Perspective: On The Abolishment Of The Case Manager

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Perspective

On The Abolishment Of The Case Manager

by Leonard I. Stein

The case manager solution adopted by most states to take responsibility for the community care of persons with severe and persistent mental illness is inadequate to carry out the complex tasks required to do the job. This inadequacy goes beyond the level of case manager education or type of case management. The problem is structural in nature and stems from the absence of a multidisciplinary approach and insufficient availability. In this essay I recommend a model that corrects for this problem and that specializes in subpopulations of the seriously mentally ill, based on difficulty to manage.

Case managers, as individuals, are hard-working, caring, and committed people. The recommendation to abolish the case manager is directed not at them but at a model of service that is inadequate for the needs of their clients and frustrates their best efforts to succeed. Given these managers’ experience with and commitment to working with persons with serious and persistent mental illness, they could contribute much of value to the new approach that I describe here.

The Problem

There is general agreement on the goal that persons with severe and persistent mental illness should receive the necessary services and supports to help them live stable lives of decent quality in their home communities. Many states are developing policies congruent with that goal, such as merging separate hospital and community funding streams into one and giving control of the funds to local authorities. The local authority is then responsible for planning, executing, and paying for the broad range of services and supports required to achieve this goal.

The problem in reaching this goal can be summarized as follows. First, to reallocate hospital dollars for community care, state hospitals must be downsized; more specifically, the number of bed days must be sufficiently decreased so that entire wards can be closed. Second, patients with long stays in state hospitals and those who tend to rotate regularly in and out of the hospital are difficult to stabilize in the community. There are still large numbers of persons with serious and persistent mental illness who experience frequent relapses and are readmitted to hospitals at a high rate. While in the community, between hospitalizations, their quality of life is poor, they live in isolation or have tenuous interpersonal relationships, they have little to do that they see as useful during the day, their health (both physical and psychiatric) is marginal, and they often experience their lives as meaningless and chaotic. Similarly, long-stay patients are difficult to place and sustain in the community and are living out their lives in institutions, separated from their families and denied the opportunity to be involved in fulfilling activities.

Third, the case manager model has not been effective in successfully helping this kind of patient to achieve a stable life in the

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community. Fourth, complicating the problem is the fragmented nonsystem of public mental health care that exists in the United States. The variety of community and hospital services are uncoordinated and noncollaborative, and no one is responsible to ensure that patients’ needs are met. These needs are many: housing, finances, socialization, mental and physical health treatment, and meaningful activities, to name just a few. Furthering the problem is the fact that many communities, if not most, do not have all of the needed services. Even when all services are available, a few patients get more than they need, many patients get less than they need, and some get nothing at all. A major problem with this nonsystem is that it is episode oriented rather than oriented toward providing continuous care. This nonsystem fails the patient and undermines the potential effectiveness of the professionals working in it.

**Required Services**

To enhance understanding of what kinds of services are required by persons with serious and persistent mental illness, I briefly review the nature of the disorder. Like most chronic diseases, serious and persistent mental illness has two phases: the out-of-control phase and the long-term impairment phase. The out-of-control phase is the psychosis characterized by delusions, hallucinations, disordered affect, and bizarre behavior. Fortunately, for most patients the psychotic phase is easily treated with medication; this phase frequently also requires the structure, support, and safety of the hospital. This phase is generally brought under control in a matter of days to a few weeks.

Long-term impairments continue after the psychosis is brought under control and are not affected by medication. They continue to interfere seriously with the patient’s ability to make an unaided, sustained adjustment to life in the community. These long-term impairments are characterized by a high vulnerability to stress (a small amount of stress can cause the patient extreme anxiety or regression into psychosis), difficulty with interpersonal relationships, marked dependency (many of these patients have been dependent on hospitals or family for long periods), deficiency in coping skills (such as the ability to shop in a supermarket, use public transportation, or budget money), and poor transfer of learning.

The latter problem is particularly significant. Even when hospital staff spend substantial time teaching patients the skills that they need, patients often do not use these skills after discharge. This is in part because they have difficulty generalizing what they have learned in the hospital setting to the new community setting. Perhaps even more importantly, many people with serious and persistent mental illness find that anything new is highly stressful. Therefore, they tend to avoid new situations and new experiences, even though they may have mastered the skills required to cope with them.

Because of these long-term impairments, persons with serious and persistent mental illness require continuous (time-unlimited) interventions that are directed toward a number of different areas that influence their quality of life and tenure in the community. These include psychiatric care, medical care, housing, finances, socialization needs, vocational and/or avocational needs, skills of daily living, help in getting along with significant others in the community (from family to landlord), and emergency services available twenty-four hours a day to help resolve the inevitable crises as they arise.

To ensure adequate continuous care, the following tasks are required: (1) fully evaluate the patient to determine needs; (2) develop a comprehensive treatment plan to address these needs; (3) provide most of the required services, brokering for some of them and taking the responsibility to provide those services where other providers cannot be found or are not doing the job well; (4) monitor the patient closely enough to change the treatment plan when needed; and (5) be able to intervene directly or cooperate with efforts at crisis stabilization whenever necessary. Accomplishing these tasks requires twenty-four-hour availability and expertise in several areas: clinical care,
rehabilitation, and providing practical help. Furthermore, the interrelatedness of these interventions and supports cannot be over-emphasized. They must be provided in a way that ensures that they are integrated with one another and are timed to be relevant to the patient’s current needs.

An Inadequate Remedy

In an attempt to compensate for the current fragmented system, states have introduced the case manager into that system. The role of the case manager is to ensure that the patient receives needed services and supports. Initially, the case manager process was conceptualized as a broker service, linking needed services with patients. As such, it was referred to as the “glue” of the system; however, for a large number of clients, the glue has not been sticking. To rectify this situation, the case manager concept has received much attention in the literature, and modifications and additions to its original linking function have been suggested. Despite attempts to improve the model, serious problems continue.

In large part, the case manager model is inadequate because it is based on faulty assumptions. The first assumption is that the variety of needed expertise and services are all present in the community and simply require linking to the client. The fact is, this is rarely the case. Further, the case manager model assumes that these services, once linked, will be provided in an integrated and collaborative manner within the current context of the patient’s needs. Again, this is rarely true. When it became clear that those assumptions were wrong, the case manager was expected to rectify the situation by at least providing some of the clinical services; however, case managers do not have the variety of skills required to fill in wherever needed. When it became obvious that some clients are so difficult to manage that a forty-to-one client-to-case-manager ratio was unworkable, the “intensive case management model” was developed. Here, there is a ten-to-one client-to-case-manager ratio, with the case managers carrying a beeper so that they can be notified of problems after hours and on weekends. However, being available by beeper cannot possibly substitute for night and weekend coverage, and further, being constantly available just leads to quicker burnout. When it was recognized that one person carrying a caseload leads to early burnout, the “team case management” model was developed, so that case managers could share the load. However, even a team of case managers lack the variety of expertise and availability to fill in wherever needed and to respond to crises as they arise. The result is underserved patients who suffer the consequences of an inadequate model.

The central point of this essay is that the tasks necessary to help persons with severe and persistent mental illness to live stable lives of decent quality are too complex to be successfully carried out by case managers. To accomplish these tasks requires more than a modification of the case manager role—it requires a new remedy.

A Suggested Remedy

The complex set of responsibilities given to case managers cannot be accomplished by one professional discipline. This can only be achieved by multidisciplinary continuous care teams that have the expertise, sufficient staff, and time of operation to carry them out. These teams should specialize in working with subpopulations of the seriously mentally ill, based on difficulty to treat, and should vary accordingly in composition and work schedules. Difficulty to treat should be based on behavioral characteristics such as willingness to come in for services, medication compliance, frequency of crises, and so forth. The teams that work with the most difficult-to-treat clients should include psychiatrists, psychologists, social workers, nurses, rehabilitation workers, and psychiatric technicians. The client-to-staff ratio should be no greater than ten to one, and the team should operate seven days a week.

At the other end of the spectrum, with stable clients, the team comprises a psychiatrist and several nurses, with a client-to-staff ratio of fifty to one, and a nine-to-five, Mon-
day through Friday work week. These teams need to be backed up by a well-functioning crisis resolution unit that operates around the clock and works cooperatively with the team.

In each continuous care team, team members cross-train one another so that all are at least somewhat familiar with the functions of their colleagues. For example, a psychiatric technician learns to recognize medication side effects so that he or she can call a client to the attention of a psychiatrist as soon as the side effects are perceived. Psychiatrists learn about agencies and will interact with the agency when the agency insists that they are only willing to talk to “the doctor.” These teams are not treatment, rehabilitation, or case management teams. They are best conceptualized as continuous care teams that are vehicles to provide for whatever service or practical need a patient requires. By being the provider of most of the services (it brokers for only a few), the continuous care team assures that the services are integrated and provided in the context of the client’s current needs, with all activities directed toward helping the client to live a stable life of decent quality in the community. A major focus of the team is also to help the client to gain the skills and confidence needed to move toward greater degrees of independence. This is best accomplished through relating to clients as participants in the process and creating an environment between team and client that facilitates the empowerment of clients. As clients gain self-reliance and confidence, they are gradually transferred to less-intensive continuous care teams. This allows both for efficient use of resources and for client growth toward independence.

An example. To give a clearer picture of how the continuous care teams operate, I describe a team that works with the most difficult clients in Dane County, Wisconsin. This program is a direct replication of the Training in Community Living program, also known as the Program of Assertive Community Treatment (PACT) model, which was first developed and researched in the early 1970s. Initially, there was resistance to accepting a model that required dramatic changes in how mental health professionals operated in outpatient settings; namely, to be available after usual working hours, to work with patients in vivo rather than from across a desk, and to be responsive to a wide variety of patients’ concerns (such as housing and finances) that were seen as outside the purview of the field. The model gained acceptance in the 1980s and is now widely used.

Clients in the Dane County program have a history of repeated hospitalizations; they often resist coming in regularly for services and thus require assertive outreach. They often are not compliant with medication regimens; this, too, requires a specialized approach. Most have not yet learned to identify the early signs of relapse, and thus when they first experience symptoms of the psychotic phase, they interpret them as coming from an external source and act on them as if they are real. Thus, they require frequent contact of sufficient intensity for staff to be able to learn when early symptoms appear so that timely intervention can be initiated. In addition, these clients tend to have frequent and sometimes severe crises, again requiring early intervention on the part of the continuous care team; help from the crisis resolution unit is often required. The continuous care team must provide a good deal of support and actively help clients to develop supportive folk networks. Finally, clients have significant deficits in coping skills and are not able to carry out all of the daily activity functions required to live stably in the community; thus, the continuous care team must provide much practical help.

The team operates two shifts a day, from 8:30 a.m. until 10:30 p.m., seven days a week; nighttime emergency backup is provided by the crisis resolution service. The team currently has fourteen full-time personnel, consisting of two social workers, a psychiatrist, a vocational specialist, three nurses, six psychiatric technicians, and a program secretary.

Much of the program is oriented toward providing help with the normal tasks of daily living, teaching clients coping skills where they will be using them, so that over time
they can accomplish these tasks on their own. Many of the interventions involve practical activities, such as helping a client to maintain an apartment, going shopping with the client for groceries, or teaching the client how to use a washing machine. Verbal interaction between staff and clients is important, but it is easier to form relationships when staff spend time helping clients to meet their concrete needs than it is when contact is restricted to talking in a therapist’s office. Two key parts of the program are assertive outreach (the team is mobile) and a strong practical help orientation that assures that problems are recognized early in their development, that patients’ needs are being met, and that patients do not drop out of treatment.

Medication is an important part of the treatment regimen, and having a psychiatrist as a member of the continuous care team ensures close monitoring of the client and thus accurate prescribing of medication type and dosage. In addition, having a psychiatrist as a team member allows the test of the team to learn about medication side effects and further enhances medication monitoring. The psychiatrist’s skill in group process also is used in helping the team work through negative feelings, which are inevitably generated when working with very difficult persons. Working through these feelings helps the team to maintain a positive and helpful attitude when working with these clients.

An important priority of the team is to work closely with other parts of the client’s support system. For example, many clients also have a welfare worker or receive visits from the Visiting Nurse Service. Sometimes, the waitress in the restaurant where the client eats every day is in a better position to help monitor the client and detect early signs of crisis than is the staff member who may see the client less often than every day. Employers and landlords are much more willing to be helpful when they receive support and assistance from the team staff. Finally, families are often an important and positive support in the client’s life; educating them about mental illness is useful. An evaluation of this program found that, as in other programs like it, patients were stabilized and hospitalization was dramatically decreased.7

### Finances

What about cost? As noted earlier, in most states the majority of the public mental health budget goes to institutional care, leaving a smaller percentage for community care. That distribution of funds has an historical origin dating back to the days when the institution was the primary locus of care. Unfortunately, continuation of that funding allocation inhibits the development of a comprehensive system of care in the community and thus forces the mental health system to inappropriately provide episode-oriented care. The case management model was developed to operate within those financial constraints. Its relative ineffectiveness with difficult-to-manage clients, however, results in continued high hospitalization rates, thus perpetuating inappropriate funding patterns and system fragmentation.

Continuous care teams with crisis resolution units to back them up will dramatically reduce hospital usage and allow for reallocation of hospital dollars to fund those teams. The net cost will be about the same.8 However, patient outcomes will be significantly better.9 Several states are now in the process of developing mechanisms so that hospital dollars can be reallocated to community care. This cannot be successfully done, however, unless community services are sufficiently effective to markedly reduce hospital use, thus allowing for reallocation of dollars. This will not happen unless the model is shifted from the case manager model to the continuous care team model. Dane County, Wisconsin, is an example of how a system can shift its primary locus of care from the hospital to the community. Over the past ten years Dane County has put in place the system partially described here and has been successful in more than reversing the traditional allocation of public mental health dollars. Rather than spending the usual two-thirds of its dollars on hospital
care, it is currently spending 80 percent on community care and 20 percent on hospital care. I do not necessarily suggest that this can be done quickly; however, if well planned, such a strategy can move forward and he accomplished within a decade.


9. Stein and Test, “Alternative to Mental Hospital Treatment.”

NOTES


7. Summary

Stabilizing clients in the midst of a psychotic episode in the hospital can be a difficult task that requires a multidisciplinary team. The task of helping those persons to live stable lives of decent quality after they leave the hospital is at least as difficult, and much more complex. Thus, it is not surprising that the case management model, which is not multidisciplinary and is available only on weekdays, is inadequate to deliver well-integrated, constantly available services to difficult clients. The effect on clients is that few are receiving adequate rehabilitation, and many are unstable and frequently rehospitalized. The effect on the system is that a large portion of the mental health budget goes to hospital care, frustrating attempts to reallocate dollars to develop comprehensive services in the community.