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Case management, care management and care programming

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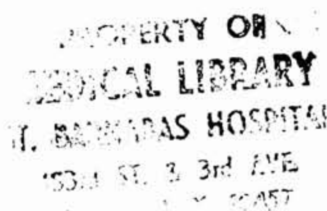

Leona Bachrach has highlighted the semantic problems surrounding case management in the USA, even suggesting that the term might have lost any real value (Bachrach, 1989). These concerns are now evident on this side of the Atlantic. In a recent editorial in the *British Medical Journal* (Marshall, 1995), Max Marshall dubbed case management "a dubious practice . . . underevaluated and ineffective, but now government policy", and one which had been "bedevilled by a tendency to lump two different approaches under one name". He may have increased, rather than reduced, that confusion by equating the care programme approach (CPA) with 'standard' case management, and calling what is frequently referred to as case management, or intensive case management in the American literature, "assertive community treatment". In an earlier *Lancet* editorial (1995), 'Care-management: a disastrous mistake', case- and care- are used interchangeably and the overlap between case management and the CPA emphasised.

Are these terms really that difficult to distinguish and is there anything to be achieved by doing so? Despite their complex, interdependent relationships over time, it is probably not that difficult to distinguish them and there is certainly value in doing so. This is, however, unlikely to be a once-and-for-all exercise. Case management and care management in the UK in 10 years' time will probably be very different to what they are now. As with many vigorous ideas, the meaning of case management has evolved rapidly as the context in which it operated has changed and understanding of its functioning developed. A willingness to understand this historical development (and tolerate inevitable future changes and ambiguities) is required if sense is to be made of the burgeoning literature in this field.

Case managers arose as a response to deinstitutionalisation in the USA, where their origins can be traced to 'systems agents' in the 1970s (Intagliata, 1982). Their aim was to "enhance the continuity of care and its accessibility, accountability and efficiency" for the discharged patient facing confusing and fragmented health and social services. The central components of case management that Intagliata identified are still recognised in most programmes – assessment of needs, planning comprehensive services, arranging delivery of services, monitoring and assessing those services, and evaluation and follow-up. The emphasis has, however, varied between services and over time.

Initially, the focus was on coordination of care and obtaining access to support and benefits. The case manager was an office-based administrator, often with no health or social service background. This model of case management, now usually referred to as 'brokerage case management' (Holloway *et al*, 1991), was soon recognised to be of limited value in the care of the seriously mentally ill. These doubts were confirmed by controlled studies (Curtis *et al*, 1992; Franklin *et al*, 1994), and case management services had already responded by shifting their emphasis to more direct care of patients. This approach, referred to as 'full support' or 'clinical case management', has become the dominant approach in the USA. Public law 99-660 requires all States to demonstrate substantial progress towards providing case management services to all severely mentally disabled adults (Solomon, 1992).

CLINICAL CASE MANAGEMENT

Clinical case management stresses the importance of small case-loads and a broad clinical remit. Although it has broader origins in the USA, the term is now often used interchangeably in the UK with 'assertive community treatment'. This, in its turn, evolved from 'training in community living' (Stein & Test, 1980) and is characterised by individualised treatments, programmatic flexibility, outreach, care of the most severely mentally ill, inter-agency cooperation and continuity of care. These assertive community treatment teams, usually employing a 'PACT' (Programme for Assertive Community Treatment) approach, have been described in detail and subjected to over 13 randomised controlled trials. These have generally demonstrated advantages over local standard care across a varying range of outcome measures (Burns & Santos, 1985; Solomon, 1992; Holloway *et al*, 1995).

Virtually all of the earlier studies found that the PACT approach reduced the need for in-patient care (increased 'community tenure'). The costs of the experimental services were partially or totally met by the in-patient reductions (Stein & Test, 1980; Hoult *et al*, 1983; Dincin *et al*, 1993), although the savings in some recent studies have been marginal (Knapp *et al*, 1994). Community tenure is loosely equated with avoidance of relapse, although its status as an outcome measure is questionable. Critics have commented that reduced hospitalisation in PACT services is more a process measure that they are working properly (Holloway *et al*, 1995).

There is little consistency, as yet, in choice of outcome indicators for such studies. Where clinical outcome is reported (Stein & Test, 1980; Hoult *et al*, 1983; Muijen *et al*, 1992) it has favoured the PACT approach. Patient or carer satisfaction, occupational functioning, social networks, compliance with treatment, and use of other services have all favoured the experimental condition when reported (Holloway *et al*, 1995; Burns & Santos, 1995). Some of the different outcomes may reflect varying rigour in applying the various components of the approach (Teague *et al*, 1995), or the degree to which PACT principles may have been adopted in the control service, as well as the nature of the health care system in which the PACT team operates (Burns & Priebe, 1996). However, few other mental health service innovations have been subject to such extensive and rigorous evaluation.

CARE MANAGEMENT

Care management is the term adopted by British social services to describe their approach to case management. It was introduced in April 1993 as a core element in the Care in the Community programme as outlined in the Department of Health and

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Social Services Inspectorate's (1991) guidelines. 'Care management' was preferred to 'case management' because 'case' was considered offensive to service users. The model adopted for care management is that of 'extended brokerage case management' – assessing needs and then 'purchasing' (i.e. brokering) appropriate packages of care. Some departments have designated care manager social workers as 'purchasers', in contrast to other staff (both within social services and contracting agencies) who are 'providers'. It is not a pure brokerage model as the care manager has appropriate professional training and inevitably is involved in some direct service provision. Individual departments vary their style of care management reflecting local professional and managerial cultures, but the defining characteristic remains a central brokerage function with a varying degree of budgetary control as recommended in *Caring for People* (Department of Health, 1990*a*).

Mental health professionals may have difficulty in understanding social services' choice of this model of case management in the face of the scientific evidence. It reflects, however, a widespread political policy of devolving budgetary decisions down to individual professionals. The stated purpose of this is to ensure greater responsiveness to patient or client need, but it is also clearly an effort at cost containment. The long-established and influential social work tradition of emphasising client choice is also of central relevance in this decision. It carries a recognition that the client's interests and those of the service can be at variance. The brokerage model, clearly advocated in the *Caring for People* policy guidance, is seen as affording the client protection in this situation:

> "Care Managers should, in effect, act as brokers for services across the statutory and independent sectors. They should not, therefore, be involved in direct service delivery; nor should they normally carry managerial responsibility for the services they arrange. This removes any possible conflict of interest . . ." (Department of Health, 1990*a*)

The evidence concerning outcomes in care management for the severely mentally ill is less extensive than for clinical case management, but probably more consistent. It is a costly approach with no obvious benefits for patients (Franklin *et al*, 1994; Marshall *et al*, 1995). Only time will tell whether it really is "a disastrous mistake" leading to ". . . an exodus of the most experienced and skilled social work practitioners . . ." as claimed in the *Lancet* editorial.

THE CARE PROGRAMME APPROACH

Health professionals may have doubts about the value of the care management approach adopted by social services as opposed to clinical case management when applied to the severely mentally ill. In their inevitable joint clinical involvement with patients, they could reduce confusion (both clinically and academically) by acknowledging the differing backgrounds and practices of the two models. As Marshall (1995) points out, however, the existence of the CPA makes this nigh on impossible.

The CPA owes its origins to the thinking behind case management. It was promulgated (Department of Health, 1990*b*) to promote targeting of resources on the severely mentally ill and to improve the coordination and continuity of their care. The central components are an assessment of needs and a planned programme of care recorded on the care plan, a date for regular review, and the nomination of a responsible keyworker. Using the CPA to coordinate the care of individuals with long-term and complex problems is a clinically coherent development of case management thinking. It generates little controversy apart from a difficulty in distinguishing keyworker from case manager.

Insisting that every patient of the mental health services should be included confuses the status of the CPA. Is it clinically-derived best practice for the severely mentally ill, or is it an administrative framework for recording specialist mental health practice? Baldly stated by Marshall, ". . . case management [*i.e. CPA*] in Britain is no longer just an intervention, but a government policy". Confusion about the status of the CPA is amplified by proposals to 'integrate' CPA and care management paperwork. This plays down their differences and emphasises their common features to make health and social care professionals equally comfortable with both procedures.

THE SEMANTIC CHALLENGE

None of these concepts is simple or static. That case management, care management and the CPA all have substantial areas of overlap does not mean that they are the same thing. Neither does the difficulty of finding absolute and incontrovertible definitions for them mean they are useless or lack any internal coherence. For such complex phenomena as human behaviours, definitions must be either contextual or else legalistically pedantic. Psychiatry is a discipline with one foot in the biological and one in the social sciences (where concepts can create and change social reality as well as define it). This requires us to embrace such linguistic complexities and resist the 'hard-sciences' temptation to dismiss them as just semantics.

All three processes have distinct identities which can be understood. For two of them there is adequate evidence to make informed decisions about their value. Clinical case management (at least that based on the PACT approach) has demonstrated important benefits for this patient group, although fading in later replications. Care management, on the other hand (from the perspective of evidence-based medicine), has little to recommend it and much against it. There are, however, other frames of reference for judging care management – for instance, its merits in affording choice and obtaining access to services for a profoundly disenfranchised group of citizens.

Clinicians need to take responsibility for clarifying the anomalous status of the CPA. Only when it is clear what it is can it be properly researched. Even then allowances may still have to be made, as its practice may have changed by the time the research is published. Mental health service researchers have to accept that not only can we not control the social framework in which services are delivered (and which powerfully affect their impact), but also that the very definitions of the terms used are not our sole prerogative. We need to embrace semantic complexity, acknowledge the evolving meanings of terms, and keep defining and working with them no matter how frustrating it is.

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