individual level—is geared to assist clients with finding options or solutions to their problems in living. To perform this role, you will engage in direct service activities such as conducting interviews, doing intakes, and creating individual treatment plans. The three chapters of Section 1 focus on these direct services practices. In Chapter 1 there is an examination of human services models and theories so that you gain some exposure to evidence-based practices. This theoretical material is followed by an examination of systems theories and how they are used in human services practice. In Chapter 2 there is a discussion about the essential elements of the case management process that covers assessment, planning, and monitoring outcomes of the client. The final discussion in this chapter focuses on the complexities of assuming the role of legal guardianship while being a case manager. The focus of Chapter 3 is the interviewing process. Interviewing is a singular practice that can be used in multiple ways, and you will explore different interview types, formats, and skills. Legal issues related to interviewing clients and managing clients’ legal records will also be covered.

The chapters in Section 1 of this text are intended to provide a foundation in direct service approaches that can be applied to work in a wide variety of public agencies and nonprofit human services settings. Mastering these approaches is essential to human services practice, but it should be remembered that direct service is not the only practice of a human services generalist. Human services practice is also about creating efficient and effective delivery systems and promoting community change, and these topics will be covered in Sections 1 and 2 of the book.
As a human services generalist, your work will encompass doing direct service, which means you need to develop a case management knowledge base and acquire interviewing skills to work with clients one on one. When working one on one with a client, you will typically engage in case management, which is a process that involves assessing the needs of clients so that services can be arranged, coordinated, evaluated, and monitored. In addition, the process involves advocating for services and resources to meet specific client needs.

At no time in the history of case management has any one profession laid claim to it. At present, case management is used by professionals in human services, nursing, criminal justice, social work, and psychology. Professionals who use case management (whatever the approach) are working with their clients rather than telling them what to do, which is typical under the medical model.

In this chapter you will learn about case management history and models, system theories, case management process, and the art of interviewing. All of this material is presented to give you a theoretical foundation in human services practice.

A Historical Perspective of Case Management

The use of case management by health and human service workers can be traced back to the early 1800s (Murphy, Tobias, Rajabium, & Abuchar, 2003). It was at this time that case management was first conceptualized...
as a way to coordinate a complex network of services for vulnerable populations in need of social and medical care because clients were unfamiliar with the myriad services available to them and the associated bureaucracy. Therefore, each client would be assigned a case worker to help him or her to navigate complex delivery systems. For example, in the late 1800s, during the American public health movement, case management was used by nurses who were working to track the spread of communicable diseases in communities. Case management was also used by settlement workers—like Jane Addams of Hull House—to track clients and coordinate complex services for the poor in Chicago (Knight, 2005).

After World War II, the federal government began using case management to coordinate complex services for people receiving veterans’ benefits, Medicare, and Medicaid (Finkelman, 2011). The use of case management would increase in both the public and private sectors over the next several decades. For instance, in 1964 the Johnson administration initiated the War on Poverty; this was an initiative that led to the creation of a new series of community programs throughout the United States (Milkis, 2005). As these federally funded anti-poverty programs increased in number, so did the use of case management as an approach to assist clients better utilize new service programs in their communities.

Some believed that the use of case management would ensure better coordination and continuity of federal services (Holt, 2000). Federal policymakers then began to mandate that the delivery of health and human services be done in a coordinated manner for veterans, families, children, elderly, and the disabled. Legislation like the Older Americans Act of 1965, for example, also had mandates for coordinated services. This mandate specified that a case manager would be assigned to individuals enrolled in specific federal welfare programs. The case manager would oversee each client to ensure that he or she was receiving services in an efficient and coordinated manner.

However, not all human services legislation was so explicit about mandating coordinated services. For example, in the 1970s, a new federal policy mandated the deinstitutionalization of patients with chronic mental health problems. This new policy caused massive systemic changes among human service delivery systems in the United States. Costly long-term mental health facilities were closed and replaced with community mental health centers (Burns & Perkins, 2000). Newly released mentally ill clients were placed into residential community settings to ensure that they had the least restrictive environment, which was to improve their mental health. Yet the concept of the least restrictive environment, in reality, resulted in the mentally ill having little to no care or support with their activities of daily living. The use of mental health case managers to oversee the newly deinstitutionalized mentally ill would be an afterthought.

By the 1980s, some believed that case management could be the most efficient way of handling mental health clients (Rothman & Sager, 1998). Case management became the default intervention to assist deinstitutionalized clients in a community setting. Workers who used case management during the deinstitutionalization period were called “systems agents.” Systems agents used a brokerage case management approach to handle their clients (Burns & Perkins, 2000), which meant that they only coordinated services to ensure the continuity of care for their mentally ill clients. Systems agents did not provide direct care (Intagliata, 1982). Direct care involved engaging in a therapeutic relationship with mental health clients, which was left to licensed professionals such as psychiatrists, psychologists, and clinical social workers.
The Meaning of Case Management

In the last few decades, there has been a renewed interest in formalizing the use of case management in many helping fields (Roberts-DeGennaro, 1993). This renewed interest in case management has resulted in several debates. One debate is whether case management should be considered its own profession or come under the control of some other profession. Another debate concerns whether case management is a method or intervention. What is apparent from the literature is that there is no standard methodology for case management.

Case management means different things to different people and to different professions, but there are some core components that most would agree upon. In this book, we will consider case management as a process with several overlapping steps: (a) assessment, (b) planning, (c) service coordination, (d) observation, (e) evaluation, and (f) advocating for services. Case management can be used as a short-term intervention to prevent or help manage a crisis in a client’s life. On the other hand, case management can be used for an extended period of time; for example, a practitioner can assist clients with complex or unremitting problems in living. Overall, the goals of case management are to assist clients to their highest level of functioning and/or help clients manage their personal life challenges so that they can regain and maintain their personal autonomy.

Because case management is used for various purposes among professions, the definitions are different. Review the definitions of case management from two other professional groups:

Social work case management is a method of providing services whereby a professional social worker assesses the needs of the client and the client’s family, when appropriate, and arranges, coordinates, monitors, evaluates, and advocates for a package of multiple services to meet the specific client’s complex needs. [Social work] case management is both micro and macro in nature: intervention occurs at both the client and system levels. It requires the social worker to develop and maintain a therapeutic relationship with the client, which may include linking the client with systems that provide him or her with needed services, resources, and opportunities. (Retrieved from National Association of Social Workers website).

Case Management Society of America defines case management as a collaborative process that has assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes (Finkelman, 2011).

When you review the different definitions of case management in this chapter, you will note similarities and differences among the definitions. However, there is much more to case management than any single definition.

How Case Management Is Used in Human Services

Case management practice often depends on the practitioner’s education and training. It is also affected by the organization’s financial resources and structure (Greene & Kropf, 1995). Human services practitioners in both private organizations and public agencies use case management to assist different types of clients who are in need of varying degrees of assistance, services, and resources. In general, a human services...
generalist as case manager performs a variety of roles to assist the client through complex human service systems. Both the client and case manager collaborate about coordinating formal services, informal resources, and care.

Your role as a case manager will vary according to the agency or organization by which you are employed. In other words, the organizational structure in which you work will determine how you function as a case manager (Woodside & McClam, 2003). Therefore, it is important that you understand the type of organization you are working in. According to Edgar Schein (1997), an expert in organizational cultures, the reason you should understand an organization's culture is because it helps you see how the organization goes about doing its work. And in terms of a human services organization, understanding its culture will also help you understand what you can and cannot do for your clients.

Consider the following example. Government policy makers have determined that case management is an effective means for public service providers to help clients navigate complex human service systems, and that case management is also a cost-effective method for helping vulnerable populations (Murphy, Tobias, Rajabium, & Abuchar, 2003). In addition, the Government Performance and Results Act of 1993 mandates that federal agencies reduce waste and inefficiency. Therefore, public agencies are accountable for achieving planned results, program outcomes, service quality, and consumer satisfaction. If you are a case manager in a government agency, you will be directly impacted by these policies. You will have to adopt a federally approved case management model while also holding down costs, reducing waste, achieving planned results, keeping up service quality, and ensuring that your clients are satisfied with services. Does this all seem a little overwhelming? I give you this example to impress upon you that where you work will determine how you engage in case management. Your practice is not simply determined by your education and training. Be open to the fact that your employer will have a say in how you work with the agency’s clients.

Case Management Models and Theories

It is time to talk about case management models as an evidence-based practice. “Evidence-based practice” is a term that refers to the use of practices that have been researched and proven to be effective. Research involves the process of collecting data that are statistically measured. Statistical measurements are reported as significant or insignificant. In terms of case management, the statistical measurement tells whether the practice under study is effective or not with clients. All the models that are examined in this section of the chapter have been researched and have been statistically measured and found to have varying degrees of effectiveness. The following six case management models are examined:

1. Assertive Community Treatment
2. Intensive Case Management
3. Comprehensive Enhancement Practice Model
4. Kinship Care Case Management
5. Strength-Based Case Management
6. Brokerage Case Management

As you examine the six different models, it is important to think critically about the research that pertains to each model before making a determination about its worth. An evidence-based practice should be your goal because this will ensure that your clients are receiving care that has been scientifically proven to be effective. By no stretch of the
imagination does this book review all the case management models that are available to you. The models that are offered are promising for use in human services practice.

**Assertive Community Treatment**

*Assertive Community Treatment* (ACT) was developed in the 1970s out of a program called Training in Community Living (TCL), an intensive community-based program for the severely mentally ill (it is now used with other vulnerable populations like battered women and AIDS clients). ACT is a team case management approach where the caseload is shared among a team who collectively create comprehensive individualized service plans for clients and do intense outreach. Yet clients are managed by a primary case manager who is a member of the team. It is believed that helping professionals who work as a team will experience less burnout on the job and in turn clients have greater continuity in care.

Before a full explanation is given about how this approach works, here is a brief outline of how it was first conceptualized. First, Stein and Test (1980) developed ACT through extensive research of community-based programs. ACTs critical practice features initially included the following:

1. maintaining low client or staff caseloads,
2. having 24-hour crisis support by the treatment team,
3. using a whole-team approach with a multidisciplinary team,
4. providing direct services such as monitoring client medication,
5. creating individualized care plans,
6. working with clients in the community,
7. holding regular staff meetings to collaborate on caseload, and
8. maintaining a no discharge policy of clients.

After two landmark studies about ACT, it was hailed as an innovative case management approach for the care of the severely mentally ill (Burns, 2010). During the 1980s, ACT became a routine clinical delivery approach that was widely used in the mental health field around the world. After more extensive research, changes and additions were made to ACT to make it more effective with different types of clients. Currently, ACT has the following core features:

1. multidisciplinary staffing,
2. integration of services,
3. team approach,
4. small caseloads (staff–client ratio 1:10 or 1:12),
5. locus of contact in the community,
6. management of medications,
7. focus on activities of daily living,
8. rapid access,
9. assertive outreach,
10. individualized services, and
11. time-unlimited services.

**HOW THE ACT MODEL WORKS**

In general, if your agency is using the ACT approach you would be assigned to a multidisciplinary team. Typically, a multidisciplinary team of professionals comprises a variety of practitioners like a human services
generalist, nurse, crisis mobile team member, social worker, occupational therapist, vocational rehabilitation counselor, and physician. Each team member possesses different specialized skills and knowledge to address a client’s problems; having practitioners from different disciplines allows team members to use different approaches as they coordinate care for the client. A human services generalist, for example, who has a rehabilitative or substance abuse background would have a different approach of looking at a client’s problems versus a physician who would primarily be focused on a client’s medical problems.

Each team member is assigned a part of the team caseload, usually between 10 and 12 clients. ACT teams maintain low staff-client ratio (e.g., 10 team members are responsible for approximately 100 clients), which allows the team to give comprehensive and individualized care, offer clients rapid access to services, and increase service continuity for the client. Having low caseloads also allows the team to engage in assertive outreach to clients who are reluctant or resistant to accepting care. Assertive outreach is based on the premise that once a case is open, the client and team have a lifelong relationship. Ideally no case is ever closed; therefore clients always have a group of professionals who are prepared to help when needed. However, the ACT approach necessitates that the team must have frequent case meetings to discuss their shared caseloads.

As the case manager you will be the primary coordinator for a specific group of clients, which means you would regularly interface with the client, monitor client outcomes, and oversee the client’s records. You would also help create an individual service plan with each client (if the client is able). This plan focuses on activities such as how the client would manage handling personal hygiene, taking medication, paying rent, working, and other activities of daily living.

Typically, the case manager is the first person on the team whom the client would reach out to when he or she needed something. However, even though you might be the primary case manager, your work is never done in isolation because you are part of a multidisciplinary team. ACT is a team approach, which means that you are equally invested in the welfare of your assigned clients and the clients of other team members. For example, a client’s service plan is further developed with the help and expertise of other team members. The overall goal of the individual service plan is focused on strategizing how to help the client independently function in a community setting, and this might involve several team members and the primary case manager.

ACT team members have frequent contacts with clients in settings outside the agency. Ideally, 80% of client contact occurs in their homes or a natural setting, for example, their jobsite. Contacts outside the therapeutic setting are called “in vivo” contacts. During in vivo contacts, team members have the opportunity to meet with the client’s family or caretaker. The benefit of this is it gives the team the opportunity to communicate and gather client information from the family or caretaker. Moreover, the in vivo visit gives multiple team members an opportunity to work with and teach clients new skills. For instance, the nurse team member could assess and determine the best way for the client to take his or her medication. The vocational rehabilitation counselor team member could do supervised job training with the client on the job site. The human services generalist who is also the primary case manager could work with the client on activities of daily living such as riding public transportation, managing money, paying bills, finding housing, shopping, and cooking in either a home or a natural setting.
During in vivo contacts, team members engage in direct observations of clients, which allows for a more accurate client assessment rather than solely relying on client self-reports, and team members can better determine whether clients are accomplishing their activities of daily living (e.g., taking medication or maintaining personal hygiene) and making adequate adjustment to living in the community.

Moreover, the ACT team uses an integrated service approach that allows them to tailor in-house services for the client. Client services are integrated at the practitioner level rather than coordinated at the administrative level. (Schaedle, McGrew, Bond, & Epstein, 2002). In other words, the team directly offers services to the client, such as direct counseling, skill building, and family advising. Every effort is made by the team to offer clients direct integrated services rather than referring them out for services; in turn, this creates greater continuity of care for clients. Overall, each team member acts as a case manager for one set of clients, but the team works together to ensure that the group's clients all receive the best care in the most efficient and effective manner.

**POPULATIONS BEST SERVED BY ACT** ACT has been extensively researched, compared with other case management approaches. This approach has also been found to be a relatively effective approach that can be used to address problems of a variety of client populations and can be used as a whole-person approach because it allows the case manager to address client-in-context problems.

Overall, it has been suggested that ACT is an effective case management approach with different client populations. ACT has also been successfully adapted to accommodate different ethnic minority groups and can be used in different settings (Ackerson & Karoll, 2005). For example, when an ACT team is working with ethnic minorities who have chronic mental illness, efforts are made to include team members who are culturally similar to the clients. These team members must have an in-depth understanding of the clients' cultures, which will help with implementing the case management process (Law, 2007).

ACT has also been adapted for use in the criminal justice field and is called the Forensic Assertive Community Treatment (FACT). In this instance, FACT is designed as a reentry case management approach to help mentally ill prisoners. Case managers are focused on helping newly released prisoners—known as parolees—adjust to the demands of living in a community. It was reported that parolees receiving FACT case management were less likely to be re-incarcerated, less likely to need outpatient care, and less likely to be admitted to a psychiatric unit.

**RESEARCH FINDINGS ABOUT ACT** Many practitioners find ACT to be an effective case management approach. It was reported that ACT reduces the length and frequency of inpatient psychiatric stays of different service users that include the homeless mentally ill (Coldwell & Bender, 2007), ethnic minorities with severe chronic mental illness (Law, 2007), the mentally ill with schizophrenia, psychosis (Bond et al., 2001), depression, bipolar disorder, and the dual diagnosed (Ackerson & Karoll, 2005).

In studies about ACT, the positive outcomes reported were as follows: (a) clients had greater success in independent living, (b) improved quality of life, and (c) improved social functioning when they received more services (Bigelow & Young, 1991). Other positive outcomes reported about ACT were that clients had reduced psychiatric hospital stays, increased housing stability, and controlled mental health symptoms (Schaedle et al., 2002). Plus clients reported that the best parts about ACT were the staff availability, home visits, and help with activities of daily living (McGrew & Wilson, 1996).
From the team perspective, the most important client service of ACT was the frequent home visits (Prince, Demidenko, & Gerber, 2000). The research indicated that when staff worked as a team, it decreased practitioner burnout. In turn, when there was a lower rate of burnout, there was lower rate of turnover among staff, which resulted in better continuity of care of clients. However, in the process of implementing ACT it was unclear which specific practices reduced psychiatric readmissions (Udechuku et al., 2005). Similarly, it was not clear what elements of the case management approach worked or could be eliminated if implementation costs were a concern to practitioners (Burns & Perkins, 2000). There were also concerns about the capability of team members to effectively engage in a team approach because the concept was not clearly defined (Burns, 2010). It was inferred that practitioners didn’t have the background in building teams and managing work groups.

Because of ACT’s general success, many countries around the world use ACT in place of institutional care (Mowbray, Plum, & Materson, 1997). However, it has been reported that ACT has not effectively reduced hospital admissions of the mentally ill in the United Kingdom (Marshall & Francis, 2000) and in the Netherlands (Sytema et al., 2007). All case management approaches have problems that should be considered before using them with clients.

**Intensive Case Management**

**Intensive Case Management (ICM)** is a team approach where practitioners support each other as they independently work to link and coordinate services for clients. Some believe that ICM is not represented by one well-defined model but seems to be based on different case management models (Schaedle, 1999). In general, the ICM approach is more extreme or intense than those used in general case management (Vanderplasschen, Wolf, Rapp, & Broekaert, 2007). Although there is no consensus for one definition for ICM, some critical features include the following:

1. The practitioner individually manages small caseloads.
2. The primary function of the practitioner is to link and coordinate client services.
3. The practitioner encourages client empowerment.
4. Client outreach occurs only when it is necessary.
5. Cases are closed when clients refuse services or when they are institutionalized.
6. Team management is considered less important.

Originally, ICM was focused on maintaining continuity of client services, reducing costs for services, and increasing the mentally ill client’s quality of life and function. You might be thinking that ACT and ICM approaches have a similar focus on the mentally ill. You are correct: Both approaches were designed to help chronically mentally ill clients integrate into their communities. The common features between the two models are as follows: (a) both serve clients in need of intensive care, (b) both are used in a community setting, and (c) both address practical client problems (Schaedle et al., 2002). So what makes ICM different from ACT? You will see the differences between the models when you examine how ICM works.

**HOW ICM WORKS** Implementing ICM involves assembling a team of professionals. The team serves as a support for its members instead of the arena in which client problems are collectively handled. Therefore, team management is less important in the ICM approach because each team member is expected to work independently with his or her clients.
The primary function of ICM is to link and coordinate client services and encourage client empowerment. Case managers handle multiple client problems because they have small caseloads. They also view clients as autonomous beings who make individual choices and take responsibility for their own lives. Therefore, a case manager makes little effort to do outreach to clients. Finally, under the IMC approach when clients refuse services or are institutionalized, the case manager will close the case.

**POPULATIONS BEST SERVED BY ICM** The clients that seem to be best served by ICM include a full range of vulnerable populations. The literature contains data that reveal that the following groups have benefited from ICM: the severely mentally ill with and without a history of violence (Dvoskin & Steadman, 1994), frail older adults in need of health services (Young, 2003), homeless mothers with severe mental illness seeking reunification with their minor children (Hoffman & Rosenheck, 2001), adults with schizophrenia (Preston, 2000), women who have been stalked by former intimate partners (Spence-Diehl, 2004), and people with HIV/AIDS.

**RESEARCH FINDINGS ABOUT ICM** Research study outcomes have shown that ICM varies in its effectiveness. However, there is research that indicates that ICM is effective with clients with mental illness (Dvoskin & Steadman, 1994). It was reported that mentally ill clients receiving ICM were more likely to live independently and less likely to be hospitalized. Overall, a broad array of clients reported satisfaction with their care, having access to tangible services and greater support (Hoffman & Rosenheck, 2001; Preston, 2000; Young, 2003).

**Comprehensive Enhancement Practice Model**

**Comprehensive Enhancement Practice Model (CEPM)** is an empirically based case management model with 15 overlapping functions performed in a time-phased sequence that begins with client referral for service and proceeds through therapeutic interventions and advocacy for additional services to meet the client’s needs. This case management approach is a time-phased sequence of functions used with vulnerable populations that have long-term complex problems in living (Rothman & Sager, 1998). Overall, CEPM has the case manager focusing on the individual client. One limitation of CEPM is that it does not focus on social action or community development on behalf of different client populations, which would be useful for engaging in a whole-person approach.

CEPM was developed by a group of researchers at the University of California Los Angeles Center for the Child and Family Policy Studies and the Los Angeles Department of Mental Health. This group of researchers sought to create a standard practice for case management based on effective practices in the field and case management literature. After an in-depth study, CEPM was conceptualized (Rothman, 1991). The model has 15 sequential functions that the case manager uses to help clients with complex problems (Rothman & Sager, 1998). The 15 sequential case management functions are as follows:

1. referral,
2. intake,
3. assessment,
4. goal setting,
5. intervention planning,
6. resource identification and indexing,
7. formal linkage to external sources,
8. informal linkage to family and social networks,
9. monitoring,
10. reassessment,
11. outcome evaluation for termination,
12. interagency coordination,
13. counseling,
14. therapy, and
15. advocacy.

HOW CEPM WORKS  The 15 sequential functions are used by the case manager during the case management process. Each function is performed in a time-phased sequence, but some functions overlap and other functions become alternative options or recur at different times (Rothman, 1991).

REFERRAL TO THE AGENCY  The first function is getting a referral, which is how prospective clients come to the organization for service. Typically, clients come to the organization via referrals from social networks and/or professional networks. In addition, administrators in the organization work to develop reciprocal referral systems with other organizations and have staff engage in community outreach. Once a referral is received, it is incumbent upon staff to make every effort to be responsive to the referred client by quickly accommodating him or her with an appointment. Overall, the access function is to ensure that there is a continual flow of viable clients into the organization.

INTAKE FUNCTION  Once a prospective client comes into the agency, a formal intake interview is done. The intake function is the time when client information that is required to complete organizational forms is gathered. This information will help the organization determine whether the client is eligible for services and can pay for services. After completion of the intake, the prospective client receives information about the agency services, requirements, and limitations.

ASSESSMENT FUNCTION  If the client qualifies for services with the agency, then the next function is the assessment. During the assessment, the case manager begins to gather information to determine what type of problem the client is experiencing. Client problems are determined by doing a case history. If necessary, psychosocial assessment or psychological tests are needed, and they are typically done by licensed professionals like psychologists or clinical social workers. Moreover, an assessment will not be complete until client records are requested from outside agencies. This will ensure that the most comprehensive client assessment is being done.

GOAL-SETTING FUNCTION  Goal setting is built on the assessment. Goal setting is a part of developing a client’s individual service plan. Short- and long-term goal setting should occur with client input. In the process of setting goals, there should be a realistic outlook regarding the limitations of vulnerable clients. These limitations should be calculated into all forms of future planning made by the case manager. The case manager will also determine whether immediate services to handle a crisis are needed for the client during this planning phase.
**INTERVENTION FUNCTION** Intervention planning is the fifth function, which is when the practitioner will make a choice about the type of treatment (e.g., counseling or therapy) the client will need in the long term. This choice involves linking the client to external services and occurs in conjunction with the development of the individual service plan. The major objective of intervention planning is to help clients move through their short- and long-term goals.

The next three functions are resource identification and indexing, formal linkage to agencies and programs, and informal linkages to families and social networks. These three functions don’t follow a logical progression because client resources and service delivery systems are constantly changing.

**RESOURCE IDENTIFICATION AND INDEXING FUNCTION** When case managers work to discover what barriers exist at the client and system levels, this is the first part of resource identification and indexing. Once those barriers are identified, the case manager can systematically determine what relevant informal and formal resource linkages are accessible to the client. Then the case manager would create a database of resources in the community and service area that might be of importance or use to the client. Once a database of informal and formal resource linkages is created, the next two functions deal with formal and informal linkages that can be made on behalf of the client.

**FORMAL LINKAGE FUNCTION** An important case management function involves formally linking clients, which means (a) making sure the correct service is provided, (b) making initial contact with an agency on behalf of the client, (c) orienting clients about agency processes, (d) preparing documentation, and (e) visiting external agencies to ensure appropriate referrals are made in the future. Linking clients to external services means that the case manager must remain vigilant about updating and developing resource information about formal resources because they change or become defunct.

**INFORMAL LINKAGE FUNCTION** To make informal linkages, the case manager must learn about a client’s immediate and extended family members and who might be of assistance to the client. The other resource would be determining who the client believes might be available to help among his or her social network like friends, clergy members, and employers. Linking clients to family or social networks means that the case manager must again remain vigilant about updating and developing resource information about informal resources because they change. The next two functions are monitoring and reassessment, and they are overlapping functions.

**MONITORING FUNCTION** The purpose of the monitoring function in case management is to appraise whether the different interventions are working for the client. The case manager needs a substantial amount of time to engage in monitoring, which includes telephoning external agency staff, doing a crisis intervention, visiting with the client, or communicating with the client via telephone or email.

**REASSESSMENT FUNCTION** Reassessment means the case manager is readjusting the client’s service plan or revising goals with the client if things are not working as planned. The case manager will make both informal and formal reassessments of goals with the client on a regular basis. The reassessment function is when the case manager should probe for additional client information and determine if new obstacles or problems
have occurred. If the case manager is working with a client for a long-term period, he or she will repeatedly engage in monitoring and reassessment over the duration of the case management process. In turn, the practitioner will be working with the client to set new goals and will repeatedly be doing intervention planning, monitoring, and reassessing as needed.

**Outcome Evaluation For Termination** The next function is intermittently used in the case management sequence. This function is outcome evaluation, which is when the case manager is focusing on termination or discharge of the client because the client no longer needs ongoing professional services. Termination of case management rarely occurs with vulnerable populations like the chronically mentally disabled or physically disabled clients.

**Interagency Coordination Function** This function is not usually done by the case manager. Interagency coordination is usually done by the administration. Typically, only administrators have the power to create policy agreements with other organizations. Because administrators are knowledgeable about service patterns, type and number of clients, legal issues, and fiscal obligations, they are in a better position to do interagency coordination.

**Counseling And Therapy Functions** Counseling function is short term and is a form of advice or information giving to help the client with day-to-day problems. And the case manager can offer this type of counseling to clients. In CEPM, counseling is a function that is different from therapy, which is usually done by licensed practitioners. Therapy is used for personality restructuring and is based on decreasing psychological dysfunctions. In addition, therapy helps clients manage their immediate social realities.

**Advocacy Function** The final function of CEPM is advocacy. The case manager will intermittently advocate on behalf of the client to get services or resources that are being unjustly withheld from them. The case manager may guide clients through a bureaucratic process and teach them to advocate on their own behalf to obtain benefits that are due them. However, to be an effective advocate, the case manager needs to be knowledgeable about the advocacy process and lobbying in the political arena.

**Clients Best Served By CEPM** The model is designed to be used with vulnerable populations that include the elderly, children, and disabled. Researchers have determined from data that vulnerable populations commonly needed long-term services to live in the community (Rothman & Sager, 1998). CEPM is a comprehensive case management approach that could easily be used to scaffold clients throughout their life.

**Research Findings About CEPM** The CEPM is an empirically grounded model that guides the practice of case managers, which is not considered rigid practice. It is assumed that before using the model a case manager has basic knowledge and skills about interpersonal processes. This model was designed as a working tool to help professionals manage their caseloads with flexible and overlapping functions. It is based on data obtained from a large group of case managers working in the field. Most of the follow-up research about CEPM was done by Jack Rothman who also created the model. Overall, it is a promising case management approach.
Kinship Care Case Management

In 1992, the Michigan Kinship Project worked to identify best practice approaches for kinship care of children at risk (Rothman, 1991). After extensive field testing, the **Kinship Care Case Management** Model was developed. The model is designed to help family members who are willing to be kinship caregivers of a minor child who is at risk of being put into foster care. Both the child and kinship caregiver have overlapping concerns that are taken into consideration as the individual service plan is created. The objective of the case management approach is to support the family that is caring for the child and avoid placing the child into foster care. The featured components of the Kinship Care Case Management Model are as follows:

1. attention to cultural diversity,
2. family participation and decision making,
3. systematic assessment, and
4. individualized and comprehensive services.

**HOW KINSHIP CARE WORKS**  The first step in this case management process is an assessment of the minor child—who is the client. This assessment is also done in conjunction with a family conference. During the assessment process, the client (if he or she is capable) is asked to provide personal information and is encouraged to be an active partner in creating a treatment plan. In addition, information is collected from the foster parent (a designated family member) about the client's needs, formal supports, finances, resources, strengths, goals, and tasks related to placement decisions. Because the client is cared for by a family member, it is essential to get information about the child's family system and social network.

When using the Kinship Care Model, the assessment data are collected in three steps. The first step involves getting a picture of the client's family system. The two

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**FIGURE 1.1**
Ecomap

![Ecomap Diagram](image-url)
diagrams typically used to depict a family system are an **ecomap** and a **genogram**. Why use diagrams? These diagrams are visual aids that summarize information about your client, which allows you or another team member to get a sense of the client's family dynamic in one glance. The diagrams also efficiently relay complex information without having to rummage through pages of a client's case report. Both the ecomap and genogram are tools that help the case manager organize complex client information and reduce the need for writing lengthy reports.

The ecomap depicts the client's relationship with his or her family and social networks (see Figure 1.1). The ecomap is also a visual representation of the positive and aversive relationships among family members and the client's social network.

The genogram is used to depict data about the client's multigenerational family system (see Figure 1.2). With one glance, you can visualize the client's family roles and relationships with the genogram.

The second step of data collection involves asking critical questions of the kinship caregiver to determine what formal services and support will be necessary to maintain the child in his or her household. Focus the questions on family finances, stressors, and whether the current housing situation is adequate.

The third step of data collection involves asking the child (if he or she is able to communicate) questions about his or her life and needs. In addition, the child's academic records and health records should also be obtained.

After data are collected for the assessment, there will be a family conference. During the family conference, the case manager reviews the collected data with the kinship caregiver. The caregiver is encouraged to be actively involved in the preparation of the client's service plan. In the service plan, there are action steps and measurable objectives to be completed within a 90-day period. The service plan should be signed by the kinship caregiver. Then a weekly meeting is scheduled with the child and the caregiver to ensure there is progression toward the client's goals. During these weekly meetings, the client or caregiver can address any concerns during the process.
To effectively use the Kinship Care Case Management approach, practitioners must work at being culturally aware. They must become knowledgeable about multicultural interactions in the context of their work. Becoming a competent multicultural practitioner takes time and great effort. Please be advised that when you work with minor children, it is essential that you know and understand the dos and don'ts. Do not assume that you understand all the policies and laws for working with children. To be safe, double-check with your agency about their policies and get clarification of state laws before beginning work with minor children and their families.

**CLIENTS BEST SERVED BY THE KINSHIP MODEL** The kinship case management approach uses the natural strength found in the family network to help support children at risk (Mills & Usher, 1996). The research indicates that kinship case management is effective with children involved in foster care and adoption services. With minor modifications, this model may be appropriate for prevention and protective services for children.

**RESEARCH FINDINGS ABOUT THE KINSHIP MODEL** It was reported that there are instances where the kinship system will fail because the adult family member is overwhelmed with the level of care or the child begins to act out. As a result, a formal agency will have to intervene. In some cases, the minor child—who is the client—is removed from the designated caregiver and put into the regular foster care system (Mills & Usher, 1996).

There is a body of literature about the effectiveness of kinship foster care, but there is little literature about the kinship case management model. Yet the lack of research about the kinship case management model doesn't diminish its importance. Providing support and protection to children should be a major concern of all the helping professions.

**Strength-Based Case Management**

The *Strength-Based Case Management* (SCM) approach is designed to activate the client's abilities and inner resources so that he or she can cope with personal challenges. The approach emphasizes the client's strengths and does not dwell on his or her deficits. The features of SCM are as follows:

1. help clients discover their strengths,
2. focus on client strengths and self-direction,
3. promote use of informal helping networks,
4. offer assertive community involvement,
5. develop a strong positive relationship with the client.

Starting in the 1980s, SCM was used in community mental health centers and hospitals to help clients effectively function in the community. SCM is based on four major assumptions about people. First, all people possess the inner strength and abilities to deal with the world they live in. It is also assumed that people possess the knowledge to explain all aspects of the life and have the potential to find solutions to their own problems. Third, it is assumed that individuals will ultimately survive and thrive despite their misfortunes experienced in life. The final assumption is that some people will need assistance to find their strengths and abilities to change their life.
**HOW THE SCM MODEL WORKS** When a practitioner uses SCM, the first step is to do an assessment. During the assessment, the client is asked to identify his or her personal capabilities and assets. To get to this information, the client is encouraged to share personal stories of life challenges. The client is helped with exploring his or her perceptions and rediscovering personal abilities.

Next the treatment plan—also known as the service plan—is developed. This plan is based on the strengths, needs, and goals identified by the client. The practitioner plans activities that are flexible and tailored to the client’s needs and internal strengths. Then the planned activities are used to move the client toward his or her goals.

During all interactions, the practitioner focuses on the client’s strengths, explores the client's strength perceptions, and learns about the oppression the client endures. The client is encouraged to offer insights about personal capabilities, which are used as a foundation to be built on in the future. And clients are encouraged to use informal help networks rather than formal community resources (e.g., social service agencies) to help them develop their own abilities to deal with personal challenges.

To avoid an oppressive interaction, the practitioner repeatedly asks the client to make a critical analysis of the case management process. The practitioner works to develop a close professional relationship with his or her clients but maintains professional boundaries at all times.

**CLIENTS BEST SERVED BY SCM** The SCM approach has been successfully used with a variety of client populations. The groups that benefit from this case management approach are the elderly, mentally ill, and individuals with substance abuse problems.

**RESEARCH FINDINGS ABOUT SCM** There is a growing body of empirical evidence that reports positive outcomes of SCM. Clients who received SCM had higher levels of satisfaction with services than clients that received standard care (Bjorkman, Hansson, & Sandlund, 2002). In addition, mentally ill clients who received SCM spent significantly fewer days in the psychiatric unit.

Clients receiving SCM reported that it was useful to reflect on their problems and appreciated the close relationship developed with their case managers (Brun, Rapp, 2001). Yet this close relationship was sometimes a strain on clients and thwarted their progress.

It has also been reported that SCM does not have any significant impact on psychological symptoms, quality of life, and social and vocational functioning (Bjorkman, Hansson, & Sandlund, 2002). It is suggested that SCM is a naïve approach because it merely encourages clients to engage in positive thinking. Therefore, it doesn't help the client to reframe the objective reality that is behind the problems being experienced. Moreover, some consider SCM to be a questionable intervention or think it should not be used at all.

**Brokerage Case Management**

**Brokerage Case Management (BCM)** is considered a brief case management approach, which means the contact between the client and case manager is limited to one or two sessions. The case manager acts as a broker working on behalf of the client to secure information about client services, locate external linkages to agencies, and find financial support for clients (Moseley, 2004). The goals of BCM are to prevent inpatient hospital
stays, improve the client’s quality of life, and elevate the client’s personal functioning (Bond et al., 2001).

**HOW THE BCM MODEL WORKS** In the BCM process, a client assessment is done by the case manager. This assessment helps prioritize client needs and deficits. The case manager uses the assessment information to locate, coordinate, and refer clients to services. The goal of BCM is to reduce the institutional care of clients in favor of community-based care.

Brokerage case managers typically have relatively heavy caseloads, and this leaves them no time to create formal external linkages to other organizations. If BCM is to work, case managers must have the support of their administrations to develop informal or formal collaborative agreements with external agencies. These collaborative agreements are designed to promote professional communication among staff from different organizations. As a result, collaborating agencies are supposed to accept appropriate referrals from each other. This collaboration creates a seamless network among formal community resources, which allows the practitioner to better serve and support clients.

**CLIENTS BEST SERVED BY BCM** It has been reported that mentally ill clients are best served by BCM (Bond et al., 2001). However, it was not clear why. Little research was found about the BCM model. Nevertheless, from my own practical experiences in the field, I have seen BCM used in some shape or form in organizations for HIV/AIDS, domestic violence, and mental health. Case managers using BCM were often put in the position of trying to create collaborative agreements with external agencies. In the real world, this meant that collaborative agreements were not made because frontline workers didn’t have the time or the clout to create interorganizational contracts.

**RESEARCH FINDINGS ABOUT BCM** In the few studies done on BCM, the results indicated that the client group that received BCM were given only a referral to external services, and clients failed to use the services provided. For example, referring elderly clients (65 years or older) to services in the community resulted in low rates of access and usage of mental health and substance abuse services (Bond et al., 2001). In addition, it was reported that BCM did not reduce these clients’ use of the hospital to manage mental health and substance abuse problems.

**Systems Theories**

In the 1930s, Ludwig von Bertalanffy, a biologist, developed **general systems theory**, which describes the relationship among individual internal organic systems in their interactions with their external environment. Followers of Bertalanffy proposed that many phenomena could be viewed as a web of relationships or interactions among systems, and, moreover, that all systems have common patterns or behaviors. The knowledge of systemic patterns or behaviors and their interactions could be used to increase the understanding of complex phenomena. Bertalanffy’s work went beyond biology and was used in different fields of study, including engineering and psychology. By the mid-1900s, social scientists began to adapt the concepts of general systems theory to metaphorically explain how human beings interacted with human systems that started at the
level of family, workplace, and neighborhood and extended to religious and educational affiliations, which were all encompassed by political and government systems, the economic system, and systems of transit, commerce and industry, mass media, and finally social norms derived from dominant belief and value systems.

**Bioecological Theory**

Urie Bronfenbrenner (2005), a social scientist, worked on a bioecological theory that would influence the fields of human services and social work. Bronfenbrenner proposes that human development, throughout one's lifetime, is influenced by the events that occur in the social environment in which a person lives (e.g., a family or community). In addition, events that occur outside the person's personal sphere, like social policies and practices, regulate one's behavior in society. However, these external events also indirectly influence human development. For instance, you live in a society that has laws prohibiting the murder of people and this law in turn regulates your behavior. Are there people who break the public laws, norms, or social conventions? Yes! Nevertheless, human behavior is influenced by external forces that are not under the control of that individual. Bronfenbrenner struggled to test the synergistic interaction between the biopsychological makeup of humans and their environment. He wanted to know how the human physical body and mind all interacted with the physical environment and how it affected human development.

**HOW THE BIOECOLOGICAL THEORY WORKS**

Bronfenbrenner (1979) theorized that some critical elements that drive human development are the objective and subjective experiences that humans have with their environment. The objective experience refers to concrete things that people come into contact with in the environment, and the subjective experience refers to the full range of feelings (both positive and negative) about self, others, and events experienced throughout life. He characterized feelings as both stable and changeable plus they are emotionally and motivationally loaded. Through the human life cycle, human development is based on progressively more complex shared interactions with people, objects, and symbols in the external environment, which Bronfenbrenner called the “proximal processes.” For instance, if a child is to effectively develop intellectually, emotionally, socially, and morally, shared interactions (proximal processes) must occur on a regular basis for extended periods of time.

Some examples of proximal processes are learning, playing, reading, and learning a new skill. These and other shared interactions are considered the primary engines of human development. Bronfenbrenner believed that these shared interactions develops strong emotional attachment between a child and a committed caregiver. Over time the child internalizes the caregiver's feelings and activities, which results in motivating a child to explore, manipulate, and engage in his or her environment. Support of the caregiver by a third party (another adult or parent) serves to increase the quality of the interaction and leads to more positive development. However, human development during the proximal process systematically varies because there are differences in people's genetic inheritance, immediate and remote environments, and environmental permanencies and changes over an extended period of time.

Some say that the bioecological theory has a gap between the social development of individuals and their social networks; plus there is also a problem understanding changes over time (Cairns & Cairns, 2005). Yet social scientists started using system
theory terminology such as open/closed systems, positive/negative feedback, steady state, and equilibrium to help explain micro-level through macro-level workings of people, groups, and organizations independently and interactively. In practical terms, translating Bronfenbrenner’s bioecological theory into practice has not been as successful as some might have hoped. However, there have been attempts to make the theory relevant to human services practice.

**Human Services Organic Model: A Whole-Person Approach**

Joann Chenault, a pioneer in human services education, created the Human Services Organic Model to conceptualize the different levels of society, which factor into human problems and influence human development. The Human Services Organic Model has two fundamental principles, which are the principle of interconnection and the principle of constant change that govern the overall functioning of the systems and environments of human interaction (Chenault, 1975).

**HOW THE HUMAN SERVICES ORGANIC MODEL WORKS** The principle of interconnection refers to the connection of human systems that form larger organic (i.e., living) networks. Human systems include individuals, groups, communities, organizations, and different societies. Chenault (1975) theorizes that all human systems are interconnected and compose complex networks. The complexity of an individual’s interconnection with other systems is infinite. Yet, the reality of the interconnections within a human system is that each connection has some type of influence upon the individual that you must be aware of, so you can work to change it, when necessary. Furthermore, the principle of interconnection means that you must consider your client’s problems from a multidimensional perspective (i.e., whole-person perspective).

The second concept of the Human Services Organic Model is that there is constant change within human systems, which means that human systems are always fluid, self-correcting, and renewing. Therefore, individuals, families, communities, social institutions, organizations, and societies are all continually changing, self-correcting, and renewing themselves. Clients don’t live in a vacuum; whether they like it or not, they are caught in the flow of constant change, which can create a series of problems for the client. Change is also caused by the individual, and some is caused by external forces. If not all change comes from the individual, then you must be cognizant of what external forces are causing change.

Chenault created her model to challenge human services practitioners’ rigid and absolute beliefs. The model requires practitioners to be cognizant of multiple possibilities for choices, rather than automatically defaulting to simple either-or choices. She felt that simple either-or choices were based on people’s assumptions and result in the suppression of their creative choices. Creative choices increase alternatives to new concepts and innovative ways of dealing with issues and problems. Chenault maintained that comfort with one’s positions or answers should be a signal that other viable options might have been overlooked, especially when attempting to solve client problems.

Overall, the Human Services Organic Model was an attempt to illustrate the complexities of determining the influences upon an individual. It illustrates why practitioners might have difficulty choosing innovative ways of solving a client’s problems. There is little research about this model; therefore, it cannot be put into the category of evidence-based practice. However, the importance of the whole-person approach...
continues to be an overarching practice in human services. Using a whole-person approach poses challenges to your practice. Nevertheless, striving to better serve our clients in their environmental context remains a major concern despite the limitations of models or theories.

In the case management process, you will do an assessment of the client’s problems from a whole-person perspective, which means looking at a client’s problems in the context of the person, his or her social environment, and the society he or she is a part of. When you are working with clients you should be asking yourself: (a) How does the client contribute to his or her problems? (b) How does the client’s personal environment contribute to his or her problems? and (c) How does society contribute to the client’s problems? If you are going to address the root cause of a client’s problems, you have to ask all of these three questions, which means you are using a whole-person approach.

Summary

Since the early 1900s, government agencies and nonprofit organizations have used case management for coordinating human services. Yet, there is no single definition for case management, and case management practice is not controlled by any one profession. How a practitioner engages in case management practice will depend on where the individual works. Generally, case management has several overlapping steps: (a) assessment, (b) planning, (c) service coordination, (d) observation, (e) evaluation, and (f) advocating for client services. Some case management models are designed for specific service populations. ACT and ICM, for example, are two case management approaches that focus on reintegrating chronically mentally ill clients back into communities. The Comprehensive Enhancement Practice Model is used with vulnerable populations like the disabled, elderly, and children, while the Kinship Care Model is used only with children. SCM focuses on empowerment of the client, and BCM focuses on coordinating services for the client. In choosing a case management approach, it is important to consider client problems in context by using systems theory. Systems theories have been designed to help practitioners conceptualize client’s problems as a result of the interconnection between the client and external environments that are not under the control of the client. However, the adoption of general systems theory into human services practice has not been as successful as some might have hoped.

Assess your analysis and evaluation of this chapter’s content by completing the Chapter Review.

References
References and Further Readings for Chapter 1


CHAPTER 2

Case Management
A Human Services Practice

Learning Objectives

There is no agreed-upon method of case management among the different helping professions. Yet, there are some practices that can be found in almost every case management approach. These practices involve getting information from clients and strategizing a client plan. This chapter will cover these two essential practices and, in addition, introduce the important principles surrounding legal guardianship—an essential element of human services practice that may be appropriate in a number of different situations.

This chapter is designed to give you a general sense of the case management process, but there is no focus on any specific case management approach. First, you will examine what is involved in doing a client assessment. Client assessment means gathering information, analyzing it, and then drawing conclusions about what problems in life the client is having. Next you will examine what it takes to develop an individual service plan to address a client’s problems in living. Finally, there is a discussion about what is involved if you must act as a legal guardian or case manager for a client. Overall, you will be given a foundation on some essential case management components and a related legal issue that can be built upon regardless of the case management approach you adopt.

Case Management Assessment

Case management is used in an array of settings that include social service agencies, drug programs, community mental health facilities, schools, and hospitals. Yet across different agencies the process of learning about and how to do case management is neither systematic nor
comprehensive. Different types of practitioners will emerge with different knowledge about how to do case management, because agency-based learning depends on whatever in-house learning opportunities and expertise are available to practitioners at the time (Schneider & Amerman, 1997). Similarly, case management is taught in different academic disciplines, and there is no standardized case management approach used by all disciplines and their practitioners. However, almost all case management approaches have assessment and planning components.

When you are assigned to be the case manager for a client, one of the first things you will do is an assessment. There is no agreed-upon method on how to do an assessment among different professions. Nonetheless, the purpose of an assessment is to gather information from a client and other sources so that you can calculate what problems you will be helping the client address, understand the factors causing the problem, find resources for creating change, anticipate unintended problems, and measure the amount of change in the client's life (Fischer, 1978). To help you understand the complexity of the assessment process, it is broken down into the following three steps: (a) gathering information, (b) analyzing the information, and (c) drawing conclusions.

Gathering Information
The first step of doing an assessment involves gathering information directly from the client, from the client's family, from peer and support networks of the client, and from professionals who have worked with the client in other institutions. In other words, you should be using a whole-person approach for gathering client information, which necessitates getting information from the individual and the individual's social network, plus gathering information about the sociocultural environments and society that impact the client.

During an assessment interview, the questions asked of clients are designed to assess their level of functioning, current problems, and needs in terms of resources that will sustain them. In an ideal world, an assessment interview would last as long as necessary to get all the relevant information. However, in the real world you will typically have a very short period of time to complete an entire assessment. If the client is in crisis, for example, is the victim of abuse, domestic violence, or elder neglect, your agency might push you to complete the assessment and take action all in the same day.

You will now examine the type of information that is typically gathered from an assessment interview. Consider an assessment as an ongoing event in which information is gathered in snapshots that will be assembled over time and will give you a detailed view of the client's life. In many agencies, the assessment interview is structured so that each client is asked the same set of questions. This process is considered a standardized assessment.

Why have standardized assessments? It allows agencies to determine the types and quantities of services offered to clients (Rothman, 1991). The limitations of a structured assessment are that it may not highlight the root causes of the client's problems because not enough interrelated information is gathered about the client and the context he or she lives in (Schneider & Amerman, 1997). Therefore, the case manager must determine which standardized answers signal the need to probe for additional information related to a client's problem. However, if you lack extensive knowledge about the problems of the service population that you intend to work with, your standardized assessment may be incomplete, because you might not know what questions to ask or might not comprehend what critical information you are lacking.
In other instances, you might be required to construct questions for specific information categories that are based on the type of service population you are working with. In this instance, you will conduct what is considered a semistructured assessment interview. Regardless of the interviewing format—structured or unstructured—using well-designed questions is an efficient way to gather information from clients and external informants (e.g., family members, friends, or professionals).

Questions used in an assessment interview focus on information from different sources. The first source is your client. Assessment questions should be designed to elicit information that will give you the necessary information to assist the client. Depending on the agency and available community resources, questions during the assessment interview might focus on one or more of the following topics: housing, employment, health, education, finances, social interaction, legal issues, recreation, independent living, personal relationships, transportation, and social barriers.

Furthermore, assessment questions should be designed to get clients to explain how the overall social, political, and economic circumstances they are in affect their lives. Questions should also be asked so that it can be determined whether human service programs that are servicing the client are effective and efficient. These social-service questions are asked because quality of life is directly affected by the quality of services produced by social welfare, education, medical and mental health-care programs. There should be a set of questions that will help you determine whether clients understand social welfare policies (e.g., Social Security, Medicare, and Medicaid) that may impact their life. There should also be a set of questions to determine what clients perceive as social barriers to achieving their goals. If assessment questions are properly designed, you will get a comprehensive understanding of the many different social factors that have shaped the client's views and life.

Another source of information for the client’s assessment can come from secondary sources such as school records, bank records, health records, legal documents, service records from other agencies, and standardized tests (Box 2.1). Some of the records collected and standardized tests assessed are done by licensed professionals and can be beyond your comprehension. Don’t be afraid to ask for help if you are unable

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**Box 2.1 Examples of Standardized Assessment Tools**

**Intelligence Tests**
- Stanford-Binet IQ Test
- Wechsler Adult Intelligence Scale
- Wechsler Intelligence Scale for Children (WISC)
- Wechsler Preschool and Primary Scale of Intelligence

**Cognitive Development Tests**
- Cambridge Neuropsychological Test Automated Battery
- Draw-a-Person Test

**Personality Tests**
- Minnesota Multiphasic Personality Inventory (MMPI)
- Thematic Apperception Test (TAT)
- Rorschach Test
- Myers-Briggs Type Indicator (MBTI)
to interpret certain records or test results. It’s more important that you understand the information—so ask for help from team members in your agency.

To get client records from a secondary source, you will need the proper releases, or what is called a signed informed consent document from the client. You must do this before you can make a request for records (e.g., school transcripts) or speak with professionals (e.g., drug rehab counselors) from another agency. Getting information from external informants who know your client will involve interviewing people like family members, friends, or professionals. I will stress this point once again—the appropriate releases must first be obtained from the client before you speak with any external informant.

**Analyzing Information**

The second step of doing an assessment involves analyzing a client’s records, which is done solely by the practitioner. An analysis of intake summaries, case notes, and secondary sources can offer an in-depth view of a client from many different perspectives that are represented in the formal notes written by other professionals. Even if the client is new to your agency, I guarantee they will have a paper or digital record trail, which means you need to be prepared to obtain them so you can do a thorough analysis.

Is a comprehensive review of records labor intensive? Yes! It takes a lot of time and practice to review client records. So you must learn how to assemble client records in a manner that will help you better understand your client. The discussion now focuses on what it means to analyze information contained in client records.

First, you need to be open to the information in the client records. In other words, try not to look for information that will confirm your preconceived ideas about the client, because if you search for information to confirm your beliefs about the client’s problems and needs you may not be open to other information in the records. When you first get a set of records, do a quick review of them to get a general idea of what they contain. Are there several intakes from different agencies? Do the case notes have any relevant information? Are you missing important information about the client? Was there any indication that referrals had been made for the client?

Next, get pen and paper and begin taking notes during your second review of the client records. At this time you will begin a critical analysis of the records. To make the analysis easier, use the sample document titled “Client Information Analysis Outline” (Exhibit 2.1), which will help you organize the information in the client record that you are analyzing. I use this document to do a record analysis, but you can develop your own. The major objective is to look for similarities and differences across the records.

Where do you start? Start looking for similarities across the data for problems described by the client. For instance, during a data analysis, does the client describe his or her problem consistently and in the same manner across all the internal and external case notes under review? If so, you can look in the records for similarities in plans, actions, and outcomes.

You must also look for differences across the data. For example, are the client’s presenting problems described the same way across all records? If not, why not? As you assess the case, can you determine why the client’s descriptions of his or her presenting problems have been inconsistent? Did the client express his or her needs differently to different practitioners? Were different plans and actions taken? If there are differences across the records, you will need to find out why this is the case.
A critical analysis also involves looking for major themes throughout the records. For example, you note that the client has a crisis and begins to drink and drug to self-medicate, which is reported in case notes from several different agencies. Another theme that is reported throughout the client's records is that the client takes a job and then does something to get fired from the job, which creates another crisis. When you discover repeating themes in the client's record, make short summaries of themes and keep track of where you found the information.

If you aren't sure what a major theme is, examine the client's records with these questions in mind: (a) What problems does the client identify as a challenge? (b) What are the client's needs? (c) What client strengths and weaknesses have been identified? (d) What have other agencies done for the client, and was it effective? (e) What external factors or barriers might have caused the client's problems? If you systematically analyze the client's records and then organize the information around meaningful themes, you should be able to see definite themes and patterns. You can then draw more accurate conclusions.

**Drawing Conclusions**

The third step in doing an assessment involves the following: (a) drawing conclusions about the client's problems, (b) determining the causes of the client's problems, (c) assessing the client's ability to deal with his or her problems, and (d) deciding the best methods to deal with the client's problems. Conclusions are based on your analysis of the client's records and not on experiences you have had in the past with other clients.

---

**Client Information Analysis Outline**

I. SIMILARITIES AMONG CLIENT RECORDS:

II. DIFFERENCES AMONG CLIENT RECORDS:

III. MAJOR MACRO-THEMES: SOCIETAL CAUSES AND BARRIERS RELATED TO THE PROBLEMS:

IV. MAJOR MEZZO-THEMES: COMMUNITY AND FAMILY CAUSES AND BARRIERS RELATED TO THE PROBLEMS

V. MAJOR MICRO-THEMES: CLIENT'S DESCRIPTIONS OF PROBLEMS, STRENGTHS, AND NEEDS:
Factually based conclusions guide the planning phase of the case management process, in which the individual service plan is created. You and the client may conclude, for example, that a certain set of problems should be addressed in the individual service plan because the problems have repeatedly been addressed and not adequately solved, which is supported by the client's records. Conclusions can also be made with respect to the duration of the problems, the severity of the problems, and whether the client is motivated to address the problems. In addition, conclusions can be drawn about the different external pressures that might be contributing to the client's problem followed by determining possible plans of actions that can be taken.

We have examined the most basic components of assessment. What I want you to take away from this discussion is some general understanding of how to do a systematic assessment that includes gathering information, analyzing information, and drawing conclusions based on the information. As you create an individual service plan with your client, you should do so based on facts rather than on arbitrary beliefs of what is best for the client.

As you become more knowledgeable about working with clients, you will begin to understand the difficulties of implementing change at different social levels (individual, group, and societal). Why is change so hard to implement? According to Saul Alinsky (1971), “the fear of change is one of [peoples’] deepest fears, and a new idea must be at the least couched in the language of past ideas; often, it must be, at first, diluted with vestiges of the past” (p. 108). Remember Alinsky's words as you begin your work with clients—it might help you understand the complexity of change for all people, especially your clients.

**Case Management Planning**

Another essential component of most case management approaches is planning, which typically deals with creating an individual service plan. The overall goal of creating the individual service plan is to connect clients to both formal and informal services, so that they can achieve their desired life goals.

**Person-Centered Planning**

Planning should be person centered, which means putting the client at the center of the planning process. In addition, person-centered planning involves respecting the client's personal preferences, culture, and values. Person-centered planning was originally an approach used to plan services for disabled adults (Houston, 2003), but now it is an accepted practice with all service populations. Planning focused on the client's view of his or her circumstances, support networks, and ambitions for the future is planning that humanizes the rigid bureaucracies within human service systems that are more focused on expediently getting the job done despite the fact that it is impersonal.

Person-centered planning can be difficult because the practitioner’s and client's approach to setting goals may be different because of influencing factors such as economic status, cultural norms, religious beliefs, and individual characteristics. When there is no agreement, you will need to be open to the client's world views and be prepared to compromise to keep an open exchange between you and the client. Current research suggests that clients who define their needs and participate in forming solutions to their problems are more likely to remain involved in the service planning process (Anthony & Crawford, 2000).
**PLANNING WITH CHILDREN**  When you are working with children, the approach to get them involved in service planning might not be as straightforward as outlined previously. Thomson and Walker (2010) suggest that to involve children in service planning you first need to read the child's file and speak with other professionals who have worked with the child so that you have something to work with. If possible, meet the child at his or her home. This is an opportunity to gather information to make an assessment about the home situation, and it's an opportunity to build a relationship with the child outside of the office.

Be prepared to ask questions that will encourage a dialogue and will get you additional information about the client (Thomson & Walker, 2010). Asking questions that have already been asked and answered is a turnoff. Furthermore, children are sometimes more willing to speak in an environment that is nontargeting and where they don't have to have eye contact with the practitioner. If possible, find a neutral venue like a game room in your center or a public park to develop a relationship with the client before the actual work begins. You will need to be mindful of confidentiality issues in the different venues to which you take your client.

Finally, as you engage a child in a conversation, follow the rapport-building techniques outlined in Chapter 3 because they apply in this situation too. When you answer a child, be prepared to repeat your answer several times. The number of times you might have to repeat information will be dependent on the child's age. Therefore, be prepared to have the same conversation when working with children because it takes time for them to digest what is being said.

**Planning Goals With the Client**

Creating goals for the service plan is a collaborative (two-way) process between the practitioner and client. This process is also a democratic dialogue in which the client and practitioner mutually agree on the best goals to be included in the service plan. Goals in the service plan should also be derived from the client assessment. Moreover, goals should be realistic and attainable within a limited timeframe. The goals for the service plan are designed to

1. have clients strive for positive changes in thoughts and behaviors,
2. have clients strive for the greatest self-determination possible,
3. have clients better utilize their support network for positive growth, and
4. have clients effectively utilize community service agencies and resources.

Here is a sample document for an individual service plan (see Exhibit 2.2). This is a collaborative and flexible plan between the client and case manager and can be changed by both parties when mutually agreed upon. Note that the sample service plan has five categories to be filled in: (a) responsible person, (b) short-term goals, (c) plan/strategy and begin date, (d) outcome and target date, and (e) outcome completion date.

The first thing to be entered into the service plan is the name of the person responsible for carrying out the plan to meet a specific goal. Having an identified responsible party ensures that the person assigned understands what is expected of him or her. The next column is where the goal is written. The service plan can have both short-term and long-term goals. Short-term goals typically address a crisis that the client is having or some immediate need of the client. Long-term goals address changes that the
# Individual Service Plan

**Client Name:** ______________________  **Client ID:** ______________________

**Summary of Problems:** ____________________________________________

## SHORT-TERM GOALS

<table>
<thead>
<tr>
<th>Responsible Person, Title &amp; Agency or Relationship to Client</th>
<th>Short-term Goals</th>
<th>Plan/Strategy and Begin Date</th>
<th>Outcome and Target Date</th>
<th>Outcome Completed Date</th>
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## LONG-TERM GOALS

<table>
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<tr>
<th>Responsible Person, Title &amp; Agency or Relationship to Client</th>
<th>Long-term Goals</th>
<th>Plan/Strategy and Begin Date</th>
<th>Outcome and Target Date</th>
<th>Outcome Completed Date</th>
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**Case Manager Signature:** ______________________  **Date:** ______________________

**Supervisor Signature:** ______________________  **Date:** ______________________

Client wants to make, with the understanding that it takes a relatively longer amount of time to initiate change. All goals should be unambiguous, which means they should be clear-cut. Examples of short-term and long-term service plan goals are listed below (see Exhibit 2.3).

### Strategy Planning

A plan is a tentative course of action that—in terms of case management—is written down by the client and case manager before the delivery of services. The plan describes the activities that different parties will engage in to reach a planned objective related to the client’s needs (e.g. services, shelter, or other resources). When you look at the sample document of the individual service plan, please note that it has a space for the person that is responsible for a specific strategy and the date the strategy began. How do you write a good strategy? The strategy should be based on the goal
that was determined from the analysis of the client’s records. The ultimate goal is to ensure that the client will achieve a desired outcome. Planning strategies is a creative process that you and the client will be involved in together. There are no books or checklists that will help you develop the perfect plan. What you have at your disposal is the information from the client file that you have systematically synthesized, information about the success (or otherwise) of strategies that have been used in the past, strategies not taken, strategies that were considered but there was no follow through. You may also have a client who will express a preference for a particular strategy that is appropriate for his or her lifestyle. Don't lose sight of the fact that this planning is supposed to be a teachable moment in which clients are learning to take control of their lives.

Will you make the perfect plan? It's best to remember that a plan is not set in stone. Be ready to revise your plan if need be as circumstances change, as steps in the plan work or falter, or as opportunities arise. A plan should not constantly change—it is supposed to provide some stability, attainable milestones, and sought-after improvements. However, the plan is not life, and life is full of surprises. Be flexible.
What should the plan do if it’s helpful? A useful plan is a guide for both client and case manager, a statement of concrete actions to be undertaken in succession, with identifiable and measurable milestones toward accomplishment of larger goals. Celebrate the accomplishments and strategize about reaching the next milestone.

For example, one long-term goal on the client’s list in Exhibit 2.3 was to secure new housing near near her job. The sample document in Exhibit 2.4 outlines a three-step strategy that moves the client from thinking about where she might move to concrete steps to make the move followed by actual places to rent his or her new apartment. Once you have a plan, make sure the client signs it, which indicates that he or she agreed with you about the plan.

Monitoring the Outcomes

Completed outcomes and the outcome targets are both components in the plan, which can be used to monitor and evaluate the effectiveness of planned strategies. Outcomes can be used to inform clients of their individual progress. Outcomes can be used to report to the team members, supervisors, external delivery services, administrators, stakeholders, and funding sources. Reports can detail what worked, how it worked, and time and resources needed to make things work.

What if the plan fails? Plans will fail, but you and the client must learn to be open to learning from failures. Confronting failure is an issue studied and discussed in organizational psychology, but it is applicable to human services. According to Cannon and Edmondson (2001), identifying failure is essential to learning from it, followed by a discussion and analysis of the relevant lesson learned, and finally learning to cope during a discussion of failures and identified causes. In the context of monitoring outcomes, if there are failures, you and the client should be prepared to learn from the failures, which means that you and the client are willing to identify a failure, discuss, and analyze it, and productively deal with the fallout. I want you to be prepared and have the attitude that you and the client can learn from mistakes or failures.

THE IMPORTANCE OF WORKING WELL WITH OTHERS

While working in a human service organization, you will have to deal with both internal organizational and external organizational processes with respect to their service delivery networks (Austin, 2002). The coordination and integration of services improves outcomes for clients that have multiple, complex, and long-term service needs (Gans & Horton, 1975). The effectiveness of community service delivery is dependent on the effectiveness of the working relationships of agency practitioners delivering services plus the quality of services they provide (Sauber, 1983).

A place where internal and external organizational processes come together is in the case conference. The case conference is a formal meeting in which the case manager meets face to face with team members (internal and external) working with the same client. Using a team approach can build trust and cohesion that leads to achieving
## Individual Service Plan

**Client Name: __________________________  Client ID# __________________________**

**Summary of Problems:**

### Long-Term Goals

<table>
<thead>
<tr>
<th>Responsible Person, Title &amp; Agency or Relationship to Client</th>
<th>Long-Term Goals</th>
<th>Plan/Strategy and Begin Date</th>
<th>Target Outcome and Date</th>
<th>Outcome Completed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Client</td>
<td>Secure new housing near job</td>
<td>Step 1. Identify neighborhoods that have housing that fits client’s budget. 9/1</td>
<td>1. Client will have information to review with case manager in two weeks. 9/15</td>
<td>1.</td>
</tr>
<tr>
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<td>Step 2. Review things that will be needed to move into new housing: security deposits for apartment and utilities. 9/3</td>
<td>2. Client will outline all possible expenses to make the move. 9/7</td>
<td>2.</td>
</tr>
<tr>
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<td></td>
<td>Step 3. Identify at least 3 possible housing options. Have addresses, monthly rental rate, and landlord name and phone number. 10/15</td>
<td>3. Client will choose which apartment he or she desires most. 10/30</td>
<td>3.</td>
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Common goals for the client in a coordinated fashion. However, teams can also be dysfunctional because of factors like turf wars, personal conflicts, mismatched goals, poor communication, and the lack of coordinated leadership (Rothman & Sager, 1998). While such conflicts are unfortunate, your best approach in this situation is to remain focused on your client’s need.

Before your presentation, do your homework and be prepared to present the case in a logical and succinct manner. (see Exhibit 2.5, which is a sample of a case conference form; you could use a form such as this to organize your case presentation). Typically you would explain the reason for the meeting, which should be important because team members don’t want you wasting their time. Quickly summarize the client’s current problems and needs—this is followed by making a brief outline of planned actions. Check with team members about what has or has not been done, ask that answers be brief and to the point. The discussion that follows the presentation is when team members share additional information and updates, which all can be used to make adjustments to the client’s individual care plan.
### Case Conference Form

**Client Name:** __________________________  **Client ID#:** __________________

**Case Conference Date:** __________________________  **Client File No.:** __________________

<table>
<thead>
<tr>
<th>Participant’s Name &amp; Position</th>
<th>Agency Name &amp; Direct-Dial Phone &amp; Email</th>
<th>Phone, Skype, or In-person</th>
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</table>

**Did the client attend the case conference?** Yes ____ No ____

**Is there a written and signed informed consent from the client for every participating agency listed above?** Yes ____ No ____

**Reason for Case Conference:**

______________________________

**Assessment of Client’s Current Problems and Needs:**

______________________________

<table>
<thead>
<tr>
<th>Planned Actions</th>
<th>Individual &amp; Agency</th>
<th>Agrees to:</th>
<th>Date to be Completed</th>
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**Case Manager Signature:** __________________________  **Date:** __________________

**Legal Guardianship and Case Management**

You have examined some essential components of case management in this chapter, but what happens if you are appointed a **legal guardian** of your client? How does that change your role if you are the case manager? For instance, your agency might be appointed to be the legal guardian for a client who is defined as legally incompetent, which is a complex legal concept. According to Donald Dickson (1995), individuals are presumed to be incompetent if they are mentally ill and civilly committed, mentally disabled, drug addicted, or alcohol dependent. In addition, a child under the age of 18 is a minor and is considered to be incompetent and in some circumstances to be a ward.
of the court (Jenson & Fraser, 2006). The concept of competency varies according to different state laws and the criteria for being a legal guardian also varies, and so check your state laws.

If you are acting as the agency's representative who assumes the role of legal guardian, you are technically the client's case manager. The twist is, as legal guardian you can have either partial or total control of the decision-making process for the incompetent client (Dickson, 1995), which is not in line with client-centered case management. To have complete or partial control of a client or his or her property can be a daunting task because of the unequal power dynamic introduced into the case management process.

What's the difference between total and partial control? To have total control means you have guardianship of both the client and his or her property. If you are given only control of either the client or the client's property, then you have partial control. Guardianship of the client means you have the power to make personal decisions for the client, such as health care, living arrangements, or travel. As the guardian of the client's property, you can make decisions about paying bills, selling, buying, or investing assets for the client. However, as a legal guardian you might be responsible to the court—depending on the laws of the state—to make periodic or annual reports about actions taken on behalf of the client. If you are handling the client's finances, the court might require your agency to post a cash bond to ensure the safety of the client's funds plus require an accounting of financial transactions made on behalf of the client. If you are wondering why all these measures are taken to safeguard the client, I would have you look no further than the local and national stories of human service professionals mishandling funds and donations of their organizations. Being a legal guardian is a huge responsibility, because you have the power to make life-altering decisions for an adult or child.

**Primary Role of the Legal Guardian**

The primary role of the legal guardian is to make decisions for the incompetent client. Courts have devised standards for making decisions on behalf of the client, which are the substitute judgment standard and the best interests standard. According to the legal scholar Dickson (1995), the substitute judgment standard requires that the legal guardian attempt to replicate the decision that the incapacitated person would make if he or she were able to make a choice. In addition, prior to being incompetent, an individual might have expressed a preference that you should take under consideration despite the fact that it might not be the best decision. As we discussed earlier in the chapter, your personal values and goals might be different from the client’s; keep in mind that as a human services practitioner you are working on behalf of the client even if you’re the legal guardian. Another approach to decision making for an incompetent client is a best interests standard, which means the legal guardian has to determine what is best for the incompetent client. From an objective perspective, your decisions are guided by what is best for the client, even if it’s in conflict with the client’s or your preference.
I have only touched upon the legal complexities of being a guardian for a client. If you assume this role, as a representative of your organization, make sure that you understand the legal implications for taking that role. Talk with a supervisor and have a clear understanding of what is expected of you and if you believe this is beyond your professional scope, inform your superiors.

**Summary**

Currently there is no standardized case management approach. However, case management models do have similar components such as assessment, planning, and monitoring outcomes. Assessment deals with gathering and analyzing client information that helps the practitioner determine the cause of the client’s problems. After the assessment comes planning, when the practitioner and the client create an individual service plan for the client. To ensure a plan is working, the practitioner continually monitors the client’s outcomes. The case management process is fluid. The practitioner must be prepared to make needed adjustments to a client’s individual service plan to reflect the changes in the client’s life. Moreover, a practitioner should make regular use of case conferences to work with team members and clients to find the most effective approach to address the client’s problems in living. Legal guardianship is an option in some states for the case management of an incompetent client, but much care must be taken to understand and observe the state’s laws and practices.

**References**
References and Further Readings for Chapter 2


