

ONE DAY IN THE LIFE OF A MENTAL HEALTH CASE MANAGER

By Rupert van Wormer, MSW, Mental Health Case Manager, Downtown Emergency Service Center, Seattle, Washington

After learning about the harm reduction model as a transfer student at a school of social work in England, the author found work at an agency in Seattle, Washington, which was founded on the principles of this innovative framework. The agency works with clients who are sheltered homeless people suffering from both drug addictions and mental illness. Their goal is to help them stay alive, stay out of the criminal justice system, and live as functioning members of the community.

It is Monday morning, the busiest day of the week at the Downtown Emergency Service Center (DESC) Mental Health Program. After a half-hour bus ride, I arrive in downtown Seattle at the Pioneer Square district, the old part of the downtown area. The agency itself is one block away from Yesler Way, famed for being the original Skid Row. Hundreds of homeless people live in this area today. This area is reported as having the highest arrest rates in the entire city: panhandling, public consumption of alcohol, drug dealing, and prostitution are common sights. The alleyway next to the building that houses the outpatient mental health program is commonly used by people as a place to smoke crack cocaine and inject heroin.

As I approach the front entrance to the clinic where I have worked for just over a year as a mental health case manager, I see a gathering of about 30 people, mostly our clients, waiting for the door to open at 9 a.m. I unlock the door to let myself in and am greeted by four or five of my clients simultaneously; some just say hello while others ask to meet with me immediately. I explain that I will see them after the clinic opens at nine. (To get my work done, I had to learn early on how important it is to set limits.) Entering the building, I lock the door behind me. This may sound like your typical bureaucratic agency; in fact, it is anything but.

Run by a predominately social worker trained staff, DESC clinic is regarded as an extension of the clients' home. Clients come here to talk, for recreation, to get help with major crises, and to receive medication monitoring service. Unlike the traditional agency, appointments are encouraged but not required. Also unlike traditional treatment centers, clients are not required to be clean and sober to get treatment or housing. As a politically progressive social worker who studied addiction treatment in Britain, I often don't realize how unique this program is, given the more punitive American context.

I have an interesting and diverse caseload. Many of my clients are dually diagnosed; often they have spent several years living on the streets. Typical clients we serve have either schizophrenia with co-existing chemical dependency or major depression with chemical dependency. The people with schizophrenia are generally prescribed what are called "atypical anti-psychotics," which include Clozaril, Risperdall, Seroquel, and Zyprexa. For depression, Paxil, Prozac, Zoloft, Effexor, and Wellbutrin are commonly prescribed. Drugs most commonly misused by my clients include heroin, crack cocaine, methamphetamine, marijuana, and alcohol. Many of my clients also have physical health concerns as well, including Hepatitis C, TB, HIV/AIDS, and diabetes. Although I had studied social work with the mentally ill in my



MSW program, no academic course could have prepared me for the magnitude of the problems these clients, with their multiple diagnoses, face every day.

At DESC, we endorse the harm reduction model. While we would like our clients to get off drugs, we realize the impetus for change must come from within. In the meantime, we strive to build a relationship with each individual, whom we regard as special. Our goals are to keep the clients alive and as healthy as possible, and to deter them from engaging in illegal behavior. If someone has a bad liver, for example, I might advise him or her to smoke marijuana rather than to take other drugs that might be lethal. For a man who is breaking antennae off cars (to use to smoke crack), I might advise him to buy a glass pipe at the shop down the street. Consistent with the strengths-based perspective, I reinforce positive small steps in the direction of recovery and independence.

We run what we think of as “pre-recovery” treatment groups at the center. Sometimes clients in the group are nodding off from heroin. Still, we’d rather have them come than to lose touch with them. We provide coffee and bagels and plenty of nurturing along the way. The groups are unstructured, non-confrontive; the focus is on being open and honest about substance use. When our clients go off to AA or NA meetings or traditional treatment programs, though, they tend to get confused. Sometimes they are told to get off all mood-altering drugs, including their anti-depressants that the doctor here has urged them to take. Because of their emotional instability, these clients can’t handle the contradictions. Also, they often can’t resist the temptation to use once off their antidepressants.



I pour myself a cup of coffee and walk back to my cubicle to check my voice mail. Typically, I have anywhere from five to fifteen messages on a Monday morning. Often these messages are from clients or mental health workers reporting an incident, arrest, or hospitalization that occurred during the after hours. A few minutes after 9 a.m., the receptionist at the front desk pages me with a list of clients waiting for me in the reception area. I try to be as fair as possible; however, clients with emergency situations are always bumped to the top of the list. I usually reserve the first hour or two each day for this type of client—the “walk-ins.” The rest of the day I meet with the more stable clients who have scheduled appointments.

Fourteen of my twenty-eight clients are money-management clients, which means that my agency is their representative payee. Their SSI (Supplemental Security Income) and SSDI (Social Security Disability Income) checks are sent to my agency and we assist these clients with their finances. For most of our payee clients, this means we pay their bills and disperse cash to them between one and five times per week, depending on their level of need. At the end of each month, I sit down with these clients individually and help them plan the next month’s budget. One client with whom I work comes in daily, Monday through Friday, and collects \$10 on each visit. He also picks up his daily medications at the nurse station. For many clients, the money-management program encourages treatment involvement. Take Ben (not his real name) as a case in point.

Ben lived a life of instability until recently, when he became a payee client. Before this change, his SSDI check was sent to his mother, who would then send him a money order for the full amount (\$688) at the beginning of each month. Ben would be flat broke in less than two weeks, would have nothing to show for it, and would still live at the shelter to get room and board. During this

time Ben had frequent drug binges, taking his psychiatric medications for schizophrenia inconsistently. This resulted in frequent psychiatric hospitalizations. While Ben was “decompensated” he would think he was a pedophile and would turn himself in at various police stations. But after DESC became his representative payee, stability returned to his life one step at a time. Ben started coming in regularly for medications. I met with him twice a week, during which time I helped him fill out housing applications and encouraged him to continue taking his medications consistently. I also used our time together to discourage him from using alcohol and other drugs. After a few weeks of counseling, I worked with him, coaching him in role playing for the interview with an apartment manager. He did well at the interview and was able to get “clean and sober” housing that provided daily medication monitoring.

The clients I see first thing in the morning are usually money-management clients. Money is a good engagement tool. While I am disbursing money to the clients, I have the opportunity to ask them how they are doing. I try to engage clients in conversation relating to nutrition, housing, drug use, relationships, personal hygiene, medication compliance, and psychiatric stability. This contact also provides me an opportunity to assess how the client is getting along, just through observation. A client who is “decompensated,” for example, will often have worse than usual hygiene, may be responding to hallucinations, and may seem confused. A few things I always need to monitor for are suicidal and homicidal ideation and grave disability. Many of these problems could require immediate psychiatric hospitalization.

By the time 11:45 rolls around, I will have met individually with nine clients for money management. Today their sessions range from five minutes to a half-hour. Those clients who need additional time with me are given appointments later in the week.

I spend the afternoon doing the progress notes for each of the client interactions I have had in the morning, and answering mail. Today there is a letter from the Social Security Administration telling me that one of my clients is up for “disability review.” I fill out the multi-page form and drop it in the outgoing mailbox.

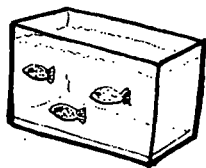
Then it is off to the DESC Shelter, home to about 250 people each night, a place for homeless people to socialize or rest by day. The purpose of my visit is to look for a man in his mid forties diagnosed with schizophrenia whom I have not seen in several weeks. (This part of the job is referred to as “outreach and engagement.”) As I walk through the shelter hallway, I am reminded of a 19th century insane asylum. Momentarily, a wave of anger arises in me: we could do better than this in the 21st century. This place is dirty, there is a foul odor, and there are dozens of disheveled looking people lining the wall. Some are standing or sitting while others are stretched out asleep on the linoleum tile floor. Scanning the faces looking for my client, I notice one person talking to himself in “word salad.” Then I see my client. He is leaning against a wall, staring blankly. I say hello and try to interest him in reconnecting with mental health services. I suggest that we meet later to work on housing applications. We set a time and I return to my office.

Back at the office, I check my voice mail: a few new messages but nothing urgent. It is now 2:15, and my 2:00 appointment is still not here. I have in my office some possessions that belong to a client who has recently moved into an assisted living facility. Since this person’s new residence is only about ten blocks away, I decide now would be a good time to take her her things. Gathering them up in a bag, I start walking toward her residence.

Mary (not her real name), a 68-year-old woman suffering from paranoid schizophrenia, lived at the shelter for about 20 years. Recently we were able to persuade her to move into a



nursing facility. Of all my clients, Mary is the most difficult to engage. Sometimes wearing three coats at a time, Mary is paranoid and especially suspicious of mental health treatment providers. Any direct contact with this client was out of the question. Establishing a relationship was important so that we could move this physically (and mentally) ill woman from the overcrowded shelter into a nursing home. So the problem was how to communicate with her in some way to make her want to get the care she needed. The means to engage Mary came in the form of fish. Every day Mary would appear at the clinic and dutifully empty half of the fish tanks (she believed the water was poisoned and that the fish would die if she did not care for them). As Mary performed her ritual, she would talk in familiar tones of affection to her charges—the fish. Through trial and error, I discovered I could use the fish tank as an engagement tool, chatting with Mary as she eliminated the “poisoned” water. If I talked to her about her circumstances, she would clam up entirely, but I could talk to her about others who had found housing, and who had shopped for new clothes. Gradually over time, I built up enough trust to get her to try out the nursing home. She did obtain housing in this way. But a weird thing happened. Although we took over care of the fish in the aquarium, all but one of the fish died, just as Mary had said they would.



Walking now to the nursing home, I go about half a block from my building when I notice one of my other clients, Joe, walking toward me. He stops in front of me and says “Guess what?” Since Joe has a big smile on his face, I expect that it will be something positive. To my surprise, and horror, however,

it is not—a case of inappropriate affect. Joe tells me that he has just swallowed all of his medications and injected a gram of heroin, an obvious suicidal gesture that could have been fatal. My adrenaline is high; we must act fast. I get him to come with me back to the clinic so we can get a “med list” from the nurse. After getting the list, we arrive at the ER, pushing our way to the front of the line. I explain the situation to the intake nurse and give her the med list. While Joe is getting his stomach pumped, I talk to the hospital social worker and advocate for my client to be admitted into the inpatient psychiatric unit of the hospital after he is medically cleared. Confident that the appropriate follow-up care will be provided, I leave.

It is now almost 5 p.m. A few blocks from the hospital is the assisted living facility that was my original destination this afternoon. Fortunately, I remembered to bring Mary’s bag of possessions with me. Feeling somewhat emotionally drained from the medical crisis, I make this delivery and call it a day.

Comment

One of the toughest things about my job, and the area of greatest personal frustration, is the difficulty associated with trying to get clients into inpatient chemical dependency programs. Frequently, clients will reach a point when they realize they are in need of inpatient chemical dependency treatment, and they are ready and willing to get intensive treatment, long-term treatment. The hard part for me at such a moment comes when I have to explain that I can try to get them on a list somewhere, but it may be three months to a year before they will be admitted. The problem stems from the shortage of publicly funded inpatient chemical dependency centers. The few centers that do exist have the option of being selective when it comes to admission. Clients with a diagnosis of schizophrenia, bipolar mood disorder, or major depression, as well as chemical dependency, generally have a

harder time getting into treatment than people who are not identified as having mental health problems. One client, a daily crack cocaine user, had his moment of clarity nearly six months ago. He completed an application to an appropriate treatment facility, and we are still waiting. Another client from our agency was awaiting an opening at another treatment center. But before she could get the help she needed, she was picked up by the police and was sentenced to three years in prison for providing an undercover agent with crack cocaine.

As I reflect on my work at the clinic, I feel grateful to be a part of an establishment that operates as an oasis of caring within a wider social welfare system with ever declining benefits. Here social workers function as a close-knit team, putting the interests of the clients first. Staff members actively advocate on behalf of homeless, disabled people through lobbying city officials and writing grants for expanded facilities and outreach programming. But then, again, I feel despair at living in a society that creates the conditions that give rise to homelessness in the first place.

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