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Client-Case Manager Relationship: The Effects and Impact of Rule 79 Case Managers Testimony in Commitment Court

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ABSTRACT

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Changes in the mental health laws in the United States over the last 50 years has altered the manner in which individuals with a serious and persistent mental illness (SPMI) are involuntarily committed. The changes have increased the need for mental health professionals to be involved with the court system to aid in understanding the client's mental disorder.

The Minnesota Comprehensive Adult and Children's Mental Health Act (MCACMHA) provides mental health case management for individuals with a SPMI. This exploratory study focuses on how the client-case manager relationship is impacted by the requirement that case managers be involved in all commitment procedures about clients. Previous research supports case management as an effective method of community treatment for the SPMI population, and that the client-case manager relationship was important for successful community integration and stabilization.

Data for this study was attained through a self-administered survey to all Rule 79 case managers in an urban county (N=20). The study explored the effects on the client-case manager relationship when the case manager testifies about a client in commitment court. The findings indicated that there were consequential effects on the client-case manager relationship when a case manager testified in commitment court, such as a strained relationship or the client terminated the relationship. The findings suggested a gender difference in how male and female case managers' view the positive outcomes for the client-case manager relationship after testifying in court. Implications for social work practice and policy, along with recommendations for future research are discussed.

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CHAPTER I

INTRODUCTION

This chapter introduces the problem and explores the effects upon the client-case manager relationship when a mental health case manager testifies about a client in commitment court, and how that testimony may cause negative and/or positive outcomes for the client. The chapter also includes the purpose and significance of this exploratory study and the research question.

Background of the Problem

The Fourteenth Amendment of the U.S. Constitution states, "that a state cannot deprive any person of his or her liberty without due process of law" (Bednar, Bednar, Lambert & Waite, 1991, p.189). The improvement of mental health laws in the United States over the last 50 years has changed the manner in which individuals with a serious and persistent mental illness (SPMI) are involuntary committed. These changes in the mental health laws may require mental health professionals to monitor court orders and comply with subpoenas. Much of the literature about mental health professionals and the court system deals with being an expert witness or providing forensic testimony in criminal or civil court. The literature suggests that mental health professionals will continue to be subpoenaed to commitment court to aid in understanding the client's mental disorder and the ability to function.

The (Group for the Advancement of Psychiatry, 1991) was one of the few publications found that addressed the adversarial role such testimony creates for mental health professionals. The group described how the legal process is designed to be adversarial using the opposing principles of advocacy and conflict. The principle of

advocacy versus conflict is developed out of the cross-examination method in searching for the truth. The (Group for the Advancement of Psychiatry, 1991) also states there is a need for mental health professionals to be involved with the court system, but that there needs to be recognition of the role confusion that the legal system can create for mental health professionals and clients. It is important for mental health professionals to understand and distinguish between their clinical responsibility toward the clients and their civic responsibilities toward the legal systems.

Numerous articles and research studies supported case management as an effective form of community treatment for individuals with a SPMI, and that the client-case manager relationship was important for successful community integration and stabilization. For instance, Harris and Bergman (1987) discussed how case management is a form of therapy, and that, through the process of the relationship, case management can increase the client's own capacities to cope and function.

Statement of the Problem

The Minnesota Comprehensive Adult and Children's Mental Health Act (MCACMHA) was implemented in 1989. MCACMHA was enacted to ensure that all counties in Minnesota were providing community mental health services for adults and children with a serious and persistent mental illness (SPMI). The services under MCACMHA include case management services, community support programs, emergency psychiatric services, residential treatment and outpatient services. Case management is often the entry point for many individuals in accessing mental health services in the community. Rule 79 of the MCACMHA pertains specifically to the delivery of case management services. Rule 79 case management has a lengthy job

description that includes, but is not limited to, crisis intervention, information/referral, advocacy, housing, benefits coordination, counseling and overall case coordination. It is not uncommon for an individual with a SPMI to have a case manager for years and for that case manager to be involved with many aspects of the individual's life.

The study problem focused on a specific job function stipulated in Rule 79; the requirement that case managers be involved in any civil commitment procedures involving clients. The Commitment Act of Minnesota requires that all individuals committed with a diagnosis of SPMI must have a county case manager. The MCACHMA provides commitment court with a Rule 79 case manager. The case manager is often subpoenaed to testify about a client in commitment court and is required to monitor any conditions that the court imposes on that client. At this point, the relationship between the case manager and client shifts, and the case manager becomes an adversary instead of an advocate. One of the goals of case management is to develop a trusting working relationship which may be potentially jeopardized by the testimony and general court proceedings. The requirements of Rule 79 and the Commitment Act may create an ethical dilemma for case managers by forcing them into a dual role of balancing the obligations to the case manager-client relationship and those of the legal system.

Purpose and Significance of the Research Problem

In addition to research that supports case management as an effective method of treatment for individuals with a SPMI, social work practice emphasizes the relationship between client and social worker as well as the importance of self-determination and privileged communication that develops in that relationship. There were few publications

or studies located in the literature search that addressed the dual role of providing case management services and testifying in commitment court about a client.

The purpose of this study was to explore and identify the consequences, if any, of having case managers testify about a client and participate in court proceedings. The research focused on case manager's perceptions of the client's level of trust after a case manager testified in commitment court, and if client mistrust led to premature termination of case management services. The study also explored the effects of balancing the client-case manager relationship and the legal requirements from the case manager's perspective. The possible significance of the study's findings may provide new insights and/or hypotheses for social workers, social programs and policy developers to further study this problem under more rigorous research designs. This study may increase awareness in the mental health community that dual roles exist for mental health professionals and that these dual roles may affect the quality of services to individuals with a SPMI. The findings may serve as a tool for the continuing development of alternative practice methods which assist individuals with a SPMI without becoming adversarial in time of a psychiatric crisis leading to a civil commitment.

Research Question

The research question studied was:

> What are the effects on the client-case manager relationship when the case manager testifies in commitment court about a client?

Summary

Chapter one discussed the issue of case managers balancing the dual roles of advocate and adversary in the area of testifying in commitment court about a client with

whom the practitioner has a relationship. To address this role conflict, this study will explore the Rule 79 case manager's perspective of the positive and/or negative outcomes to the relationship after testifying in commitment court about a client. Chapter two will discuss the literature review specifically in the areas of civil commitment laws, case management theory, strengths perspective theory, case management research and therapeutic jurisprudence. Chapter three explains the methodology and data collection procedures. Chapter four displays the results of the study. Chapter five will discuss the findings as they relate to the theoretical framework used in this study, the literature reviewed, the limitations of the study, the implications for social work practice and policy and future research recommendations.

CHAPTER II

LITERATURE REVIEW

The literature review was conducted in three major areas for the purpose of this research study. First, a historical review of civil commitments in the United States, the Civil Commitment Act of Minnesota, an overview of the MCACMHA and the components directly related to case management is presented. Second, an overview of previous research completed on case management for individuals with a SPMI is outlined. Third, the therapeutic jurisprudence concept used in courts is discussed.

Legal Issues

History of Civil Commitment

For many years the rights of individuals experiencing a SPMI were largely violated, ignored and abused. Shuman (1985) depicted how in colonial America individuals experiencing a SPMI were dealt with outside the judicial system and were often confined to community wards, almshouses or prisons. The first state mental hospital was established in Virginia in 1773 (Meyers, 1984). During the nineteenth century, many state hospitals were built in the United States to treat and house individuals with a SPMI. Meyers (1984) notes that these institutions were not protected by the courts, and patients often endured horrible conditions, neglect, abuse and were often locked away for life with no due process of the law. Meyers (1984) states, "it was in part the appalling conditions found in many state operated institutions which gave rise to the deinstitutionalization movement during the 1950s and 1960s" (p.374).

Since the 1960s, each decade has seen improved changes in the civil commitment laws. Prior studies have identified deinstitutionalization as one of the major themes for

prompting many needed changes in the commitment laws (Bednar, Bednar, Lambert & Waite, 1991; Parry, 1994; Shuman, 1985; Swartz, Burns, Hiday, George, Swanson & Wagner, 1995; Szasz,1990; Test, 1981; Torrey & Kaplan, 1995; Turkheimer & Parry, 1992). Each of these studies discussed the history of confining individuals with a SPMI in state mental hospitals without any judicial purview; commitment was based on medical reasons or community 'fear', often only requiring one doctor's signature for an involuntary commitment. Meyers (1984) further explained how deinstitutionalization played a role in the mental health law reforms. He stated that in 1955 there were over 559,000 individuals residing in state mental hospitals that were often in poor condition with poorly trained staff. The deinstitutionalization of the 1960s placed a larger number of individuals experiencing a SPMI in the community, thus requiring more community mental health services and the need for legal policies to effectively address the issue of integrating this population into the community. In fact, by 1992 the estimated number of individuals in state hospitals fell to approximately 83,000 (Torrey & Kaplan, 1995)

In addition to the deinstitutionalization movement, there were two other reasons for the shift in attitudes regarding the rights of individuals with a SPMI. First, the Fourteenth Amendment of the U. S. Constitution states "that a state cannot deprive any person of his or her liberty without due process of law" (Bednar, Bednar, Lambert & Waite, 1991, p.189). Second, Wexler (1990) explains that modern mental health laws were conceived when the courts recognized that psychiatrists and mental health professionals could not adequately deliver what society and the legal system mandated. Deinstitutionalization created opportunities for individuals with a SPMI to live in the community, and, in response, the community wanted laws to ensure protection from

individuals with a mental illness. Meyer, Landis and Hays (1988) best describe the combination of these events and attitudes. They state that laws exist to promote social order, and that it may be necessary to limit the actions of individuals who may be destructive to that order. They further point out that an individual can be committed if he/she is diagnosed with a mental illness and poses a danger to themselves or others or is gravely disabled.

Minnesota's Civil Commitment Act

In 1982 the State of Minnesota passed the Minnesota Commitment Act to ensure due process for individuals with a SPMI and who were in the process of being committed involuntarily for treatment at a Regional Treatment Center (RTC), formerly known as state mental hospital. An individual under petition for a civil commitment in Minnesota must meet the following criteria to be considered for a civil commitment to an RTC: a) the individual needs to meet one of the legal definitions of mental illness found in the Diagnostic and Statistical Manual of Mental Disorders, 4th ed., and b) the individual must have recently exhibited behaviors that are a danger to self and/or others, or be gravely disabled (Civil Commitment Act, 1982). Bednar, Bednar, Lambert & Waite (1991) define danger to self or others as any self-injurious or suicidal behaviors or behaviors that could be harmful to another individual. The expression 'gravely disabled' describes any individual so impaired that he/she is unable to meet their basic needs to survive.

Minnesota's Civil Commitment Act stipulates 13 primary rules that must be followed prior to an involuntary commitment of an individual to a RTC. The following is a brief description of the rules (see appendix A for further explanation of the rules). Rule 1., determine whether the individual meets the requirements of petition for commitment,

Rule 2., summons, apprehend and confine orders are served to the individual, Rule 3., provision of counsel is provided to the individual, Rule 4., role of the respondents counsel is reviewed, Rule 5., access to medical records needs to be provided to respondents attorney, Rule 6., preliminary hearing is conducted, Rule 7., appointment of court examiners, Rule 8., examination of respondent by court examiners, Rule 9., location of hearing must be held in a courtroom, Rule 10., presence of respondent at hearing has been notified, Rule 11., disposition or court hearing to justify the commitment that are based on facts, Rule 12., indeterminate commitment of persons with mental illness to RTC, and Rule 13., a Guardian Ad Litem is assigned to appropriate cases (MN Civil Commitment Act, 1982).

The question put forth in this study is not whether individuals with a SPMI should be involuntarily committed but rather should the mental health case manager involved with these individuals be forced into dual roles of mental health service providers as well as reporters to and agents of the court. It was established in Minnesota's Civil Commitment Act that all clients committed mentally ill were mandated to receive case management services. The Civil Commitment Act also includes that case managers are required to be involved with all court procedures, including testifying about a client.

History of the Minnesota Comprehensive Adult and Children's Mental Health Act

In the late 1980s the State of Minnesota approved the MCACMHA. By January 1, 1989 all counties in Minnesota were required to provide community mental health services such as day treatment, residential programs, emergency psychiatric services and case management. Rule 79 of the MCACMHA is the job description guidelines pertaining specifically to the delivery of case management services for individuals

experiencing a SPMI. Rule 79 case management was developed and implemented to provide quality mental health services and continuity of care for the SPMI population. This goal was identified in the mission statement that guides MCACMHA. The mission of MCACMHA is to:

(1) recognize the right of adults with mental illness to control their own lives as fully as possible;

(2) promote the independence and safety of adults with mental illness;

(3) reduce chronicity of mental illness;

(4) eliminate abuse of adults with mental illness;

(5) provide services designed to:

(i) increase the level of functioning of adults with mental illness or restore them to a previously held higher level of functioning;

(ii) stabilize adults with mental illness;

(iii) prevent the development and deepening of mental illness;

(iv) support and assist adults in resolving mental health problems that impede their functioning;

(v) promote higher and more satisfying levels of emotional functioning; and (vi) promote sound mental health; and

(6) provide a quality of service that is effective, efficient, appropriate, and consistent with contemporary professional standards in the field of mental health (CAMHA 245.461.Subd.2. 1992).

The State of Minnesota implemented case management as the method for providing mental health services to individuals with a SPMI. Minnesota defined case management services as:

> "activities that are coordinated with the community support services and are designed to help adults with serious and persistent mental illness in gaining access to needed client's mental health needs. Case management services include developing a functional assessment, an individual community support plan, referring and assisting the person to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services" (MN Stat. 245.462 Subd. 3.).

MCACMHA made Rule 79 case management available for any adult with a SPMI who lived in the county and requested services, or for whom civil commitment court appointed a case manager (MN Stat. 245.4711). The point where Rule 79 of the MCACMHA and Minnesota's Civil Commitment Act intersect is the Civil Commitment Act mandates that all individuals committed with a SPMI have a case manager. Rule 79 provides the civil commitment courts with that case manager.

Social Services Issues

Case Management Research

From 1955 to 1980 the population in the state hospital declined from 559,000 to 175,000 (Rapp, 1985). Through the use of new and improved psychotropic medications, more individuals with a mental illness were being discharged into the community. The idea that deinstitutionalization would improve the quality of life for individuals experiencing a mental illness was quickly discarded. Inadequate housing resulted in

large numbers of homeless individuals with serious mental illness. There was also a lack of support services and financial assistance available to assist individuals in the community. In 1978, the federal government implemented the Community Support Program (CSP). The key service of CSPs was the implementation of case management for individuals with a SPMI (Rapp, 1985). The government saw case management as a cost-effective program to provide services to a large and vulnerable population. Since 1978, there have been many advancements and changes in case management. Weil and Karls (1985) explain that case management has evolved and expanded to meet the needs of a complex society and a complex human service system.

Throughout the literature, there was not one agreed upon definition of case management. Weil and Karls (1985) state that, "there is no universally accepted model or framework for case management in community mental health programs, there is considerable agreement about the program elements necessary to perform the tasks" (p.211). Subsequent literature consistently described case management as having five basic functions. Those functions include: 1) outreach, 2) assessment, 3) service or treatment planning, 4) linkage or referring to services, and 5) monitoring and advocacy of delivered services (Fiorentine & Grusky, 1990; Moxley, 1989; Raiff & Shore, 1993; Rose & Moore, 1994; Weil & Karls, 1985).

There were numerous research studies and articles that concluded that case management was an effective method of providing services for individuals with a SPMI, and that the client-case manager relationship was important and essential (Bachrach, 1993; Dietzen & Bond, 1993; Fiorentine & Grusky, 1990; Lamb, 1980; Swartz et al., 1995; Weil & Karls, 1985). A study of 19 clients by Rothman (1992) showed that case

management programs positively affected community living and reduced the incidences of reinstitutionalization. Of the 19 clients, 60% achieved their goals for living in the community, and none were hospitalized over a seven-month period. Rapp and Chamberlain (1985) completed an exploratory study on case management for the SPMI and found that the relationship between the case manager and client was essential for integrating the client into the community. The study showed that SPMI clients who felt supported and respected by their case manager followed through with goals at a higher rate than SPMI clients who did not have a positive relationship with their case manager. Land (1992) evaluated a community support system in New York State and showed that individuals with a SPMI benefited from case management services. The clients that used this program had reduced the number and length of inpatient hospitalizations. Another study was completed by Hammaker (1983) who tracked a random sample of 400 discharged patients from a state hospital after a community support program opened. His results indicated that there was a reduction in both the recidivism and length of hospital stays by adults with a SPMI.

Rapp & Wintersteen (1986) completed a study with 155 SPMI young-adult clients. The clients in the study were diagnosed as psychotic and had a long history of multiple psychiatric hospitalizations. They applied the strengths perspective model of case management to study the effectiveness with clients with a SPMI. The model stressed client strengths not pathology, client self-determination rather than helplessness, the community as a resource not an obstacle and focused on clients' day-to-day coping and problem solving. The results included decreased hospitalizations and clients who reported success in attaining their quality of life goals.

Harris and Bergman (1987) discussed how case management is a form of therapy and that, through the process of the relationship, case management can increase the client's own capacities to cope and function. They emphasized the relationship between the client and case manager as a crucial part of the client's development.

The literature regarding previous research on the effectiveness of case management showed predominantly positive outcomes; only a few research articles showed negative outcomes for the client (Beyers, Cohen & Harshberger, 1978; Callahan, 1989). Rothman (1992) stated that "there is a body of evidence indicating the efficacy of case management, a smaller number of studies indicate lack of association between case manager and positive client outcomes"(p.66). A study completed by Franklin, Solovitz, Mason, Clemmons & Miller (1987) indicated that case-managed clients differed unfavorably from non-case-managed clients. The study showed that clients with case managers had more re-hospitalizations, needed more community services and clients reported no improvement in quality of life indicators.

Therapeutic Jurisprudence

Despite the extensive literature regarding the efficacy of case management, there was limited information about case managers or mental health professionals who have a relationship with clients and are forced by subpoenas to participate in commitment court. Much of the literature about mental health professionals and the court system dealt with being an expert witness or providing forensic testimony in criminal or civil court (Bala, 1994; Meyers, 1984; Rappeport, 1993; Schapp & Quattrocchi, 1995). Some articles acknowledged the dual role of mental health professionals involved with civil commitments where a relationship existed with a client prior to the court hearing (Meyer,

Landis & Hays, 1988; Shore, 1985; Shuman, 1993; Turkheimer & Parry, 1992). Each article briefly discussed the dangers of performing both roles and how it might effect the client relationship. Shuman (1993) discussed that a psychiatrist or psychologist could lose objectivity in a civil hearing if he/she is to provide both the assessment and therapeutic services. He recommends separating assessment and therapeutic functions of mental health professionals in civil commitments for more effective treatment recommendations and fair judicial hearings for the client.

The (Group for the Advancement of Psychiatry, 1991) discussed the different functions played by mental health professionals in the legal system. They described roles of a therapist, an evaluator, an expert witness, and a consultant to an attorney or the court. The authors stated that each role offers both advantages and disadvantages for the professional and patient. The authors believed that,

> "the potential for role confusion is enhanced when a therapist is confronted by a forensic question about an individual with whom there has been a therapeutic relationship. Unless the request is simple and congruent with the therapeutic goals of treatment, it is generally advantageous to have the forensic evaluation performed by another expert who is not involved therapeutically"(p.42).

Therapeutic jurisprudence was the concept cited throughout the literature that justifies civil commitments and the need for mental health professionals to be involved. Therapeutic jurisprudence is defined as the involuntary commitment of an individual to an institution and/or treatment. Wexler (1990) explained that the theory of therapeutic jurisprudence includes a, "civil commitment system that seeks to remove from society those persons who have committed, or are expected to commit, harmful behavior, with

the belief that their behavior can be altered through treatment" (p. 313). The mental health professionals are used by the courts to aid in determining and understanding mental illness and the issue of danger to self or others as it relates to the civil commitment laws.

Summary

The literature on case management suggests that it is an effective form of treatment and that the relationship between the case manager-client is an important component for individuals with a SPMI to enhance community and interpersonal functioning. The research shows how trust and mutual respect are the building blocks for a positive working relationship. A testimony by a case manager in commitment court could create negative repercussions for the client-case manager relationship. Since the literature supports the effectiveness of case management, it is vital to understand how the case manager's testimony in commitment court may negatively or positively effect the client-case manager relationship. There is a gap in the literature regarding social worker's testimony in commitment court when a relationship has been established prior to the court hearing. Also, there is minimal literature that discusses the role of mental health professionals involved with the commitment courts. It is the lack of this literature that supports the purpose of this research study to explore the dual roles of mental health professionals in civil commitment court when the role is to testify about a client where a relationship existed prior to the hearing.

CHAPTER III

THEORETICAL FRAMEWORK

This chapter presents the theoretical framework used in this study. The theoretical framework used was case management theory utilizing the strengths perspective model. Included in this chapter is an explanation of how the strengths perspective model may be applied to the research question.

Case Management Theory

As previously described, case management is a concept that can be applied to many settings and situations with no universal definition. There are basic concepts that all case management models incorporate, and there is a theoretical framework that is the foundation to all case management models. Freeman and Harris (1993) discuss in detail the two values and assumptions that underlie case management theory. They describe case management theory as being organized around two philosophies of science, the interpretive and scientific schools of thought. The interpretive school of thought examines meanings and purposes rather than observable facts. It is qualitative and focuses on the particular case (Freeman & Harris, 1993). The scientific school of thought is based on empirical experimentation, operationally defined measures of theoretical constructs, general laws established through the hypothetical-deductive method, accumulated facts and quantitative analysis (Freeman & Harris, 1993).

There are five widely used models of case management that are guided by one or the other of the two schools of thought. These models of case management include the pact, strengths, rehabilitation, generalist/broker and clinical models. This research project has used the strengths model as the conceptual framework. The strengths model

is guided by the interpretive school of thought. The strengths model is highly subjective and always changing with the client and the environment.

Strengths Perspective

Saleebey (1992) explains that the strengths perspective is derived in response to the philosophy that social work and other helping professions built theories and practices around the idea that "clients become clients because they have deficits, problems, pathologies, and diseases; that they are, in some critical way, flawed or weak"(p.3). The strengths perspective theory aimed to change the assumptions and outcomes of focusing on a client's deficits by maximizing the strengths of the client and the community to promote change. It shifts the focus and manner of how social workers view their work and those they are serving. Saleebey (1992) illustrates this concept as "the shift is away from professional work as the exertion of the power of knowledge and/or institution to professional work as collaborating with the power within the individual (or community) toward a life that is palpably better in the client's own terms"(p.13).

There are six prerequisites and key concepts that form the underlying philosophy and direction of the strengths perspective. The six prerequisites are: 1) respect client strengths; 2) recognize clients have many strengths; 3) client motivation is based on fostering client strengths; 4) the social worker is a collaborator with the client; 5) clients must avoid the victim mindset; and 6) any environment is full of resources (Saleebey, 1992). These prerequisites are built upon six main concepts. The first concept is empowerment, which is centered on discovering power within a person. Second is membership within the community to ensure a sense of belonging. Third is regeneration and healing from within to incorporate the idea that clients are not exclusively healed

from outside sources. Fourth is that synergy can create new and expanded resources that are developed through interrelationships. Fifth is dialogue and collaboration, stressing the importance of relationships with other people. Finally, suspension of disbelief is needed to encourage the emergence of the client's truth and decrease the ideology of professionalism (Saleebey, 1992).

Strengths Perspective of Case Management

Rapp (1992) describes the strengths perspective of case management with SPMI as based in two main assumptions. First, "individuals are successful in everyday life when they use and develop their own potential and when they have access to resources needed to do this" (p. 146). Second, "human behavior is largely a function of the resources available to individuals" (p.146). The six principles of the strengths perspective of case management are based on these two main assumptions. The following are the six principles:

1. The focus is on individual strengths rather than pathology.
2. The case manager-client relationship is primary and essential.
3. Interventions are based on client self-determination.
4. The community is viewed as an oasis of resources, not as an obstacle.
5. Aggressive outreach is the preferred mode of intervention.
6. People suffering from severe mental illness can continue to learn, grow and change. (Rapp, 1992).

The functions of the strengths perspective case management model were developed by incorporating the philosophy, key concepts and the six principles previously discussed. These guide the functions and methods of the case management

model. Rapp (1992) described the method of the strengths perspective case management as being organized into six main functions. The first function is engagement, which stresses building the relationship and educating the client about the strengths perspective. It is also a time for the case manager to demonstrate to the client that the case manager truly cares about him/her as a person. The second function is the strengths assessment, which focuses on a holistic assessment of the client. In the strengths perspective of case management, the assessment function is never completed because people are always changing and growing. The third function is the development of personal goals and implementation. The case manager and client develop both short-term and long-term goals and how these goals will be achieved. The fourth function is to monitor the client's situation through collective, continuous and collaborative monitoring. It is important for the case manager to assist the client in developing a collective of supports in the community and that those relationships developed are continuous and healthy over time. Collaboration with these supports is essential for on-going continued growth for the client to achieve positive relationships. The fifth function is to advocate by implementing the following four A's: availability, adequacy, accessibility, and accommodation. The final function is graduated disengagement. This function guides the client and case manager's relationship in the later stages of the helping relationship when it is time to change the amount of involvement of the case manager or for the client to discontinue case management and utilize the relationships built within the community.

Research completed by the University of Kansas School of Social Welfare, regarding the strengths perspective of case management with those experiencing a SPMI, produced findings that support the effectiveness of this model. The areas in which clients

benefited from the strengths perspective case management included: (1) reduction in the number and length of hospitalizations; (2) increases in individual goal attainment; (3) client satisfaction with case management services; and (4) improved quality of client's lives (Rapp, 1992).

Application of the Strengths Perspective to Research Study

The theoretical framework used in this study may provide further insights into the dual role that testifying in commitment court creates for case managers, and how the dual role may affect clients. The strengths perspective is based on the interpretive school of thought which examines meanings and purposes rather than observable facts (Freeman & Harris, 1993).

The strengths perspective may be applied to the research question and/or problem in the following ways: First, the strengths perspective philosophy describes a different manner in which social workers view the client and community. The philosophy aims at moving away from the 'pathological' framework in understanding how client and community strengths can be the catalyst for growth and change. The 'pathological' framework encourages social workers to view clients as needing a paternalistic approach, therefore, possibly disregarding the need to understand the dual role of advocate and adversary in commitment court. Second, the strengths perspective views the community as being an 'oasis of resources' for the client. Although this is not directly specific to the research question in this study, if the community were more involved in providing services and support for clients during psychiatric crisis, the need for local government to mandate treatment might decrease, and intervention might occur naturally in the community. Community education to decrease the negative stigma and stereotypes of

mental illness is a crucial component for the community to provide psychiatric support and services. The community also needs to increase crisis services outside the hospital by providing more short-term and long-term crisis beds within the community such as adult foster care homes that are designed for people in mental health crisis. Third, the strengths perspective is built upon the idea that the case manager-client relationship is primary and essential, and that interventions are based on client self-determination (Rapp, 1993). The research question specifically addresses the issue of the client-case manager relationship and how it is affected when that relationship is not the primary consideration during a civil commitment hearing and interventions become paternalistic.

Summary

Case management theory was discussed in this chapter in relation to the strengths perspective case management model. The strengths perspective model was used to explore how the strengths perspective may be applied to the research question and/or problem. The following chapter discusses the methodology used in this study.

CHAPTER IV

METHODOLOGY

This study is exploratory due to the nature of the research question and the lack of literature addressing possible ethical dilemmas for social workers who are required to testify in court about a client. This chapter will describe the research design and question, operationalization of concepts, units of analysis, data collection procedures, analysis of data, and the ethical protection of human subjects.

Research Design

The research design was exploratory survey research. The self-administrated survey used both quantitative and qualitative questions to answer the research question. Survey research was chosen due to the purpose of the study, which is to explore the effects of a mental health case manager's testimony in court about clients. The survey was an inductive design to explore the impact, attitudes and experience during commitment court through the case manager's perspective. The survey was divided into three sections that addressed the case manager's involvement in commitment court, their experience there, and basic demographic information.

There are several strengths and weaknesses when using survey research. One of the strengths in using surveys can be to gather data on a large number of people more inexpensively and quickly than other research designs such as interviews (Rubin & Babbie, 1993). Another strength is in the measurement of the survey. As all participants have exactly the same questions, it increases the ability to have the same equal definition for all participants (Rubin & Babbie, 1993).

A weakness in using surveys is the lack of opportunity to probe for more information or observe the non-verbal behaviors of the participants as with experiment or interview designs. Artificiality is another weakness, which Rubin and Babbie describe by stating, "surveys are unable to measure social action, they can only collect self-reports of recalled past actions or of prospective action" (p. 352).

Research Question

What are the effects on the client-case manager relationship when the case manager testifies about a client in commitment court?

Definition of Conceptual and Operational Variables

The study measured the variables through a self-administered survey that included both quantitative and qualitative questions. The following are the conceptual and/or operational definitions of the five key variables used in this study.

Commitment Court: as defined by the Civil Commitment Act in Chapter 253B.02 Subd.4., means probate court or in a case where commitment proceedings are commenced. This variable was measured using a question determining if the case manager had testified in a commitment hearing.

Client: as defined in the Minnesota Comprehensive Adult Mental Health Act (MCAMHA) 245.462 Subd.20.(c)., any adult who has serious and persistent mental illness, and meets at least one of the following criteria:

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult:

(i) has a diagnosis of schizophrenia, bipolar, major depression, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have a future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or unless ongoing case management or community support services are provided;

(4) the adult has, in the last three years, been committed by a court as a mentally ill person under chapter 253B, or the adult's commitment has been stayed or continued; or (5) the adult

(i) was eligible under clauses (1) to (4), but the specified time period has expired or the adult was eligible as a child under section 245.4871, Subd.; and

(ii) has written opinion from a mental health professional, in the last three years stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless on-going case management or community support services are provided.

Mental Illness: as defined in the MCAMHA 245.462.20(a)., any organic disorder of the brain or clinically significant disorder of thought, mood perception, orientation, memory, or behavior this is listed in the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders IV,* that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

Case Manager: as defined in the MCAMHA 245.462 Subd.4., any individual employed by the county or other entity authorized by the county board to provide case management services specified in section 245.3711. This variable was measured by three qualitative questions that asked the case manager to describe their experience after testifying in commitment court about a client.

Testimony: any case manager providing information in commitment court by order of a subpoena to testify under oath as a witness to establish a fact. This variable was measured by two questions that determined if the case manager had been subpoenaed to testify in commitment court in the last 12 months about a client with whom a positive relationship existed prior to the testimony.

Study Population and Site

The population used in this study were individuals currently providing Rule 79 case management. The characteristics of this population are, all Rule 79 case managers that provide case management services in an urban county, who have testified in commitment court in the last 12 months about a client who has been diagnosed with a serious and persistent mental illness, and who had a positive relationship with that client

prior to the testimony. There are three social service agencies that provide Rule 79 case management in the urban county.

Sampling Procedures

The sampling method was to survey the entire universe of Rule 79 case manager population in the urban county. Approximately every three months, the urban county prints a list of all current Rule 79 case managers. The researcher was given permission by the Director of Mental Health Case Management in the urban county to use this list of case managers for this study. Questionnaires were mailed to all 57 case managers and 40 case managers returned the survey (response rate = 70%). Out of the 40 surveys, 20 testified in commitment court and completed the entire survey. Of the 20 case managers that did not complete the survey, 16 were not subpoenaed to testify in court and four were subpoenaed but did not testify in court.

Measurement Issues

The intent of this study was to explore the effects on the relationship between case manager and client when the case manager testifies about a client in commitment court. The information acquired about the effects on the client-case manager relationship was measured through a self-administered survey (see Appendix B). The three open-ended questions on the survey were B1- B3, and these questions were coded as discrete at a nominal level of measurement. The remaining questions on the survey were closed-ended, generating nominal and ratio levels of measurement. The questions on the survey at the nominal level discrete were A1- A2, C3, + C5- C7 while A3-A4, C1-C2, + C4 were at a ratio (continuous) level.

To increase the study's reliability and decrease the likelihood of random error, a survey was created that was brief, simple and easy to complete within 20 minutes. Two former Rule 79 case managers reviewed the survey instrument to ensure face validity, which increased the validity of this study. However, the study may be susceptible to systematic error, decreasing the validity of this study because the case managers may have answered the three open-ended questions in a manner that they believed the researcher wanted to hear, thereby possibly creating social desirability bias (Rubin & Babbie, 1993).

Data Collection Instrument

The data collection instrument was a self-administered survey (see Appendix B). The survey used open-ended and closed-ended questions to attain information consistent with the research question. There were three sections in survey. The first section addressed the case manager's involvement in commitment court during the last 12 months. This section included four closed-ended questions to determine if the case manager had been subpoenaed to testify in commitment court about client with whom the case manager had a positive relationship prior to the court hearing. These questions asked how many times did the case manager testify; and how many times was the client present during testimony. The second section consisted of three open-ended questions that explored the case manager's perspective of the positive and negative outcomes of a testimony, and what role a case manager should have in commitment court. The final section contained seven closed-ended demographic questions about the case managers, such as gender, degree, discipline, length of experience, and professional licensure.

Data Collection

The data for this study was collected through a self-administered survey to the individuals previously described in the study population. The survey included both quantitative and qualitative questions to explore the case manager's experience attitudes and outcomes in commitment court as it relates to the research question. The survey was mailed to each Rule 79 case manager at their place of employment in the urban county. The survey included a cover letter (see Appendix C) that described the study and the date to return the survey if the case manager chose to participate. The study gave the participants two weeks to complete the survey, and after two weeks, another survey was sent to each case manager as a reminder to consider completing and returning the survey if they had not yet done so.

Analysis of Data

The study used descriptive statistics for the data analysis procedures. The qualitative data that was obtained from the survey's open-ended questions were organized into categories, themes and ideas according to the research question. This information was presented primarily using narrative form, percentages, and tables. The quantitative data from the closed-ended survey questions were presented in tabular form, using crosstabs and percentages. These analysis procedures were chosen due to the exploratory nature of the study. The study is exploratory and is not attempting to make causal inferences.

Protection of Human Subjects

The research method designed for this study reduces potential harm inflicted on the participants. The participants completed the survey anonymously, that is no names

were identified in the survey. The participants were thoroughly instructed in a cover letter that involvement was strictly voluntary and that there were no foreseen consequences. The study was submitted and approved (#96-49-2) by the Augsburg College Institutional Review Board for review of human rights violation or ethical concerns of the subjects in the study (see Appendix D). The study was given permission by the Director of Mental Health Services in the urban county (see Appendix E).

Summary

This chapter described how the research study was designed and implemented. A self-administrated survey was given to all Rule 79 case managers to gather data for this study. The survey used both qualitative and quantitative questions to obtain information relating to the research question. Of the 57 Rule 79 case managers surveyed, 20 completed and returned the entire survey. The following chapter discusses the results of those 20 completed surveys.

CHAPTER V

RESULTS

This chapter will describe the demographics of the case managers surveyed, followed by a presentation of the data obtained in the surveys. The results were organized around the research question as it relates to the case managers' responses from the survey. The results were presented in narrative form, percentages, graphs and tables.

Research Question

What are the effects on the client-case manager relationship when the case manager testifies in commitment court about a client?

Demographic Data

The average age of case managers surveyed was 37 years. Twenty-five percent of the case managers were between the ages of 30-39, with another 20% between 20-29 (Table 1). However, one-quarter of the case managers did not provide their age. Seventy percent of the case managers were women. The average length of time for case managers working with SPMI was 9 years and the average length of time as a Rule 79 case manager was 5 years.

Sixty percent of the case managers had graduate degrees, while 40% had a bachelor degree. Sixty-five percent of the case managers had a degree in psychology, while 30% had a degree in social work. Sixty percent of the case managers were licensed professionals. Of the 60% licensed case managers, 50% were LSW while 25% were LICSW.

Table 1: Demographics of the case managers (N=20)

Characteristic	n	%	M
Age Group	(15)		37 years
20-29	(4)	20%	
30-39	(5)	25%	
40-49	(4)	20%	
50-59	(2)	10%	
Missing	(5)	25%	
Gender	(20)		
Female	(14)	70%	
Male	(6)	30%	
Length of time working with SPMI	(20)		9 years
Length of time as a Rule 79 case manager	(20)		5 years
Highest educational level	(20)		
BA	(7)	35%	
ES	(1)	5%	
MS	(2)	10%	
MA	(8)	40%	
MSW	(2)	10%	
Ph.D	(0)	none	
Degree discipline	(20)		
counseling	(1)	5%	
nursing	(0)	none	
psychology	(13)	65%	
sociology	(0)	none	
social work	(6)	30%	
Licensed professional	(12)	60%	
Type of license	(12)		
LP	(2)	17%	
LICSW	(3)	25%	
LGSW	(1)	8%	
LSW	(6)	50%	

Outcomes in Civil Commitment Court

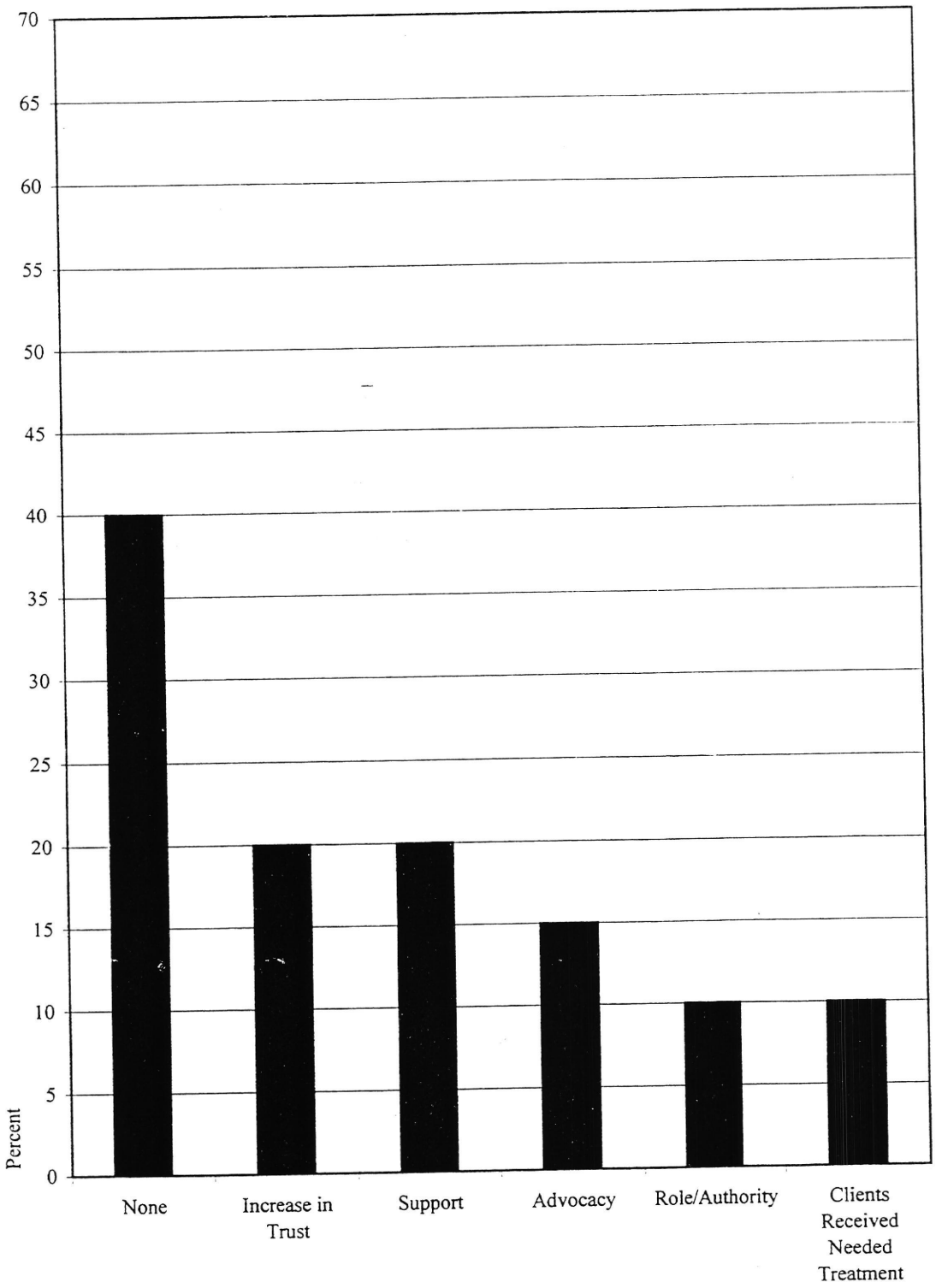
The effects on the client-case manager relationship were divided into three themes: 1) positive outcomes, 2) negative outcomes, and 3) role of the case manger in commitment court. In three open-ended question, case managers were asked to describe any positive and negative outcomes observed in the client-case manager relationship when testifying in commitment court about a client, and the role a case manager should play in commitment court. The following are the case managers' responses to the three themes that addressed the research question.

Positive Outcomes

Twelve case managers (60%) identified positive outcomes for the client-case manager relationship after testifying in commitment court, while 8 (40%) of the case managers stated there were no positive outcomes (Figure 1). Of the 12 case managers that indicated positive outcomes, 20% observed an increase in trust for the client, while another 20% felt the client received support during the court hearing. The positive outcomes identified by the case managers were:

1. Increase in trust for client toward case manager.
2. Increase in client's understanding of the case manager's role and authority.
3. Client received support through the commitment process
4. Case manager advocated for treatment during the commitment process.
5. Client received needed treatment for mental illness.

Figure 1: Positive outcomes for client-case manager relationship after testifying in commitment court (N=20) [1]



[1] Percents do not add to 100 percent; respondents were allowed multiple responses.

Negative Outcomes

There were only two case managers (10%) that did not identify any negative outcomes for the client-case manager relationship (Figure 2). Eighteen case managers (90%) identified several negative outcomes for the relationship. Eleven case managers (55%) stated that after testifying in commitment court, the testimony strained the relationship with the client, while 6 case managers (30%) noted that the client terminated the relationship after the commitment process. The negative outcomes identified by the case managers were:

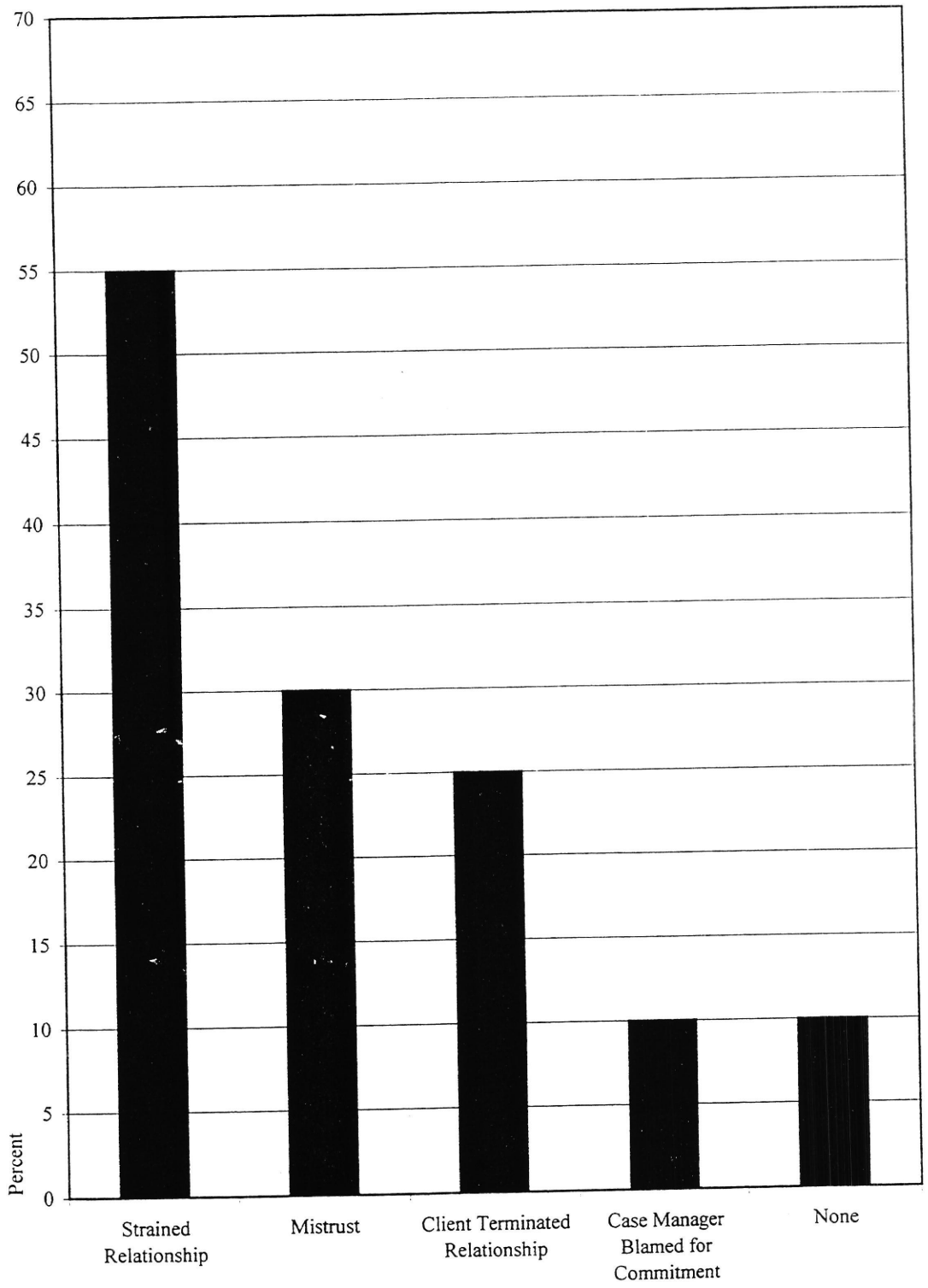
1. Client terminated relationship with case manager.
2. Client blamed the case manager for being committed.
3. Client expressed mistrust toward the case manager.
4. Testimony strained the relationship between client-case manager.

Role of Case Manger in Commitment Court

Three-fifths of the case managers thought the role should be providing information to the court regarding the client's mental health progress, problems, behavior and history (Figure 3). Thirty-five percent of the case managers indicated that the role should be to provide the court with information about appropriate treatment. There were six case managers (15%) that indicated that case managers should have no role or that the role is only as an advocate(also 15%). There was one case manager that felt the role of a case manager should be as an agent of the court.

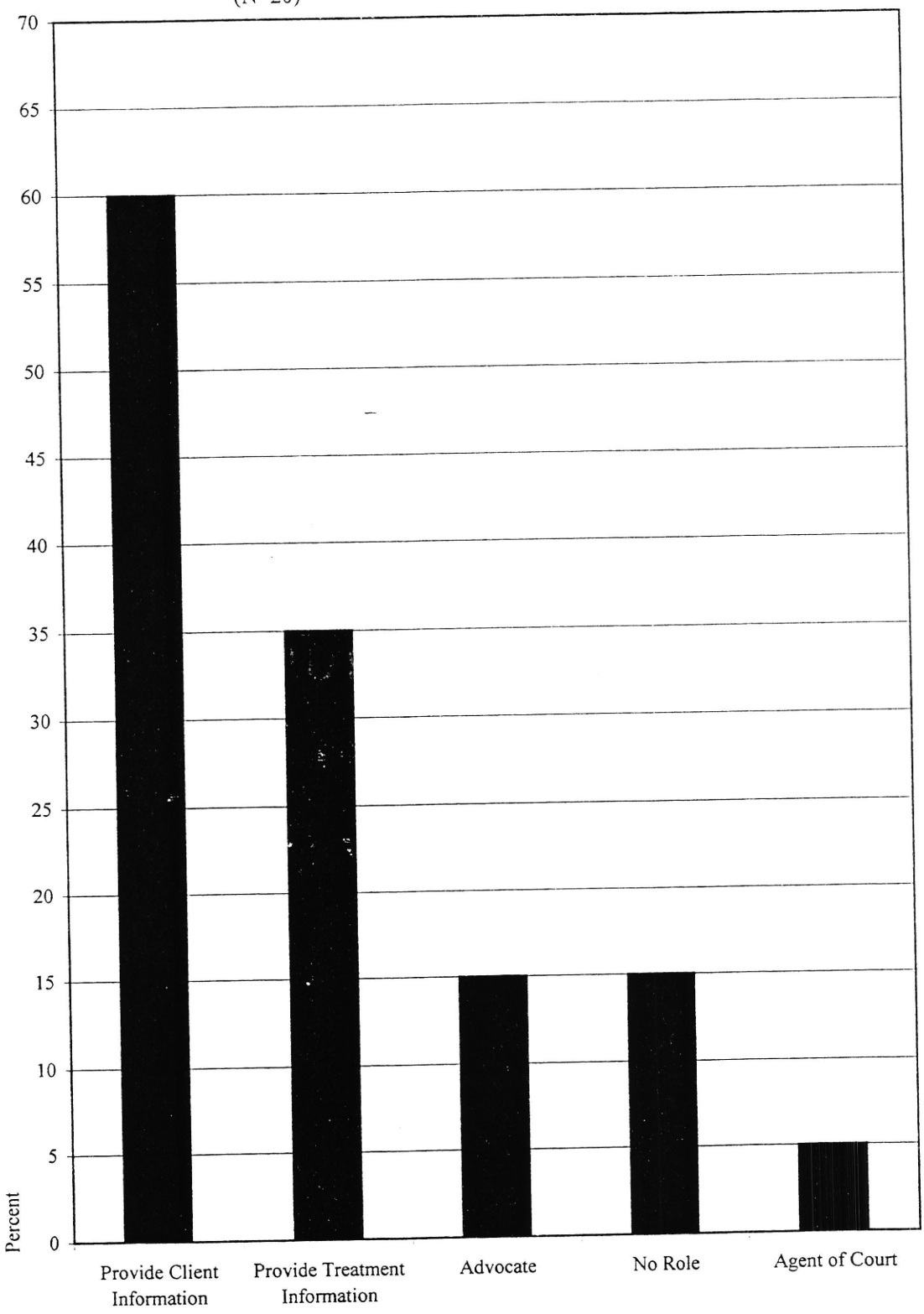
The number of times case managers testified in commitment court differs slightly between males and females, with males testifying an average of 4 times and females testified an average of 3 times (Table 2). Clients present during the testimony yielded similar results (Table 3).

Figure 2: Negative outcomes for client-case manager relationship after testifying in commitment court (N=20) [1]



[1] Percents do not add to 100 percent; respondents were allowed multiple responses.

Figure 3: Role case manager should play in commitment court (N=20) [1]



[1] Percents do not add to 100 percent; respondents were allowed multiple responses.

Table 2: Frequency of case manager's testifying in commitment court (N=20)

Gender	n	Range	M
Female	14	1-15	3
Male	6	1-9	4

Table 3: Frequency of client present during case manager's testimony (N=20)

Gender	n	Range	M
Female	14	0-10	3
Male	6	0-9	4

Summary Table of Positive Outcomes

Twelve case managers indicated that there were positive outcomes for the client-case manager relationship after testifying in commitment court (Table 4). Of the 12 case managers who reported positive outcomes, 5 were males, but there were only 6 male case managers in the study. Fifty-nine percent of the case managers held a BA degree; and of those, 50% had a BA in psychology. Thirty-three percent of the case managers were not licensed mental health professionals, while the remaining 67% were licensed at some level either in psychology or social work.

Summary Table for Negative Outcomes

There were only two case managers that identified negative outcomes for the client-case manager relationship after testifying in commitment court (Table 5). One of these case managers stated that there were neither negative outcomes nor positive outcomes. Both of these respondents were male and they held degrees in psychology, (one with a BA and the other at the graduate level). One was not a licensed professional, while the other case manager was licensed at the LICSW level.

Summary

This chapter reported the findings of the case managers' responses to the survey. The results were organized around the case managers' demographic data and the outcomes for the client-case manager after testifying in commitment court. The results were presented in narrative form, percentages, graphs and tables. The final chapter will discuss the results as they relate to the literature and theoretical framework. The chapter will include implications for social work practice and policy, with recommendations for future research.

Table 4: Summary table of positive outcomes (N=12)

Characteristics	n	%
Gender		
female	7	58%
male	5	42%
Highest educational level		
BA	7	59%
MA	3	25%
MS	1	8%
MSW	1	8%
Degree discipline		
counseling	1	8%
psychology	6	50%
social work	5	42%
Licensed professional		
No license	4	33%
LP	2	18%
LICSW	1	8%
LGSW	1	8%
LSW	4	33%

Table 5: Summary table of negative outcomes (N=2)

Characteristics	n
Gender	
female	0
male	2
Highest educational level	
BA	1
MA	1
Degree discipline	
psychology	2
Licensed professional	
no license	1
LICSW	1

CHAPTER VI

DISCUSSION AND CONCLUSIONS

This chapter will discuss the results of the study. A summary of the findings are presented and discussed in relation to the literature review and the strengths perspective of case management. Included in this chapter are the limitations of the study, the implications for social work practice and policy as well as suggestions for future research.

Summary of the Findings

The major findings for this study were concentrated in the positive and negative outcomes after testifying in court about a client where a positive relationship existed before the testimony. The study identified an unpredicted finding in the summary table of the positive outcomes for testifying in commitment court, suggesting a possible gender difference between case managers.

The primary finding regarding positive outcomes for the client-case manager relationship after a testimony was that 40% of the case managers did not identify any positive outcomes for the client-case manager relationship, while 60% observed positive outcomes for the client-case manager relationship after testifying in court. In fact, 20% of the case managers that observed positive outcomes felt that there was an increase in trust between themselves and the client.

There were four significant findings in the negative outcomes for the client-case manager relationship after a testimony. First, 90% of the case managers reported that testifying in commitment court negatively affected the client-case manager relationship. Second, 55% of the case managers indicated that the client-case manager relationship

was strained after testifying in court. Case managers described the strained relationship with words such as anger, betrayal and hostility to illustrate how the client felt toward the case manager after court. Case managers reported that some clients reacted by ruminating over the testimony, displaying an increase in paranoia, and feeling that the case manager was the 'gatekeeper' to the RTC. The third finding was that 30% of the case managers reported that the client terminated the relationship after the case manager testified in commitment court. Finally, one-quarter of the case managers reported that the client felt mistrustful toward the case manager after the testimony in commitment court.

In the summary table of positive outcomes for the client-case manager relationship, one finding possibly suggests a gender difference. There were 6 male case managers surveyed in this study, and 5 of the 6 male case managers felt that there were positive outcomes for the client-case manager relationship after testifying in commitment court.

Discussion

The findings suggest consequential effects on the client-case manager relationship after a case manager testified about a client in commitment court. Case managers reported three potentially serious negative outcomes for the relationship after testifying. The literature states that clients who felt supported and respected by their case managers attained individual goals and they reported an improvement in their quality of life and a reduction in the number of hospitalizations (Rapp & Chamberlain, 1985). The finding of a strained relationship after a court testimony may imply that the client may feel less supported and respected, thus, creating an environment that is not conducive to client growth. In fact, the literature indicates that clients experience decreased hospitalizations

and an increase in attaining life goals when a positive relationship exists between the case manager and client (Rapp & Wintersteen, 1986). Testifying in court not only strains the relationship between the client and case manager but may force premature termination of that relationship after a testimony. These current findings and the literature suggest that testifying about a client in commitment court may have irreconcilable negative effects on the client-case manager relationship such as termination, strained relationship or an increase in mistrust toward the case manager. The findings and literature may further suggest that these effects may hinder the growth of an individual with a SPMI or affect the level of success in the community (Harris & Bergman, 1987).

The findings regarding the case managers who reported positive outcomes were not consistent with the literature or the strengths perspective of case management. These findings indicated that despite the negative outcomes for the client-case manager relationship, 60% of the case managers observed positive outcomes of testifying in court. The interesting finding in this area was that 20% of the case managers reported an increase in trust with their client after testifying. The literature and the strengths perspective emphasize the importance of a respectful and trusting relationship between the client-case manager as one of the fundamental components for individuals with a SPMI to achieve success in their personal relationships, community, employment and mental health stability.

The finding in the summary table for positive outcomes for the client-case manager relationship may suggest a gender difference in how the dual role of advocate and adversary in commitment court is viewed as well as the relationship with the client. There were a total of 6 male case managers in this study. Of the 6 male case managers, 5

observed positive outcomes for the relationship after testifying in commitment court. There were a total of 14 female case managers in this study. Of the 14 female case managers, 7 observed positive outcomes for the client-case manager relationship after testifying in commitment court.

This finding was not predicted and does not directly relate to the research question, but the literature regarding gender differences may provide further answers for this study and for future research. Archer and Lloyd (1985) discuss in detail how gender socialization in American society greatly affects how men and women perceive culturally appropriate behavior, attitudes and values. They discuss how gender socialization may impact moral development between men and women.

Gilligan (1982) was instrumental in researching gender differences with moral development between men and women. She states that women and men value different things that lead to different judgements regarding what is good-bad or right-wrong. Gilligan (1982) concluded that a man's moral philosophy emphasizes abstract thinking, where as a woman's moral philosophy emphasizes relational thinking with connectedness.

A study conducted by Dobrin (1989) gave the Defining Issues Test (DIT) to male and female social workers to study gender differences in ethical judgements. The DIT scores of this study differed significantly in favor of female social workers. Dobrin (1989) explained that the high scores of female social workers relative to male scores suggest that men and women social workers may evaluate ethical problem differently, specifically in the area of compatibility of reasoning and caring.

Romans (1996) discussed a study where gender differences were found between counselors by using the Meyers-Briggs Type Indicator (MBTI). The results of the MBTI concluded that male counselors emphasize cognitive/task factors, while female counselors emphasize relationship factors in supervision and counseling. Romans (1996) notes that female counselors scored much higher on the F scores of the Thinking-Feeling Scale of the MBTI and male counselors scored higher on the T scores of the Thinking-Feeling Scale.

The literature suggests that there are gender differences in male and female moral and social development and that these differences may affect how male and female social workers view ethical decisions and their relationship with clients. The finding in the summary table of positive outcomes and the literature may suggest a gender difference between female and male case managers in how they view the ethical issues regarding the roles of advocate and adversary that are created during commitment court.

Limitations of the Study

There were several limitations of this study. The first limitation of the study is the absence of the clients' perspective regarding this problem. The case manager can observe and perceive what effects a testimony can have on the client but without the client's 'voice', this study is limited and lacks the valuable data a client's perspective would give to this issue.

The design of the study is the second limitation. Although exploratory research can uncover important aspects on a topic that need further understanding, this type of design comes with significant limits. This exploratory research design lacked the ability to provide solid answers to the research question, it may only provide a framework for

further research needed on this topic. A third limitation is the study's sample size (N-20). The sample size was too small to generalize, and did not fully represent the population being studied. It would have been more favorable for this study to sample a larger number of Rule 79 case managers in Minnesota to increase the study's credibility and answer the research question in greater depth. A larger study was not feasible due to time and financial constraints.

The final limitation is that a formal pretest was not conducted. An informal pretest was performed with this study to increase face validity. However, a formal pretest may have increased the validity of the survey by discovering that question B3 (What role, if any, do you think a case manager should have in commitment court proceedings?) on the survey was worded poorly, which resulted in data that was less useful in answering the research question.

Implications for Social Work Practice and Policy

In 1990, the field of social work in Minnesota created more opportunities for social workers to be involved with the legal system through the implementation of social work licensure. The increase of social workers involved in the legal system, such as civil commitments, has implications for social work practice and social policy.

Social work practice and the code of ethics emphasize the importance of the relationship between client and social worker; and within the relationship, the importance of self-determination and privileged communication. The implication for social work practice is understanding how, if possible, self-determination and confidentiality can be balanced in the legal system without jeopardizing the relationship. There is a need to understand the ethical dilemmas that arise for the participants in the legal system.

Further exploration of how the relationship between the client and case manager is affected during a commitment hearing could make a significant contribution to the development of social policy. If there is enough evidence to show how the dual role of advocate as well as adversary for case managers in commitment court is detrimental to the quality of services, continuity of care and success of case management, policy makers may review the commitment act policy utilizing case managers as court monitors and agents.

The strengths perspective is about building on client strengths as the tool for change and growth. This philosophy integrated in the development of social policies that build upon clients' strengths rather than the clients' problems or pathology may produce positive outcomes for social work policies.

Further understanding on how females and males differ in social and moral development and the impact on social work practice may be beneficial in applying the strengths of these differences in social policy development. Furthermore, social work education may benefit by understanding how gender differences may effect the manner in which male and female social workers practice. It could benefit the field of social work to capitalize on these differences to further develop and train social workers regardless of their gender.

Conclusion

This study explored the effects on the client-case manager relationship after the case manager testified about a client in commitment court. The findings confirm that a testimony in commitment court may negatively effect the relationship. The literature concludes that the strengths perspective is social work practice does not support the role

of the case manager in commitment court with SPMI clients. The literature on the strengths perspective discussed the importance of the relationship between the case manager and client and how that relationship was needed for success in coping and living with a SPMI in the community. The dual role of advocate and adversary in commitment court for case managers seems to contradict what the research has indicated about case management and its effectiveness in decreasing hospitalizations and increasing quality of life factors for SPMI clients. This study also identified a possible difference in gender, and how the gender of the case manager may affect how the case manager views the role in commitment court.

Data from this study suggests that the dual roles of advocate and adversary in the legal system affect clients negatively. Future research is needed to expand the literature regarding this ethical issue and the role of social workers in court. A study design with quantitative outcomes may be helpful in understanding further what implications the dual roles in court have on clients and the effectiveness of case management when these roles are part of the client-case manager relationship.

This study raised the question of gender differences between male and female case managers. It may be worthy research to study the difference between how male and female social workers deal with ethical issues like testifying in court. Further research may also be indicated regarding how women and men differ in ethical judgements and how these judgements effect the practice of social work.

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APPENDIX III

SPECIAL RULES OF PROCEDURE GOVERNING PROCEEDINGS UNDER THE MINNESOTA COMMITMENT ACT OF 1982

Effective September 1, 1982

Research Note

See Minnesota Statutes Annotated, *Volume 16A, for case annotations and historical notes.*

Use WESTLAW® *to find cases citing a rule.* WESTLAW *may also be used to search for specific terms or to update a rule; see the MN-RULES and MN-ORDERS Scope Screens for further information.*

Amendments to these rules are published, as received, in North Western Reporter 2d *advance sheets.*

Table of Rules

INTRODUCTORY STATEMENT

In the event of conflict or inconsistency with provisions of any other body of rules otherwise applicable (e.g., the Rules of Civil Procedure for the District Courts, Rules of Civil Procedure for County Courts, Rules of Civil Procedure for Municipal Courts, Probate Court Rules, etc.), the following Special Rules shall be deemed to be controlling in all proceedings under the Minnesota Commitment Act of 1982 (M.C.A.) and all amendments thereto.

RULE 1. REQUIREMENTS OF PETITION FOR COMMITMENT

Rule 1.01 The petition for commitment shall be verified and shall allege facts sufficient to support the relief prayed for, including a description of respondent's behavior and the time and place of alleged occurrences. Each factual allegation shall be supported by observations of witnesses named in the petition or in a list appended thereto. The petition shall not contain judgmental or conclusory statements unless supported by such factual observations.

Comment

See Rule 1.02 for Comment.

Rule 1.02 The petition shall specify the disposition sought.

Comments—1982

A. The term "respondent" is used in these Rules to refer to the person who is the subject of any proceeding under the M.C.A.

B. It is the intention of these Rules that the requirements of Rule 1.01 shall apply to other types of petitions filed under the M.C.A. as well [e.g., petitions filed pursuant to *Price v. Shepard*, 307 Minn. 250, 239 N.W.2d 905 (1976)].

RULE 2. SUMMONS; APPREHEND AND CONFINE ORDERS

Rule 2.01 Except in circumstances in which an apprehend and/or confine order is permitted pursuant to Rule 2.02 herein, respondent shall be personally served a summons, issued by the court, directing him to appear at stated times and places for examination and/or hearing. The summons shall state, in bold print, that an order to apprehend and/or confine respondent may be issued if he does not appear pursuant to the summons.

Comment

See Rule 2.02 for Comment.

Rule 2.02 An order to apprehend and/or confine respondent prior to commitment may be issued only if,

(a) respondent has failed to appear for examination or hearing pursuant to a summons or orders; or

(b) the court finds, on the basis of credible evidence, that serious imminent physical harm is likely if such order is not issued.

Comments—1982

A. Apprehend and confine orders should not be used initially as a device to obtain an examination of respondent. Rather, unless there is a particularized showing by petitioner that imminent serious harm is likely unless respondent is apprehended, or respondent has not voluntarily appeared for pre-hearing examination or hearing pursuant to a summons or order, a summons should be used in order to give respondent an opportunity to appear voluntarily for the pre-hearing examination or hearing. For purposes of this Rule, the term "hearing" shall include all court proceedings.

B. The Minnesota Commitment Act of 1982, Section 7, Subd. 6 (Minn.Stat. § 253B.07, Subd. 6) identifies three grounds upon which an apprehend and hold order can be issued. The first requires a showing of "serious imminent physical harm to the proposed patient or others." The second requires a showing that the proposed patient has not voluntarily appeared for examination or hearing pursuant to a summons. The third reads as follows: "A request for a petition for commitment of a person institutionalized pursuant to Section 5 has been filed." Hospitalization under Section 5 requires a finding that the person is "in imminent danger of causing injury to himself or others if not immediately restrained." Since this is essentially the same standard as is enunciated in Rule 2.02, this statutory condition is not separately referred to in the Rule.

RULE 3. PROVISION OF COUNSEL

Rule 3.01 The court shall appoint counsel for respondent immediately upon the filing of a petition, and shall assure that representation is available to respondent throughout the proceeding in accordance with these Rules.

Comment

See Rule 3.02 for Comment.

Rule 3.02 Upon request by a person committed under the M.C.A., the court shall appoint counsel to represent the person in connection with the filing of, and subsequent proceedings under, a petition pursuant to Minn.Stat. § 253B.17.

Comments—1982

A. Respondent is entitled to representation and assistance of legal counsel at each of the critical stages of a commitment proceeding under the M.C.A. Such representation and assistance includes the following:

1. seeking any appropriate remedies for release at the time of confinement and prior to the commitment hearing, including investigation, preparing for and representing respondent at the preliminary hearing; and,

2. advising and counseling respondent with respect to a request for an immediate hearing; and,

3. advising respondent with respect to any summons or other order requiring cooperation for the purpose of examination; and,

4. investigating, preparing for, and representing respondent at the commitment hearings; and,

5. counseling with respect to respondent's right to appear at the hearing; and,

6. if the respondent demands, or if otherwise appropriate, perfecting and prosecuting an appeal; and,

7. receiving reports about respondent, and taking appropriate actions in response thereto to advise the respondent of and protect his rights; and,

8. if the respondent demands, or if otherwise appropriate, opposing an order extending the commitment or making it indeterminate; and,

9. counseling and representing with respect to a petition seeking the court's review or approval of any involuntary administration of treatment or medication, such as a petition filed pursuant to *Price v. Shepard*, 307 Minn. 250, 239 N.W.2d 905 (1976); and,

10. counseling and representing with respect to any other judicial proceeding under the M.C.A. affecting respondent, whether initiated by petitioner, respondent, or other person or agency.

B. It is the intention of the Rule that respondent not be permitted to waive the right to representation in accordance with these Rules.

RULE 4. ROLE OF RESPONDENT'S COUNSEL

Rule 4.01 Respondent's counsel, as in other adversary proceedings, shall advocate vigorously on behalf of respondent.

Comment

See Rule 4.07 for Comment.

Rule 4.02 Counsel shall continue to represent respondent in all proceedings in which respondent has a right to counsel under the M.C.A. or these Rules, unless and until permitted to withdraw by the court.

Comment

See Rule 4.07 for Comment.

Rule 4.03 Counsel shall advise respondent with candor concerning all aspects of the case, including, where possible, his professional opinion as to the probable outcome.

Comment

See Rule 4.07 for Comment.

Rule 4.04 To the extent that respondent does not articulate his desires in any particular aspect of the proceeding, counsel shall take the position which preserves respondent's legal rights, including opposing the petition.

Comment

See Rule 4.07 for Comment.

Rule 4.05 Unless instructed to the contrary by respondent, counsel may present evidence of the existence of alternatives less restrictive than those sought in the petition.

Comment

See Rule 4.07 for Comment.

Rule 4.06 To the extent that respondent articulates instructions in the following areas, they are binding on counsel:

(a) what ultimate disposition to seek and which dispositions to oppose;

(b) whether to waive his right to attend the hearing or hearings;

(c) whether to testify on his own behalf;

(d) whether to demand an immediate hearing or consent to continuances.

Comment

See Rule 4.07 for Comment.

Rule 4.07 Except as provided in Rules 4.05 and 4.06 hereof, decisions as to what witnesses to call, whether and how to conduct examination of witnesses, what hearing and trial motions to make, and all other hearing and trial decisions are the exclusive province of counsel after consultation with respondent.

Comments—1982

A. All proceedings under the M.C.A. are adversarial. Minimum adversary representation ordinarily includes, but is not limited to:

1. being familiar with statute and case law and court rules which govern commitment proceedings; and,

2. interviewing respondent no later than 24 hours after confinement pursuant to an order to apprehend and/or confine, or no later than 24 hours after service of a summons, at which time the attorney should provide respondent with a detailed description of the commitment process, including respondent's right to an immediate hearing and a timely preliminary hearing; and,

3. reviewing respondent's medical records, if there are any, early enough to insure sufficient time to investigate and secure additional medical evaluations, and/or prepare for the hearings; and,

4. contacting or interviewing all persons whose testimony might tend to support respondent's position and subpoenaing witnesses if necessary; and,

5. investigating alternatives less restrictive than those sought in the petition; and,

6. attempting to interview prior to the hearing any persons who might testify for petitioner at the hearing; and,

7. informing respondent of the latter's legal rights, including the right of appeal.

B. Rule 4.02 is intended to insure that once appointed, the same lawyer will continue to represent respondent. It should be noted that the Supreme Court Study Commission on the Mentally Disabled and the Courts found many instances of successive appointments of different attorneys at the various stages of a commitment proceeding.

RULE 5. ACCESS TO MEDICAL RECORDS

Rule 5.01 Upon request of respondent's counsel, petitioner shall provide access to respondent's medical records in petitioner's control.

Comment

See Rule 5.04 for Comment.

Rule 5.02 Upon respondent's request the court shall authorize the custodian of any portion of respondent's medical records to provide respondent, or respondent's counsel, access to those records.

Comment

See Rule 5.04 for Comment.

Rule 5.03 On motion of respondent, the court shall exclude from evidence testimony based upon, or introduction of any portion of, any medical record improperly withheld.

Comment

See Rule 5.04 for Comment.

Rule 5.04 Upon request of petitioner, respondent, at least 24 hours prior to the hearing, shall provide access to medical records he intends to introduce.

Comments—1982

A. This Rule is intended to supplement the discovery and protective order provisions contained in the Minnesota Rules of Civil Procedure for County and for District Courts.

B. The term "medical records" should be construed broadly to include, but not by way of limitation, all materials contained in any hospital or medical file, laboratory or psychological test results and third party information.

RULE 6. PRELIMINARY HEARINGS

Rule 6.01 No person may be held longer than 72 hours pursuant to an order to apprehend and confine unless a hearing has been held and it has been determined by the court that cause exists to continue to hold the person.

Comment

See Rule 6.05 for Comment.

Rule 6.02 The 72-hour period shall be exclusive of Saturdays, Sundays and legal holidays. It shall commence upon the person being taken into custody; or if the person is then a patient in a hospital, upon issuance of the order to confine.

Comment

See Rule 6.05 for Comment.

Rule 6.03 At the hearing, petitioner shall have the burden of proof to show that serious imminent physical harm to the respondent or others is likely unless confinement is continued.

Comment

See Rule 6.05 for Comment.

Rule 6.04 Hearsay evidence may be admitted at the hearing; including, but not limited to, the petition, hospital records which are not privileged, police records and affidavits.

Comment

See Rule 6.05 for Comment.

Rule 6.05 The hearing may be waived by respondent either on the record or by written statement signed by respondent and respondent's counsel.

Comment—1982

See Section 7, Subd. 7 of the Minnesota Commitment Act of 1982 (Minn.Stat. § 253B.07, Subd. 7) and, *State ex rel. Doe v. Madonna*, 295 N.W.2d 356 (Minn.1980).

RULE 7. APPOINTMENT OF EXAMINERS

Rule 7.01 The court shall prepare and file a list of examiners from which it regularly makes its appointments. A statement of the manner and rate of compensation of examiners shall be attached to that list.

Comment

See Rule 7.03 for Comment.

Rule 7.02 If a second examiner is appointed upon respondent's request, this examiner shall be reimbursed according to the compensation statement in Rule 7.01, unless otherwise ordered by the court.

Comment

See Rule 7.03 for Comment.

Rule 7.03 Each county or probate court may adopt local rules governing the timing of the respondent's request for the appointment of a second examiner.

Comments—1982

A. The requirements of Rule 7.01 are designed to assist respondent and respondent's counsel in choosing an examiner. Neither the court nor respondent is limited to the names contained in the list required by Rule 7.01. The compensation statement enables a proposed examiner to know in advance what to expect when requested to serve.

B. Rule 7.02 authorizes the court to allow a higher rate of compensation in appropriate cases. If there are unusual issues or problems, the court might be asked in advance to authorize a different rate of compensation than is usual.

C. Rule 7.03 is designed to allow local flexibility in establishing procedures for the appointment of examiners. Probate and county courts are encouraged to adopt local rules which will facilitate the use of a single examiner by allowing respondent's counsel time to review the first examiner's report before being required to submit a request for the appointment of a second examiner.

RULE 8. EXAMINATION OF RESPONDENT

Rule 8.01 Each court-appointed examiner shall conduct an examination of respondent. All examinations shall conform to the same standards as apply to any aspect of professional practice.

Comment

See Rule 8.03 for Comment.

Rule 8.02 Each of the court-appointed examiners shall prepare a separate report containing a statement regarding each of the following:

(a) whether or not respondent is mentally ill, mentally retarded, or chemically dependent and the facts upon which this opinion is based;

(b) whether the examiner recommends commitment, and the facts upon which the recommendation is based;

(c) the examiner's recommendation as to the form, location and conditions of treatment, and the facts upon which this recommendation is based; and,

(d) when the petition alleges that respondent is mentally ill and dangerous to the public, whether or not there is a substantial likelihood that respondent will engage in acts capable of inflicting serious physical harm on another, and the facts upon which this opinion is based.

Comment

See Rule 8.03 for Comment.

Rule 8.03 All reports prepared by court-appointed examiners shall be made available to counsel for petitioner and counsel for respondent.

Comments—1982

A. Rules 8.01 and 8.02 require each examiner to conduct his own examination of respondent and to write an individual report for each examination. These requirements are designed to provide the court with independent opinions about respondent. However, they do not preclude examinations by different examiners held simultaneously.

B. The Supreme Court Study Commission on the Mentally Disabled and the Courts strongly urged that examinations conform to "accepted professional standards" and be conducted "in a professionally acceptable environment." Since "professional standards" are to be determined by the profession, Rule 8.01 merely requires that the standard be followed. Counsel may inquire as to the standards, and the court may make a case-by-case determination as to whether such standards are being met. In the event that standards are not met, or the place of examination is deemed inappropriate, the court may reject the examination report and appoint a new examiner, or order that the examination be repeated in an appropriate manner.

C. Rule 8.02 is intended merely to insure that the court be as fully informed as possible in order that it can make an appropriate disposition. It is not the intention of these Rules that the court include in its order a specification of the treatment to be administered.

RULE 9. LOCATION OF HEARING: RULES OF DECORUM

Rule 9.01 All hearings under the M.C.A. shall be held in a courtroom unless respondent cannot be moved without jeopardy to his physical health.

Comment

See Rule 9.03 for Comment.

Rule 9.02

(1) The courtroom, if located in a treatment facility, shall:

(a) be separate from any treatment area within the hospital; and,

(b) provide adequate space to separate physically the judge or hearing officer from respondent, petitioner, and their respective counsel; and,

(c) provide adequate space to separate physically the witnesses and observers from all others.

(2) The treatment facility in which a courtroom is located shall:

(a) if possible, provide judicial chambers apart from the courtroom; and,

(b) provide a room for private attorney-client conferences apart from, but located near, the courtroom.

(3) A courtroom located in a treatment facility shall not be employed for a hearing if respondent is not then a patient therein and respondent or respondent's counsel objects.

Comment

See Rule 9.03 for Comment.

Rule 9.03

(1) The judge or hearing officer shall assure the decorum and orderliness of the commitment hearing.

(2) The judge or hearing officer shall wear a judicial robe while conducting the commitment hearing.

(3) The judge or hearing officer shall afford to respondent an opportunity to be dressed in conformity with the dignity of court appearances.

Comments—1982

A. See comments to the Supreme Court Study Commission on the Mentally Disabled and the Courts, Recommendation 17.

B. Probate and county courts may adopt local rules, governing the location of hearings, which are consistent with the minimum standards expressed in Rule 9.

C. *Guidelines for Minnesota Court Facilities* (1979), prepared by the Minnesota Supreme Court Judicial Planning Committee, should be referred to and followed where practicable. Particular attention should be given to the "Standards for Courtrooms" section of that booklet.

D. If the courtroom is in a treatment facility, it should preferably be in the administrative area of the treatment facility.

E. A room in a treatment facility is not unsuitable for use as a courtroom merely because it is used for other purposes when court is not in session.

RULE 10. PRESENCE OF RESPONDENT AT HEARING

Rule 10.01 Except as provided in Rule 10.02 hereof, the court shall conduct no hearing in the absence of respondent, unless the court finds, from the showing made at the hearing, that respondent has been informed of his right to be present at the hearing, and has freely and knowingly chosen not to attend.

Comment

See Rule 10.02 for Comment.

Rule 10.02 The court in rare instances may exclude a respondent who is seriously disruptive or who is totally incapable of comprehending and participating in the proceedings. In such instances, the court shall, with specificity on the record, state the behavior of respondent or other circumstances justifying proceeding in the absence of the respondent.

Comment—1982

Section 8, Subd. 5 of the Minnesota Commitment Act of 1982 (Minn.Stat. § 253B.08, Subd. 5) requires that all waiv-

ers regarding the proposed patient's attendance at the hearing "shall be on the record." Rule 10.01 provides further definition of the waiver requirement.

RULE 11. DISPOSITION

Rule 11.01 The court shall not commit respondent unless commitment is justified by findings based upon evidence at the hearing.

Comments—1982

A. It is the intention of this Rule that there be no commitment by default.

B. See Recommendation 9, Final Report of the Supreme Court Study Commission on the Mentally Disabled and the Courts.

RULE 12. INDETERMINATE COMMITMENT OF PERSONS MENTALLY ILL AND DANGEROUS TO THE PUBLIC

Rule 12.01 Prior to making the final determination with regard to a person initially committed as mentally ill and dangerous to the public, the court shall hold a hearing. The hearing shall be held within 14 days of the court's receipt of the written review statement, if one is filed, or within 90 days of the date of initial commitment, whichever is earlier, unless otherwise agreed by the parties.

Rule 12.02 As its final determination, the court may, subject to Rule 20.01, subd. 4 of the Rules of Criminal Procedure:

(a) Discharge the respondent's commitment;

(b) Commit the respondent as mentally ill only, in which case the respondent's commitment shall be deemed to have commenced upon the date of initial commitment, for purposes of determining the maximum length of the determinate commitment; or,

(c) Commit the respondent for an indeterminate period as mentally ill and dangerous to the public.

Rule 12.03 At the request of respondent, the court shall appoint an examiner of the respondent's choice, in accordance with Rule 7.02, for purposes of the hearing referred to in this Rule.

Rule 12.04 The parties shall have the same rights at the hearing as would be applicable in an initial commitment hearing.

Rule 12.05 The written report of the head of the hospital, pursuant to Minn.Stat. § 253B.07, subd. 21, shall be in narrative form, and shall address the following items in detail, including supportive data and documentation therefor:

(a) respondent's present condition and current behavior, and the diagnosis;

(b) the facts, if any, that establish that respondent continues to satisfy the statutory requirements for commitment;

(c) a description of treatment efforts and response to treatment by respondent during hospitalization;

(d) respondent's prognosis;

(e) respondent's individual treatment plan;

(f) an opinion as to whether respondent is in need of further care and treatment;

(g) an opinion as to where further care and treatment, if needed, could be best provided;

(h) an opinion as to whether respondent is dangerous to the public or himself.

Rule 12.06 At the hearing, the court may consider the findings of fact made following the original commitment hearing, and other competent evidence relevant to respondent's present need for continued commitment. The burden of proof at the hearing is upon the proponent of indeterminate commitment to establish by clear and convincing evidence that:

(a) the statutory requirements for commitment under the M.C.A. continue to be met; and

(b) there is no appropriate less restrictive alternative available.

RULE 13. GUARDIANS AD LITEM

Rule 13.01 No guardian ad litem shall be appointed for respondent unless the interests of justice so require.

Comment

See Rule 13.02 for Comment.

Rule 13.02 In any case in which a guardian ad litem has been appointed, counsel for respondent shall represent respondent and not the guardian ad litem.

Comments—1982

A. In some circumstances, the instructions of a respondent to counsel (e.g., not to oppose the petition), may undermine the adversary process. Appointment of a guardian ad litem may be necessary in such cases to insure that the factual and legal issues before the court are fully explored.

B. The guardian ad litem shall be party to the proceeding, and may subpoena, examine and cross-examine witnesses and testify. It is the responsibility of the guardian ad litem to insure that a full range of evidence concerning the best interests of respondent is presented in the proceeding. The guardian ad litem, whether appointed hereunder or under any other rule or statute, shall have no authority to consent to the hospitalization of respondent, to the administration of any particular treatment to respondent, or to any disposition of the petition other than dismissal. His or her duty is to respondent, and may include, where appropriate, petitioning the court for removal of counsel for respondent.

C. In appointing a guardian ad litem, the court should be cognizant of the fact that the interests of parents, spouses, or other close relatives may be in conflict with those of respondent. Thus, despite Rule 17, Rules of Civil Procedure, priority should *not* be given to such individuals in the appointment of a guardian ad litem.

APPENDIX B

QUESTIONNAIRE

(Please return questionnaire by April 16, 1997 and please do not put your name or any identifying information on this questionnaire or the return envelope)

A. YOUR INVOLVEMENT WITH COMMITMENT COURT

A1. Have you been subpoenaed by a [redacted] County Attorney in the last 12 months to testify in commitment court about a client who has a serious and persistent mental illness?

Yes No

If you responded NO please stop and return the questionnaire.

A2. Have you ever been subpoenaed to testify in commitment court about a client with whom you had a positive relationship with prior to the court hearing?

Yes No

If you responded NO please stop and return the questionnaire.

A3. In the last 12 months, how many times have you testified in commitment court?

A4. In the last 12 months, how many times was the client present in the courtroom during your testimony?

B. YOUR EXPERIENCE IN COMMITMENT COURT

Please respond to the following questions regarding only clients with whom you had a positive relationship prior to testifying in commitment court.

B1. Please describe any **positive** outcomes you have observed in the client-case manager relationship when testifying in commitment court about your client? (please be as specific as possible)

B2. Please describe any **negative** outcomes you have observed in the client-case manager relationship when testifying in commitment court about your client? (please be as specific as possible)

B3. What role, if any, do you think a case manager **should** have in commitment court proceedings? (please be as specific as possible)

C. GENERAL INFORMATION

C1. How many years have you worked with adults experiencing a serious and persistent mental illness?

C2. How long have you been a Rule 79 case manager for [redacted] County?

C3. What is your gender?
Female Male

C4. What is your age?

C5. What level of degree(s) to you hold? (circle all that apply)
BA MSW
BS Ph.D.
Other, please specify _____

C6. What discipline is your degree(s) in? (circle all that apply)
Nursing Social work
Psychology Sociology
Other, please specify _____

C7. Are you a licensed professional?
Yes No

** If you answer **yes**, what type of license(s) do you hold? _____

THANK YOU

APPENDIX C

Dear Case Manager:

You are invited to be part of a research study regarding your experience with the Probate Court system. You were selected because you have been providing Rule 79 case management in [redacted] County. All current case managers are being surveyed. **I ask you to read this form before agreeing to participate in this study**. This study is being conducted by me, Teresa Nordin, as part of my Masters Thesis in social work at Augsburg College. Also, I am currently a Rule 79 case manager for Case Management Services.

The purpose of the study is to explore the effects, if any, on the client - case manager relationship when the case manager testifies in Probate Court against a client.

If you agree to this study, I ask that you fill out the enclosed survey and mail back to me using the enclosed, self-addressed stamped envelope by **April 16 , 1997**. In ten days following this date, you will receive another survey as a reminder. If you have already completed the first survey or have chosen not to participate, disregard this reminder.

This study is **anonymous**. Please do not sign or print your name, or use any other identifying information on the survey or the return envelope. A portion of this survey requires written or typed responses. If you choose to write your responses, I will be unable to determine your identity since I do not have access to your written documents. However, if you are a case manager for Case Management Services, your writing may reveal your identification through recognition of your handwriting. Therefore, please type your responses. You may type your responses on a separate sheet of paper.

Participation in this study is completely **voluntary**. Your decision to participate will not affect your relationship with Augsburg College, [redacted] County or this researcher. This survey takes about twenty minutes to complete. You may end anytime or leave questions blank and still remain in the study.

There are no foreseeable risks or direct benefits to you. This project has been approved by the Augsburg College Institutional Review Board (#96-50-2) and [redacted], Director of Mental Health Services for [redacted] County. All data from this survey will be kept in a locked file and will only be viewed by myself and Dr. Sharon Patten, my Thesis Advisor. No published reports will include information that could identify you. All data regarding this research will be destroyed on or before January 1, 1998.

Your participation is important for the success of this research. If you would like to obtain the results of this study, or have any questions, at any time, please contact me at work: 291-1979 or Dr. Sharon Patten at work: 330-1723. Thank you for your help.

Teresa Nordin
MSW Student and Principal Investigator
IRB #96-50-2

APPENDIX D

AUGSBURG

C • O • L • L • E • G • E

March 24, 1997

TO: Teresa M. Nordin
1422 Asbury Street
St. Paul MN 55108

FROM: Rita R. Weisbrod, Ph.D.
Chair
Institutional Review Board
(612) 330-1227 or FAX (612) 330-1649

Your IRB application: "Civil Commitment Testimonies by Mental Health Case Managers"

Your application qualifies for expedited review under category 9. Hence, I have reviewed it with another member of the Institutional Review Board. I am please to report that your project is now approved with no conditions. However, we do have two suggestions regarding your project:

1. Your number of demographic identifiers (Questions C 1-7) seem to make it likely that a few individuals could be identified through them. In order to assure anonymity, we recommend you reduce these demographic items to 4, based on your main analysis categories. We note that you intend to pre-test the survey in [redacted] County and might want to reduce the number of such items after your pre-test.

In order to further protect anonymity of your respondents, I am returning your list of case managers to you since we do not need the list in our files.

2. At the top of your survey, you need to add some directions to the respondent. We suggest you repeat the direction: "Do not put your name or any identifying information on this survey or the return envelope." You might also add the return date/deadline.

Your IRB approval number is:

#96-50- 2.

This number should appear on all participant related material, such as cover letters or consent forms.

For the return of surveys, I have assigned you College Box # 411. Return envelopes should be addressed to you at this box number, Augsburg College, 2211 Riverside Avenue, Minneapolis MN 55454. Mail room hours are 9:30 a.m. to 4:30 p.m. Monday through Fridays. If needed, you may call the Mail Room regarding pick-up of surveys (330-1119).
If there are substantive changes to your application which change your procedures regarding the use of human subjects, you should report them to me by phone (612-330-1227) or in writing so that they may be reviewed for possible increased risk.

Good luck to you in your research project!

Copy: Sharon Patten, Thesis Adviser

APPENDIX E

[redacted]

Community Human Services Department

[redacted]

Financial TDD: (612) [redacted]
Services TDD: (612) [redacted]
General Info: (612) [redacted]

ebruary 5, 1997

o Augsburg IRB:

'his letter authorizes Teresa Nordin to conduct her research project
y providing a survey to the [redacted] County Case Managers. In talking
'ith Teresa it is our agreement that client confidentiality will be
aintained.

incerely,

[redacted]

[redacted] County Human Services