



# PROVIDING CASE MANAGEMENT FOR PEOPLE WITH MENTAL ILLNESS

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# CASE MANAGEMENT-

A comprehensive service that assists eligible individuals in gaining access to needed medical, social, educational and other services.

Targeted Case Management (TCM) assists SPECIFIC individuals to access other services

Target Group	Recipients	
Target Group	Mentally Ill adults	
Target Group	Intellectually Disabled Adults	
Target Group	Disabled Children	
Target Group	Foster Children	
Target Group	Pregnant Women	
Target Group	AIDS/HIV-positive individuals	
Target Group	Adult protective service individuals	
Target Group	Technology Assisted (TA) Waiver for Adults	

TARGET  
GROUP 1:  
MENTALLY ILL  
ADULTS  
(SMI)

Defined as an individual who is 18 and over with multiple needs who requires mental health case management.

Must have approved diagnosis based on the ICD-10

Impaired role functioning

Documented inability to independently access and sustain involvement in needed services

Case  
Management  
Eligibility –  
Children

Serious  
Emotional  
Disturbance  
(SED)  
Defined

Mental health  
History: One or  
more

- Residential Tx > 2 months
- Psychotropic meds
- Outpatient Tx – 6 months/20 sessions
- 2 or more inpatient admissions

Mental Health Tx  
Needs: One or  
more

- Abuse- sexual, physical, neglect
- Family History of treatment
- Failure to thrive
- Aggression, towards self/others
- Runaway > 24 hours

Current  
Functioning  
Problem Areas:  
Two or more

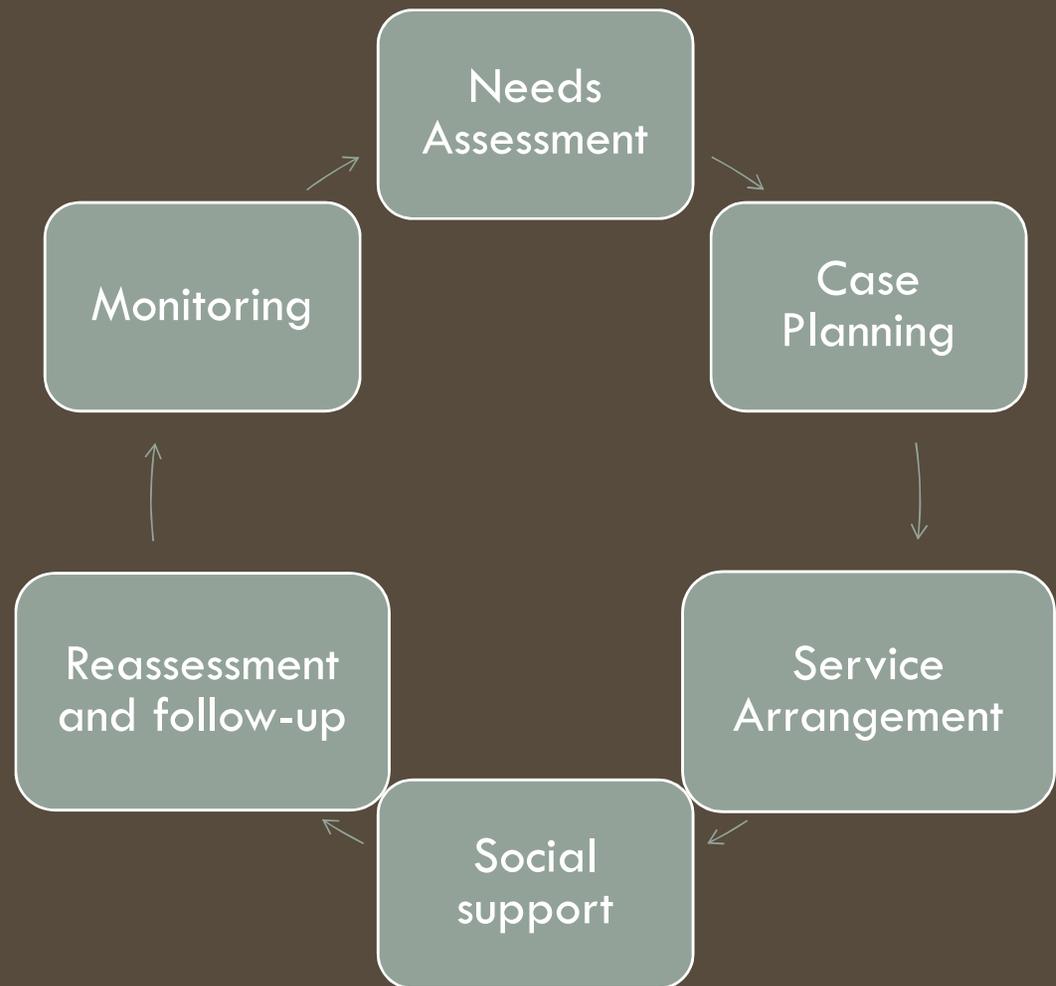
- Failure to graduate/poor grades
- Special Education
- Dysfunctional Relationships
- Basic Living Skills
- Serious Discomfort from anxiety, depression, etc.

# INTENSIVE CARE COORDINATION

There are some major changes happening this year with children's case management and children's in home.

Case management will be broken into two tiers- more traditional case management and 'intensive care coordination.'

# CORE ELEMENTS OF CASE MANAGEMENT WITH THE MENTALLY ILL



# NEEDS ASSESSMENT

We use an instrument called the “SUN” (service and unmet needs assessment). Completed within 30 days, then periodically thereafter

Gathers-

Identifying information

Socialization and recreational needs

Training needs for community living

Vocational needs

Physical needs

Medical care concerns

Social and emotional status

Housing and physical environment

Resource analysis and planning

# CASE PLANNING

Case managers develop an ISP- individualized service plan.

Systematic, client-coordinated plan of care

Lists the actions required to meet the identified needs.

Developed through a collaborative process involving the client, family or other support system, and the case manager.

Must be completed in conjunction with the needs assessment within the first 30 days of contact.

# SERVICE ARRANGEMENT

Through linkage and advocacy, case manager coordinates contacts with the recipient and appropriate person or agency.

May be face to face, phone call, or electronic communication

# SOCIAL SUPPORT

Through interviews with the recipient and significant other, the case manager determines whether the individual has an adequate personal support system.

If inadequate or nonexistent, case manager assists in expanding or establishing a network through advocacy and linking with persons, support groups, or agencies.

# REASSESSMENT & FOLLOW UP

Case Manager will evaluate progress towards goals every six months.

This is done through interviews with recipient, as well as contacts with persons or agencies providing services to the person, reviews the results of these contacts, together with changes in needs shown in reassessments, revises the case plan as necessary

# MONITORING

Determines what services have been delivered and whether they adequately meet the needs of the recipient

The plan of care may need adjustment based on this monitoring

# BENEFITS OF CASE MANAGEMENT

Of the 6-7,000 consumers at MAMHA, close to 30% receive case management services.

Helps ensure consumers remain linked to treatment. They are much more likely to maintain their medication, therapy, and other treatment recommendations.

Ensures COORDINATION between providers. Each consumer may have five-10 doctors/providers, both internal and external to the agency.

The shift in care from inpatient to in the community and through outreach

# DIFFERENT TYPES OF CASE MANAGEMENT

Custody to Community (PICM)

PATH- homeless consumers

Supported Housing

Adult

Children

Forensic

In Home Teams

# POINTS TO CONSIDER

Meet the consumer where they are at

Challenges with billing & productivity

Family involvement & external supports

The unique challenges of working with the mentally ill



QUESTIONS?