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Case Management

FRANK HOLLOWAY, ELIZABETH K. McLEAN and J. A. ROBERTSON

"This paper discusses the advantages and disadvantages of case management systems for the co-ordination of care of people with long-term mental illness living in the community. Many of the principles are equally applicable to other client groups with long-term needs, e.g. elderly people or people with learning difficulties. Some of the historical background to the emergence of case management concepts is discussed, culminating in the recent White Paper on Community Care. The underlying concept of case management is examined, together with a number of fundamental questions concerning who should act as case managers, what kinds of training they will require, problems of inter- and intra-agency co-operation, and the empirical evidence regarding its effectiveness. It is concluded that case management could be an important element in a comprehensive range of mental health services, but it is not a substitute for basic community provisions."

The summary quoted above is from an article by Shepherd (1990). The present authors were invited to comment on the study.

Frank Holloway

Case management is highly topical. Current British government policy identifies case management (CM) as a key co-ordinating mechanism across a range of community-care client groups (Her Majesty's Stationery Office, 1989), and a number of useful reviews are already available (Intagliata, 1982; Renshaw, 1988; Clifford & Craig, 1988; Kanter, 1989; Thornicroft, 1990). However, given the confusing and contradictory approaches adopted towards it in the literature (Bachrach, 1989), it is quite appropriate that Shepherd's review poses more questions than it answers.

The aims of CM systems have been succinctly defined as: "to enhance the continuity of care and its accessibility, accountability and efficiency" (Intagliata, 1982). Geoff Shepherd outlines the major components which are focused on the individual patient/client: (a) assessment of need; (b) development of a comprehensive service plan; (c) arrangement of service delivery; and (d) monitoring and assessment of services. These systems are intended to overcome the fragmentation of services, and to offer long-term, flexible support. In theory, the approach places emphasis on tailoring services to the needs of clients, rather than fitting clients into existing provision (Renshaw, 1988; Beardshaw & Towell, 1990).

Two contrasting models have been identified. Paraprofessional case managers may act as 'service brokers', responsible for but not necessarily providing the assessment and implementation of a package of care (Bachrach, 1989). Alternatively, in 'clinical case management', a highly skilled psychiatric professional is "directly concerned with all aspects of their patients' physical and social environment". The clinical case manager not only arranges access to appropriate services, but also provides a range of interventions, including intermittent psychotherapy, training in community living skills, psychoeducation of family and patient, and support during crises (Kanter, 1989). Ideally, clinical case managers should anticipate impending crises and take appropriate action: success in dealing effectively with relapses and other difficulties can then give both client and carers a sense of confidence and control over events (Harris & Bergman, 1987).

Shepherd stresses the importance to any CM system of the reliable and valid assessment of need, but the complexities inherent in the concept of need are not always acknowledged (Baldwin, 1986). The model developed by Brewin *et al* (1987) focuses too exclusively on symptoms, behavioural problems, and skills deficits to be wholly satisfactory. The 'illness' language of their model is neither understood nor accepted by many policy-makers and practitioners, particularly those from a social-work tradition. Approaches that emphasise the intrapsychic needs of patients, and the potential value of a CM service which sets out to meet these needs (Harris & Bergman, 1987), may not be adequately operationalised. Stein & Test (1980) articulated a pragmatic-needs model which underlay the initial Training in Community Living project and which has gone on to influence numerous CM services (Olfson, 1990). They identified factors they felt to be important in maintaining people with long-term disabling mental illnesses in the community. These included adequate material resources, the skills to cope with daily life, motivation

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to persevere in the fact of day-to-day problems, appropriately supportive relationships, a supportive local community, and an assertive service system. The model also explicitly acknowledges the importance of control of symptoms, and the role of in-patient psychiatric care. It has considerable credibility, and has evolved as the local service has developed (Stein *et al*, 1990).

Almost inevitably, CM requires multidisciplinary and multi-agency working; however, for this to be at all effective, shared principles and practices have to develop. The new community services that are replacing the psychiatric hospital frequently espouse the Social Role Valorisation 'philosophy' or one of its derivatives (Wolfensberger, 1972, 1983; O'Brien, 1987), and where such principles are incorporated, they have to be reconciled with more traditional, empirically based, approaches to need.

Both empirical evidence and the weight of professional opinion favour the 'clinical' model of CM over the service brokerage model, which tends to be espoused by planners and policy-makers. The latter model has been shown to result in increasing use (and costs) of services, without demonstrable improvements in the welfare of clients (Franklin *et al*, 1987). Skilled personnel who form a relationship with the client and facilitate other supportive relationships have been shown to have a positive effect on the outcome for frail elderly people, independent of the improved matching of resources to needs (Davies & Missiakoulis, 1988). Numerous studies of CM services have now been completed that derive from the community treatment approach developed by Stein & Test (1980), which in effect constituted a highly evolved form of clinical case management, and the outcomes have been generally favourable (Olfson, 1990). Assertive community treatment services can definitely decrease the use of in-patient treatment, particularly when focused on patients presenting for admission (Stein & Test, 1980; Hoult *et al*, 1983; Hoult & Reynolds, 1984; Mulder, 1985; Marks *et al*, 1988; Taube *et al*, 1990), compared with control conditions. When the focus is on out-patient populations who are felt to be at high risk of readmission, hospital days may also be reduced (Borland *et al*, 1989; Jerrell & Hu, 1989; Bush *et al*, 1990), although this has not been found in every centre (Bond *et al*, 1988). The effect of clinical case management on symptoms, social functioning, and overall costs is more variable (Olfson, 1990; Taube *et al*, 1990), although when it is measured, patient/client satisfaction does seem consistently to favour assertive CM.

Some tentative conclusions about the organisation of community support services for the mentally ill may tentatively be drawn (Holloway, 1991). Firstly, the service must be targeted towards a clearly defined client group whose needs are adequately understood and agreed by the participants in the service. This implies that the service goals and operational policy are clear and that the CM system works smoothly as a component of the overall local health and welfare system. Secondly, good-quality community psychiatric care requires teamwork (Test, 1979; Intagliata, 1982; Wooff & Goldberg, 1988); long-term continuity of care can only realistically be provided by a team. The existence of a team protects staff from the burden of sole responsibility, allows co-ordination of care from a group of relevant professionals, may improve the management of workloads, and may facilitate the establishment of common priorities. Thirdly, case managers must work effectively with colleagues from other services. It is unclear whether good professional relationships between staff across agencies will suffice, or whether budgetary control is required by the CM system (Kanter, 1989) and the role of the primary health care team in the supportive network has not been adequately explored (Kendrick, 1990). Fourthly, staff:client ratios must be realistic. Although caseloads of CM systems may vary from 4 to 50 clients (Intagliata, 1982; Kanter, 1989), intensive services adopting an assertive community treatment model have a typical ratio of 1:10 (Taube *et al*, 1990). Finally, and perhaps most fundamentally, the CM system itself must be well managed, with adequate attention being given to the selection, training, supervision, and professional and personal support of case managers.

Shepherd rightly emphasises that CM is no substitute for other community care provision, nor is it a magical solution to the fragmentation of the current health and welfare system. This is essentially a political rather than an organisational problem, which for its resolution requires existing agencies to give up some of their power (Rosenberger, 1990). British government community care policy places responsibility for the 'social' aspects of community care onto social services authorities (Her Majesty's Stationery Office, 1989). They are expected to set up case-management services which will have adherence to cash-limited local community care budgets as a primary task (Holloway, 1990). At the same time, health authorities, which retain responsibility for the 'health' components of community care, are to develop a 'care programme' approach to vulnerable patients. Conflicting priorities and ideologies, compounded by the studied absence of direction from the centre, make it unlikely that these initiatives will resolve the problem of the fragmentation of services.

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Attention has been drawn again recently (Lehman, 1989) to the need for a multidisciplinary continuous treatment team, which strives to fulfil the core CM functions within a defined catchment area – a concept developed in Britain in the 1960s (e.g. Freeman, 1963). However, if its promise is to be fulfilled, the treatment team concept needs to be adapted to local circumstances. A great deal more research is required to identify the elements of service intervention that are beneficial, exploring the functioning of services that are mature rather than experimental and the applicability of the model across client populations (Taube *et al*, 1990). Local services should be encouraged both to innovate and to evaluate systems of care that are derived from the basic model. We should look forward with interest to a research report from Dr Shepherd's Case Management Project.

Elizabeth K. McLean

I found this a very thoughtful and clear paper, blessedly free of idealistic fervour, and strong in three areas: it offered a brief and useful bibliography; it showed a real appreciation of the clinical realities and dilemmas which arise in the 'hands-on' support of long-term mentally ill people living in community settings; and it did not shrink from mentioning some of the often unmentionable difficulties that arise, such as suspicion and rivalry between caring agencies.

Shepherd discusses dilemmas already very familiar to those working in the field, but the dilemmas are far from resolved. Is the case manager a broker or a personal therapist? If a broker, what are her links with another person taking the role of therapist, and where does responsibility for decisions lie? Is the case manager's primary responsibility to her client, or has she a responsibility for the management, which in the current NHS/DSS climate can only mean rationing, of resources? What are the principal aims of the case management function? Some argue cogently that the maximisation of welfare benefits is of greater value to the client than other more traditional 'therapeutic' aims. Maximising the quality of life is a real and legitimate aim, but those who wish to do so should say how they are going to measure it. There is often an assumption that the avoidance of repeated hospital admission is an important aim, but should it be so for severely ill people, suffering from disorders whose natural history, even on maintenance medication, is one of repeated relapse? I feel that this should not be accepted as an overall aim, but that in selected cases, prompt and early admission in relapse should be married to detailed support during early discharge. This highlights the importance of setting and monitoring aims of intervention for each individual, which need to be regularly reviewed and should prudently give rise to outcome scores, so that a quotable measure of effectiveness is collected on a routine basis, as a weapon against future cuts in case management services.

The paper also highlights another hoary dilemma – is the case manager a clinician or a generic worker of relatively brief training? Clinicians usually have good links with the hospital service, which are vital at times of readmission and discharge, as well as tending to ensure that the case management team does pick up the most severely ill and disabled people. But clinicians are expensive and their skills tend to lie in assessment and active treatment; they are not always skilled in the support role. Many of the tasks which fall to an active case manager, such as acting as advocate on benefit and housing issues, staffing social support groups, or driving (for lack of any other driver) the minibus on a group outing, can be construed as a waste of a clinician's expensive postgraduate training. On the other hand, if case managers are generic workers with little professional background, will they be capable of advocating their client's view when it conflicts with a professional opinion? How will they maintain working links with the hospital services? How can they acquire the clinical knowledge to recognise early relapse?

Case management as a theoretical idea is often defined and discussed in terms of the role of an individual, but Shepherd emphasises the importance of team work, team leadership, and team support in delivering a case management package. He describes how the "drift up market" away from the most disabled clients towards "less demanding, more tractable customers" can best be combated when individual case managers are part of a high-morale team, where monitoring support and supervision are available from "experienced and high-status practitioners in the field". Such a structure lends itself to regular multidisciplinary discussion of client's aims and progress, in a way which stimulates innovation and combats burn-out. With such a team, if upmarket drift is to be avoided, there needs to be a working definition of the downmarket patients (McLean & Leibowitz, 1989); without such a definition, monitoring of a supposed drift is impossible. In exercising their mutual support role, teams need to recognise the reality of exhaustion. A well-functioning team should allow a case manager to say "I can't do any more for Bloggs", and arrange for another person to do their stint with a static or unresponsive client. A warm and mutually supportive

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emotional climate within the team is vital for the success of such transactions, but it will not persist without nurturing.

Where case managers are able to work in the same area for an extended period, burn-out and continuity are opposite faces of the same coin. But in my experience, genuine continuity of care, allowing a case manager to stay with a client for more than two years, is difficult to achieve because of the legitimate claims of career advancement and family life on the location of individual case managers. For all but the most senior professionals, promotion prospects, study leave, maternity leave, and the career moves of spouses demand dislocations at intervals which are often as close as two years. Such changes of case manager are not emphasised in clinical histories, but they may be of shattering import to the client, when the relationship established is a close one. Services which act as training centres have the additional dilemma of the conflict between training experience and continuity: undergraduate students may be attached to a team for 6–13 weeks, postgraduate students for 6–9 months. These time scales are the blinking of an eye in the 50 or more years of a psychotic life. Are students to be observers only? If we think that they 'need' genuine clinical responsibility, how is this need to be weighed against the patient's need for undisrupted continuity?

The practice of case management needs evaluation, and studies have been completed which show (not surprisingly) that it can both succeed and fail. Shepherd rightly draws attention to the mismatch between the time scales commonly feasible in an evaluation study, which are of the order of six months to two years, and the acknowledged very slow progress of patients in traditional hospital rehabilitation settings, where changes become apparent only over intervals of four to five years. It is not clear how this dilemma is to be resolved in the current climate of funding for research proposals.

Case management in community care is still an infant in Britain. Shepherd's paper gives us a good framework to think of its strengths and its needs. The next step must be to foster a quantitative approach to monitoring, so that arguments about effectiveness have something to bite on.

J. A. Robertson

The de-institutionalising of psychiatric services, now in progress throughout much of the developed world, has run into widespread difficulties which have done great harm to the underlying ideals and obscured the successes. As Shepherd observes, we all need to find a way to "glue services back together again", and he critically examines case management as one means of doing so.

It is interesting to note that the concept originated in the USA where, at least in some states, the move from the old institutions has gone so disastrously wrong, many patients being polarised between destitution on the one hand and new inferior institutions on the other. In this respect, a parallel exists with medical audit, i.e. a transatlantic imported solution to deal with an imported problem; in the case of audit, the need was to uphold clinical standards in the medical market place, in that of case management it was for re-integration of a 'mixed economy of care' which need not have been fragmented in the first place. Case management cannot now be seen in isolation from the legislative changes in the health and social services of which it is to be an essential element. While Shepherd rightly points out that it is not a panacea, it seems that the government is pushing it through as though it were just that.

Under the 'old' NHS, one could point to at least some districts where comprehensive non-institutional services were being satisfactorily developed. The essentials were adequate NHS facilities, including some for rehabilitation and continuing care; adequate resources deployed by the local authority, including some residential places; good peripatetic staff for supporting people at home; and some means of co-ordinating the system, enabling professionals to work constructively together. There was no clear formula for such co-ordination, but commitment to co-operation seemed more important than formal structures, and the quality of medical leadership could make or break the system.

My use of the past tense emphasises the wholesale change which is already upon us, if Department of Health circulars are to be taken literally: by April 1991, health authorities were required to implement a case management approach for any in-patient whom it is planned to treat 'in the community', and shortly to extend this to any patient contacting the psychiatric service. The future has already arrived.

This future looks very different from the scene we are used to. 'Purchasers' from both NHS district authorities and local authority social services will struggle to obtain services for their clients from a motley range of providers – NHS trusts, directly managed units, charities, housing associations, and the private sector. The government, having smiled on entrepreneurs in the care-home business for a decade, now seems set to make it very difficult for patients to obtain residential places outside hospital. On the other side of the fence, there are remorseless financial pressures on NHS managers to redefine

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anything apart from acute psychiatric treatment as lying outside the responsibilities of the health service. The risk of patients falling through gaps will be greatly increased. The existence of a case manager or someone similar does indeed seem essential to guide the client through the maze but, as Shepherd rightly points out, case management can never be a substitute for services themselves. He emphasises the need for an adequate 'infrastructure': apart from specific services for the mentally ill, such an infrastructure must comprise other essential elements of the welfare state, such as welfare benefits and adequate housing, which it is becoming harder to take for granted.

Case management has much to recommend it in the co-ordination of services for the 'high-uptake', long-term patient who needs a wide range of dispersed services, with the risk of duplication, confusion, or omission. It would be developed as an extension of the less formal 'key worker' principle that is already widely in use. However, its wholesale implementation as a radical new initiative raises numerous questions, some of which Shepherd considers in his article, but which Department of Health bureaucrats skate over. For instance, is it seriously intended to apply to all new patients contacting the service, including out-patients attending only for consultation, medication, or psychotherapy? This is what one circular implies, if taken literally. Can only case managers decide when their services are required, or can this be left to clinicians? Will patients want such intrusion and the multiplication of helpers? What are the implications for confidentiality? What, above all, are the manpower implications?

Shepherd's account, which is sceptical in the best sense, gives a very fair and balanced view of the issues, highlighting areas of potential conflict and difficulty. The distinction he makes between a 'managerial' and 'clinical' concept seems crucial, and managers and mental health professionals are likely to take sides accordingly. In practice, the decisive criterion is likely to be who pays the piper, and with lead responsibility and budgets going to local authorities, social services managers' conceptions of case management are likely to prevail. If they do, another range of questions needs to be answered. Will case managers be drawn from the ranks of generic field workers? If so, how will they be trained in the mental health skills they are widely perceived to lack? Many services are already troubled by lack of congruence between psychiatrists' conceptions of mental illness and social workers' of mental health; they are not simple opposites, but belong to different frames of reference. If case managers are indeed "to be able to influence both the medical and social aspects of people's problems", they must at least gain a thorough acquaintance with psychiatric language and concepts, and to respect, if not wholly to accept, the much derided 'medical model'.

The notorious split between health authorities and local social services was the most problematic feature of the old mental health scene. By artificially separating 'treatment' from 'care' and trying to locate the latter completely outside the health service, the new arrangements are likely to exacerbate the problem. Shepherd shows his awareness of this when he comments that the most important area for case managers, in terms of inter-agency co-operation, concerns the transition of patients in and out of hospital.

This process of transition between two spheres of responsibility is certainly important, but the processes of admission and discharge should not be allowed to assume exaggerated importance. The point of discharge to the community may be a momentous event for an 'old long-stay' patient, but those in a dispersed community-orientated service may need short admissions to a local unit from time to time, which need cause no more than minor disruption to the overall care programme and should be no more traumatic than, say, the transition between a hostel and sheltered housing. In achieving such a seamless service, the task confronting the mental health providers of the next decade will still be that of creating working teams or networks of professionals with different backgrounds, employers, and line managers. *Plus ça change* . . . ? If such networks are not in place, is there any chance of case managers succeeding? If they are working well, are case managers necessary?

A psychiatrist reading Shepherd's account or the official directives might be forgiven for feeling somewhat marginalised, if only because he has been accustomed to a more central role in what is, after all, his area of expertise . . . the management of mental illness. A visit to the psychiatrist by the client accompanied by the case manager "to ensure they are able to obtain whatever services they need" is made to sound little different from a visit to the social security office or housing department. Too many consultants have neglected their responsibilities to the long-term mentally ill, behaved arrogantly to other professionals, or allowed their clinical interests to drift 'up market'. On the other hand, the most significant advances in the care of this group have originated within the hospital-based psychiatric services. Such 'outreach' services have a considerably better track record than those provided by local social services. The service of Stein & Test in Madison, often quoted as a paradigm of the case

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management approach, started in this way and psychiatric involvement has been integral to it.

Case management introduces a new kind of professional responsibility, which will not replace but co-exist with the present responsibilities of doctors, social workers, and other professionals. It is at present unclear what legal authority will underpin this responsibility or how much *de facto* authority case managers will acquire through training, performance, or individual qualities. It is uncertain how they will be perceived by patients, already bewildered by a proliferation of helpers. Since the Mental Health Act leaves responsibility with doctors in the case of detained patients, the role of case management must be facilitating rather than compulsive. In the flight from the total institution with its one roof and one authority, we may end up with such diffusion of authority that nothing effective gets done, case management notwithstanding.

I would take issue with the author's comments about the 'technical' problems of assessing the need for care, and its alleged conceptual and methodological complexity. While there may be problems about the development of reliable and valid instruments for research, the requirements for the actual delivery of care are often quite elementary. The difficult issues are those of professional politics and ethics – particularly achieving the proper balance between the risk of neglect in the name of liberty and the delivery of adequate care with over-controlling paternalism. Such dilemmas are unlikely to be solved by the methods of empirical science.

It would be unfortunate if case management were to be universally and uncritically imposed without the benefit of information from pilot schemes, a number of which are already in operation. The recently announced delay in wholesale implementation of the parts of the Health and Community Care Act relating to care in the community should give an opportunity for full evaluation of these schemes and for lessons to be learned.

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