2022 National Recovery Month: The Role of Specialized Case Management in First Responder Deflection

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Tom Bashore: Hello, and thank you for joining TASC's Center for Health and Justice for our second in a series of four podcasts, *The Role of Specialized Case Management in First Responder Deflection*. I'd like to welcome our panelists today, Ryan Dylan, who's a case manager with TASC, and Emily Van Doren, who's a case manager in Longmont, Colorado. Welcome. Tell us a little bit about your work and what deflection looks like in your community. And Ryan, if you want to start.

Ryan Dylan: Yes. Hello, my name is Ryan Dylan. I work for Treatment Alternatives for Safe Communities, TASC, and we cover the county surrounding Cook County. So, still urban but also have some rural parts of it too in my surrounding communities.

Now, when it comes to deflection casework in my areas and the program that I actually do, we are post-arrest, so we're not pre-arrest. So, we come in after the arrest has been made, and the client will already have a court appearance. And at that point, the judge and the attorneys will determine if there might be a correlation between the arrest and the client's, like maybe a SUDs issue. And that's where we come in, after that.

Working for TASC, we are a designated agency in the state of Illinois to complete behavioral health assessments for the court and report our

findings. So, as deflection and the first responders and stuff, we're post that process in the client's case.

Tom: Okay, thank you. Emily.

Emily Van Doren: Yeah. As you mentioned, Tom, we're here in Longmont, Colorado. We are a city within Boulder County, which is north of Denver. And we are a case management team that has been employed within the public safety department here in Longmont.

We have a pre-arrest diversion philosophy program, and that comes through multiple pathways. We have our lead program, which is the pathway for law enforcement personnel and our public safety personnel to refer into our intensive community-based case management team. We have a program called the Angel Initiative, which is a community and self-referral pathway within the PAARI model for people who want to link to substance use treatment, and they will get connected with a peer case manager on our team. We have a community health program, which is a partnership with our two local hospitals and the organization that kind of manages our Medicaid region, [inaudible 00:02:46], and that helps to address social determinants of health, oftentimes centering around multiple ED visits or readmittance to the hospital. And then we have our co-responder team, who our case management team supports them closely in backing their co-response model by providing intensive community-based case management for those with acute mental health needs. Sometimes substance use is related, sometimes it's not.

Tom: Thank you. Sounds like you guys are doing a lot of the pathways and deflection.

Emily: Yeah.

Tom: Could you tell us a little bit about the approach you provide in specialized case management and how that has impacted the participants in your program, as opposed to, or compared to, general case management?

Emily: Sure. So, we've really taken an approach to blend a peer specialist role with a case manager role, so they're called peer case managers. And the purpose of that was really kind of using harm reduction and human connection as the foundation or the root of our relationship building. So, in that way, our case managers can build relationship with participants on a peer level. That might be different to a traditional case management model.

We're also community-based, so we're very much out in the community. We do have a home base; we have an office where participants can meet with their case managers. It's like a little harm reduction center. They can get a lot of supplies that they may need to make informed choice or safer choice in the community. But the goal is to really meet them where they're at, figuratively and literally. And so that's been a new approach for our community, certainly. There's lots of support in the community through other behavioral health resources, where they have a peer specialist and maybe a case manager and a clinical staff and a well-rounded team that way. But resource-wise, we really wanted to get our peers out on the street with people, in their homes, whatever the circumstance might be, and able to do some of that linking and referring of a case manager as well.

Tom: Good. Ryan.

Ryan: All right. So, our specialized case management starts with just having an open and honest conversation, explaining the client's responsibilities for our program, explaining the case manager's responsibilities, explaining what case management is. I always like to start off one of our first sessions as defining success, of what success looks like for our program since there is a court mandate involved. And I like to have these open, honest conversations with our clients because you got to get the client to buy in at that first couple of appointments, because if you don't have that buy-in and the client's not dedicated to his recovery, it's just going to be a struggle for the next six months to a year while he is on your caseload. So, just starting there and building from there.

Kind of what makes us different is first we offer our specialized individualized case management, where the client has rights, the clients have choices, and those choices start with where he wants us to engage him at. It could be at the client's home, it could be at our office, it could be at a community location. We want to make sure that it's a feasible and easy way for him to engage in services for us. Also, individual choices comes back to where he wants to do his treatment at too. TASC offers treatment, but in a virtual setting or at our Cook County TASC Chicago location, but a client might want to prefer our different location, something that we want to make sure we offer choices to our clients.

Another thing that makes us different, what makes our specialized case management different than our general case management is our individualized treatment plan. It's key that our case managers know that not every client fits in the same bucket. We can't just go to the well of "You need to get a job. You need to get a GED, or you need to go back to school." The client needs to have a voice, and it should be the main

voice when it comes to our treatment planning goals that we establish with our clients very early on. If the case manager is dictating goals, how much do you think the client's actually going to do if he has no buy-in on that goal? So, we make sure we individualize everything from day one all the way to the discharge.

Finally, what I think makes our specialized case management go is our case management model. Our model dictates the level of engagement that a client will go through as he or she are receiving services from our program. The majority of our clients will start off in the high-intensity model, to where there's engagement weekly and then four contacts a month, minimum. As the client goes through this process, the engagement drops from high intensity to regular to, when he gets closer to discharge, to recovery support, to where you're really focused on transitioning the client out of the program and establishing transitioning goals where the client might complete his treatment by then, so you might be discussing support meetings post-TASC. The client might have his résumé and has been involved in job training programs. Now you're talking about interview skills and maybe giving the client job leads for transitioning. I think that's a key thing that our agency offers is our case management model to where it determines a level of engagement. The case manager doesn't determine it, the client doesn't determine it. What we find from our assessment determines that level of engagement.

Jacob Walls: Perfect. Thank you, Ryan. Emily, I know you touched a little bit on the outcomes of your program, can you talk a bit more about other outcomes that you envision for the new program?

Emily: Yeah. So, I think some of our most profound outcomes have been up and running with the lead program specifically, and then certainly as our case management team has expanded since 2018, so we have a good amount of time in that implementation and development time frame. And some of our very first referrals when we launched in 2018, in the summer of 2018, their stories have just been pretty remarkable to be a part of, and we're really honored to be a part of their journey.

So, one that comes to mind is one of our very first referrals that came through the weekend before we launched on a Monday, and her and her partner were referred by law enforcement to our team and were currently living on the street and had been for quite some time, really depended on one another to just get from point A to point B every single day. We were able to have a pseudo-Housing First model with a partnership that we developed with a transitional housing provider. And shortly after they were referred into the program, we were able to

place them in a one-bedroom apartment and help with that financial barrier. So, we were able to pay rent through our grant funding.

And I think once they were in that environment and settled in and were building really meaningful relationship with their case managers, things started to become pretty clear that in their relationship, it was really challenging to navigate once there was some consistency and some stable environment around them. And they had to do a lot of hard work together to figure out what their own recovery was and what their journeys were. And they made some difficult choices. One person moved out. One person is still living there, and she's paying the rent on her own now and is actually employed with a community partner of ours, so we get to work with her, work alongside her, and really some intentional outreach to people experiencing homelessness, and just watching her skill and expertise and the impact she has on our community, having been in a position where now, she's able to use that life experience to help create equitable choice for people in our community, is just really profound and painful.

I think, very quickly, just another story that comes to mind. When I first started, even before we had launched the program, a law enforcement officer shared with me a story about a community member. He was also experiencing homelessness. He's a primary Spanish speaker, and multiple calls for service every single day, was highly intoxicated in the community. Police and the participant understandably had started to grow apathetic to one another and lost sight of empathy for one another's positions. And when I met him, it was really clear that he was experiencing some significant pain in his feet, so that's kind of where we started. Let's get you to our free medical clinic. Let's address the pain in your feet. Let's make it so that you can walk around and maybe not have to self-medicate by numbing the pain with alcohol.

Slowly but surely, we were able to help him find placement in the same partnership as the other example and he gained income through a program here in Colorado called Old Age Pension, and he's able to pay rent on his own too. And new officers, I mean, even officers who have been here for a couple of years now, they don't know his name. They don't recognize his name. And that's something that our veteran officers just thought was unfathomable. Everyone's going to know him, and we're going to know him until he's not around anymore. But ultimately, he's in his own place, and he has a really meaningful relationship with this case manager and the housing support staff there on-site. He's got a good friendship network, and he's healthy. And it's great.

Jacob: Thank you, Emily. Sounds like both of those situations came full circle.

Emily: Yeah.

Jacob: For Ryan, I know you touched on a bit about transition outcomes for TASC's case management treatment. Can you touch a little bit more about the exact type of transition outcomes for your program?

Ryan: Yeah. I guess we could put it into three different parts of the process of our program here. So, the first part of our outcomes, it's more of a judicial outcome where TASC has very little control over that outcome. So, as we do our behavioral health assessment for the courts, the judge and the attorneys will determine if the client is deemed eligible for our program through law and statutes and all that fun stuff. So, we advocate for treatment over incarceration, but ultimately it's up for the judge to determine that outcome, which could be probation, it could be TASC with probation, it could be Illinois Department of Corrections, it could be prison, it could be jail time, et cetera. So, that's our first type of outcome that we look at when we begin our case management services.

The second would be the outcome from our full behavioral health assessment that each client will undergo at the beginning of their case management process. And there, we're looking at identifying if there is a SUDs disorder and then identifying that SUDs and reporting that information back to the court and to the client, along with a treatment recommendation. Our full behavioral health assessment will also tell us if there's any biomedical or mental health issues, any recovery support issues, housing, et cetera. So, it's a full behavioral assessment, so that provides us with a lot of different avenues to address with our clients, and hopefully that their clients will then be sentenced to a term of probation that includes our services. And if that happens, then we look at our assessment and what we were able to find out and start making treatment plans based off of that.

And then our final outcome is just our basic program outcomes, our agency outcomes of "successful," which has a couple different definitions for our clients. And then we have our neutral outcomes and our unsuccessful outcomes for clients who may recidivate, or we lose our judicial mandate to continue to service them, based on a judge's decision or a probation officer's decision.

Jacob: Thank you, Ryan. Emily, I know you touched on that law enforcement and other models centered around law enforcement are involved in your case management strategies. Are there any other first responders involved in your case management free program?

Emily: Yeah. So, technically, our pathways are open to all public safety personnel. So, here in Longmont, we've got a public safety department

that has police services, fire services, and then what we call collaborative services. That's where we have our victim services, volunteers, that kind of thing. That's where we fall under, too, is in collaborative services.

I think most notably, aside from patrol, our partnership with first responders happens through our co-responder model, our program. So, here in Longmont, our co-responder teams are built of a law enforcement officer, a clinician, and a paramedic. And the three disciplines respond to behavioral health calls. They either self-dispatch or they're asked to follow up. At times, our emergency communications will also dispatch them to calls. But they're on the radio, and they just jump calls when they can too.

And we have such a close partnership with them because they just understand the intricacies of case management and the complexities of intensive community-based case management. And they're really our top referring partners beyond patrol. We have a really diverse set of patrol officers who have referred into us, so they are very much active in referring to us. There's about 90 patrol officers-ish when you include sergeants and commanders. And I think over the course of time, so even with staffing changes, about 80 percent of our patrol officers have tried at least once to refer into our team. So that's a really, really strong number that we're proud of. I think we're just constantly trying to keep a pulse on how to maintain and build meaningful relationship with first responders in general in our department, so that we can keep doing the strong work that we're all collectively doing for the community.

Jacob: Yeah, that sounds great. Giving to that strong number, that about 80 percent of officers have referred at least one time, what was the process of maintaining that number and just having officers be that involved in the process of case management?

Emily: That's a really good question, and it's evolved over time, depending on who made up the bank of patrol officers. I think one thing that has really helped and has put us a step ahead is being employed by public safety. There are pros and cons to it, for sure. I think one challenge that we've had is really building trust out in the community with our participants. We're one and the same. In public safety, there's some barrier there, so we've had to work on that. But it also has helped us internally because we've been able to communicate in a more consistent way with patrol.

And we're trying something new, even now. It's just a constant evolution. In the next couple weeks, we're going to be rolling out having our case managers at least listen to the radio, because that's the lifeline for patrol, right? And we want to be able to get to a point where they

can just ask for us rather than having to call a separate phone number to get us out onto the scene to do a referral in real time. So, trying to bridge that communication, to have it be even more closely aligned. And that's just the name of it; it's just continuing to be curious and adaptable and willing to make changes within reason so that we're all working efficiently.

Jacob: Thank you, Emily. Ryan, the type of first responders involved in your case management strategies.

Ryan: Yeah, as I stated at the beginning, we are a little later on in the process when we first engage our clients. However, TASC does do deflection casework; I just don't oversee that particular program. But we do have deflection casework happening in various, several different cities in our state and villages in our state.

So, now for my particular program, when it comes to first responders, and if you want to be a little loose with that term, we are one of the first people to respond to our clients while they're in a jail setting. When they're arrested and processed, they might not see anyone for a month or two and they could be confused, lost, scared, just, "What the heck is going on? I made a mistake, and now I'm sitting here." And we might be the first response to that client to let them know that everything's going to be okay and we are here to advocate and help for them.

We do also offer walk-in services for self-referrals, so we could walk into a situation where we are the first responder. Client could walk in from the street with an opioid issue, could be actively using, needs help, and that's where we jump in and we just provide immediate referrals to detox, to MAR services, to inpatient residential services, plus complete a full behavioral health assessment. So, that's how my area, my program, can be defined as first responders.

Jacob: Thank you, Ryan. Especially that first term, as they say, this can be very loosely based on the community you live in, as the case managers are first responders themselves, and how you describe that self-referral process.

Ryan: Yeah. When I think first responders, I think firefighters, police, and on-the-street social workers. I just want to make sure that's not what I'm saying we are too.

Tom: I want to ask both of you real quick about your initiatives, as far as how they've grown or changed at all over the time that you have had these in place. And if so, why? Emily, if you want to start.

Emily: Sure. We have certainly grown and evolved. When I first started, I was the supervisor back in 2018. I had myself, a part-time case manager, and two other full-time case managers. And then we added a third, and then we made that part-time full-time. And now, long story short, we're a team of seven peer case managers. We're not fully staffed right now; we've had some changes and restructuring. But seven full-time peer case managers and a case management supervisor, and then myself as the program manager—that makes up our case management system team.

Operationally, we've changed a lot. We've defined, we've pivoted, we've listened to our community. And I think that's the next growth opportunity for us. The pandemic and some other extenuating circumstances has really held us at a float status, a stagnant status with community voice and community input and involvement. And that includes our participants. We've kept a really close link and conversation going with them around what they need from our team.

But our next area of growth is really getting out into the larger community and starting to implore the rest of our community to be involved where they see that they can be and that they want to be. I have this vision of through the lead model, we've got a community advisory group that's made up of community members, including participants, who can help provide some guidance or steering for our work. And I just think of this diverse set of people coming together with varying perspectives and being able to broaden one another's perspectives. I get chills thinking about, there's nothing that small group of people can't do to positively impact our community and make it a more accepting and diverse place to be. And so, that's really where I see, next one, two, three years, us really growing and expanding in that way.

Tom: That's awesome, thank you. Ryan, how has the initiative that you oversee grown or changed and why?

Ryan: Yeah, there's a couple different ways I can answer this one. Maybe I'll start with, TASC has been around for almost 50 years now. And when we first started, we were working in just one county, Cook County, one city, Chicago, working with clients who are returning from the Vietnam War back in the seventies, dealing with the opioid crisis in Chicago, to now, where we are serving all 102 counties with 300 employees statewide. And not only are we doing pretrial casework, we're also in reentry casework, working with the Illinois Department of Corrections inside Department of Correction facilities, and working with clients as they get released, in a role providing community case management

reentry services. We're working closely with DCFS providing youth and family services.

Within the last five years now, we have our own deflection team working as first responders that we just have talked about in the previous question. That's one of our newer initiatives. Now we also offer our own SUDs treatment groups, IOP level two, level one. So, we've grown over these last 50 years to where when we first started as pretrial working within the opioid crisis to now 300 employees, 102 counties statewide, doing services in different parts of the judicial branches.

Another thing where we have grown, just the pandemic alone forced us to adapt and grow. We're doing a bunch of stuff virtually now, where we're offering treatment services, case management service virtually. Now, we still like to have that face-to-face contact, but not every time. We can ensure communication with the client to ensure that treatment planning is being discussed, referrals are being made, information is being shared. And if it's the more efficient way just to do it virtually, let's do it. So, we adapted that way while dealing with the pandemic and offering our specialized case management virtually.

TASC as an agency, and I was actually part of this initiative recently, where we are providing consultation and training to other different countries. We just did a whole expansion offering training to Trinidad and Tobago, teaching our specialized case management to their probation, and they call them case care workers. So, we're not just doing it within the state of Illinois, we're bringing our model internationally and throughout our own country too.

I know, as an agency, we'd love to bring our model outside the judicial field into other fields, like maybe an educational field, offer our case management model to people who are in college, and offer engagement that way. Develop, we probably wouldn't call them treatment planning goals, but different goals, various around clients' education plans as they're studying four years at a university.

The big thing though, too, what we will have to adapt to is, as our state and our federal government discussed, new criminal justice reforms, which will have a direct effect on how we operate as an agency. Most recently, our state announced last year that there's going to be a no-cash bail. So, people won't be sitting inside jails for months and months and months, and be offered immediate release.

So, how do we access that? How do we get them through our doors? When our previous process of client in jail, public defender, client's

private attorney sends us information, then we come in and we service the clients. But if the clients are being immediate released, how do we get them that information? How do we get them to come through our doors, now that they're going to be at home, living their life, going through their pretrial phase at home, and not in a jail setting to where we had access to them? So, there's a couple different other criminal justice reforms coming down the pipe, where as an agency, we are definitely going to have to adapt. We just got to see what's going to happen.

Tom: Good, thank you. Well, I appreciate our panelists today, Emily and Ryan, for a robust conversation. And I would like to thank them for their time and expertise and for all of you joining us on our podcast, *The Role of Specialized Case Management in First Responder Deflection*. Thank you.

Jacob: So, I just want to say thank you again to our audience for listening to this podcast and to the panelists for their great discussion over this topic. We at CHJ invite you to check out the COSSAP resource page at www.cossapresources.org, which has guidance for you and your communities' overall strategy to support individuals in recovery and those that want to address substance use.

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