2. Case management: problems and possibilities

David Challis, Reader in Social Work and Social Care and Assistant Director, PSSRU, University of Kent, Canterbury

We are now in a period of changing structures, organisations and vocabularies. Hence, it is probably helpful to begin with a definition of terms. Care Management and Case Management are phrases which are currently assuming such currency that their meaning may be lost in a blur of positive value as has happened in recent years to words such as ‘community’ or ‘decentralisation’. Within the Griffiths report (1988) and the prior influential Report of the Audit Commission (1986) are two potentially distinct definitions of the organisational position of those who could be seen as care managers or case managers. The Audit Commission (1986) recommended (para. 174): ‘A single budget under the control of a single manager who will purchase from whichever public or private agency he sees fit the appropriate services for elderly people in the community’. It would be easy to understand this as that of a resource manager at a relatively high tier in an organisation rather than that of a case manager in the sense of being a key worker and close to the client. On the other hand Griffiths (1988) recommended (para. 6.6): ‘In cases where a significant level of resources are involved a "care manager" should be nominated from within the social service authority’s staff to oversee the assessment and reassessment function and manage the resulting action.’

To provide a distinction between care management and case management I take the definition of case management to be the
coordination of care through an identified responsible individual or key worker whose role is to ensure the performance of the core tasks of case management. Care management I take to be ‘the management of case management’. It is, therefore, more systemically focussed and at a higher tier in the organisation than concern with the coordination and organisation of care for individual clients.

Underlying the arguments of Griffiths and others is the proposition that effective long term care at home requires us to develop two elements of the care system. The first is an improvement in the content of the services provided so that they become more responsive, flexible and better adapted to the wishes and needs of those who receive them. The second is enhanced case management, better coordination and organisation of the services around the needs of individuals rather than constrained by the organisational perceptions of a series of separate service providers (Challis and Davies, 1986). Case management can be seen as the performance of a series of core tasks in long term care which are listed in Figure 1. These core tasks are case finding and screening, assessment, care planning and monitoring and review. It is in the failure to perform all or some of these core tasks in our service system that has led to much of the critique of community care in the past and can for example be seen in the Social Services Inspectorate’s critique of the adequacy of our home care services in the performance of assessment and monitoring (Boyd, 1989a; SSI, 1987).

If we examine the core tasks of case management as a model for long term care then it is apparent that, at least for the largest long term care client group, the elderly, interventions have not usually taken the form of such a long term care model, but on the contrary have been much closer to the short term care model in Figure 1. The usual approach has tended to be much more that of an initial assessment followed by the allocation or prescription of service but lacking provision of an overall care plan with little, if any, monitoring or review until such time as there are substantial changes in the circumstances of the person receiving the service. It will of course be familiar to those who experienced the development of social work practice during the 1970s that the short term care model in the diagram is not dissimilar to a representation of the task-centred or contract based model of social work (Reid and Shyne, 1969; Goldberg et al., 1985), and that the model of the core tasks of case management perhaps represents a previously missing element in our definitions of roles and tasks of social workers, namely a model for long term care.
As such it provides an explicit definition of the roles and tasks required for social work staff in the provision of help, support and guidance to people requiring continuing care at home.

The evidence of beneficial results from a case-management approach

Let us then examine the evidence of what benefits it may be possible to deliver using a case management approach. My colleagues and I have been involved in a number of experimental studies in different parts of the country, developing case management projects in the care of elderly people. The first of these was the Thanet Community Care project in Kent which commenced in the late 1970s. The organisational model of that scheme is not dissimilar to many of the features of a post Griffiths world of social care. The key features of this approach to home care for frail, elderly people are summarised in Figure 2. Essentially the service was targeted on frail, elderly people whose needs were sufficiently great to render them on the margin of institutional care, either a hospital bed or a place in a residential home. The social workers operating this project had smaller case loads than is usual, in the region of 30 cases per worker, and were more experienced than is commonly the case in work with elderly people. In order that the staff could have greater flexibility and capacity to respond to the needs of individuals they deployed a decentralised budget which could be spent upon a variety of services not normally available through the social services system and they were required to cost the overall packages of care which they organised taking account both of the cost of existing services such as home help and meals on wheels and also their additional expenditure. They were free to organise the most appropriate packages of care according to the needs of clients and carers within an overall constraint of two thirds of the cost of a place in a residential home. Expenditure beyond this level was permissible at management discretion. The staff also had to keep more systematic and structured records than is commonly the case. These formed the basis for accountability and monitoring of the scheme by management, and covered the assessed needs of clients, the activities of field workers and the costs of care. The approach is described in detail elsewhere (Challis and Davies 1985, 1986; Davies and Challis 1986).
The evidence of this study was that social workers responded positively to the greater flexibility and opportunity to provide care more in tune with the assessed needs of clients than is normally the case. Assessments become more wide-ranging and problem-focussed and were no longer concerned narrowly with service eligibility. It was found that a number of problems which frequently prove to be associated with breakdown of community care, such as severe stress on carers, risk of falling and confusional states, were much more effectively managed at home than is normally the case. The major outcomes of the study are shown in Figure 3 and, as can be seen, the approach reduced the need for institutionalisation of elderly people, improved the levels of satisfaction and well-being of elderly people and of their carers and achieved these at no greater cost than is normally expended in the care of such clients.

These positive findings, improved quality of care and satisfaction, were replicated in a larger study in an inner city area in the Gateshead community care scheme where even lower rates of admission to institutional care were observed. As before, the cost of these benefits was no greater than was spent in providing conventional services (Challis et al., 1988). The Gateshead study is particularly important since it indicates that this case management model is transferable to an area geographically and socially different from the original setting.

The approach has also been tested in a multi-disciplinary model to discharge frail, elderly people from long stay geriatric wards to their own homes with similar beneficial results. In this scheme in Darlington elderly people received extensive levels of home support, provided by multi-purpose care workers who spanned the role of home help, nursing aide, and paramedical aide. They were supervised by case managers who deployed an overall budget as in the earlier schemes. Improvements in the well-being of elderly people and lower levels of carer stress were observed for those receiving the service compared with patients in long stay hospital care and at no greater cost (Challis et al., 1989).

Thus, there is evidence from a variety of different settings that this form of case management approach can provide enhanced levels of community care with marked benefits for elderly people and their carers. The approach has been seen as an improved model of practice by social workers working in these schemes and has produced improvements in the quality of work and service offered to a much neglected client group. These findings of more effective and efficient
care are important and very positive. However, it would be erroneous to assume that such an approach to the development of case management provides us with a relatively painless answer to many of the organisational problems which we face. First it is necessary to consider possible organisational variations around the care management approach and secondly the factors which could impede the effective implementation of case management by social services departments.

Variations in the style and organisation of case management
The Kent and Gateshead models of case management which I have referred to were based upon a single key worker acting as case manager and performing all the core tasks of case management. That worker was located within a single agency, the social services department, employed by that agency and had a significant degree of resource control. Let us look at variations around this model.

A single worker versus several staff undertaking the care tasks
An alternative model could be one where the core tasks of case management are performed by several different staff. One example could be where some tasks are identified as more specialised or more technically demanding than others. Perhaps a specialised worker could perform the ‘complex’ tasks of assessment and care planning, but less professional staff would undertake the tasks of coordination and monitoring. Such a model has a superficial attractiveness to agencies experiencing severe difficulties with recruiting staff with the necessary qualifications and experience in that it appears an efficient way to deploy scarce employees. However the loss of continuity of contact with clients in such a model makes more likely the loss of feedback. An individual worker is less likely to learn through time of effects of the prescriptions of care which they organise. This could prohibit learning and reduce many of the benefits identified in the studies which I have mentioned earlier. It could also perpetuate a problem which has bedevilled British social care, evident in the differing job descriptions of social work assistants and social workers, which has tended to separate the meeting of practical needs from helping with emotional or psychological needs. Such a separation could again diminish the very benefits evident in the work mentioned
earlier, whose strengths lay in the integration of social work and social care.

**Single agency versus joint agency models**
The Kent and Gateshead models described earlier were single agency, social services department based models and limited by direct access only to the resources of the social services department. However, it is clear that effective long term care of elderly people requires health and social care inputs to be combined. Whereas an obvious advantage of the single agency model is the relatively low amount of organisational upheaval and management effort required to establish and maintain such a system, the disadvantage is in the lack of important health care staff inputs required to achieve the objectives effectively. For example, assessment is a key task for joint working. The Griffiths report may have helped us to resolve some of the difficulties of a joint service if only through its implicit separation of responsibility and therefore budgetary accountability for acute and chronic care between the national health service and social services (para 6.12). Thus potentially there is greater clarity of financial responsibility with more clearly demarcated areas of influence. A joint agency model such as that which operated in the Darlington project (Challis et al., 1989) indicates how a case management system, operated by the social services, can operate efficiently as part of a geriatric multi-disciplinary team through clarity of accountability.

**The integration within or separation from key agencies of the case manager**
The models I have described have integrated case managers within a key agency, namely the social services department. The evidence would suggest that this gives them a degree of organisational influence and authority in their immediate access to resources and the power of a statutory organisation. It is of course possible to conceive of a more transatlantic style of an independent case management agency such as in a service for younger physically disabled people (Pilling, 1988), for people with dementia run by Age Concern (Askham et al., 1987), or the study of the use of resource workers for families with disabled children (Glendenning, 1986). The advantage of separateness would appear to be that the case manager can be a more independent advocate on behalf of the client and is not trammelled by apparent conflicts of
responsibility. However, a weakness of this argument is that it does not resolve the problem of conflicts of interests which occur between an elderly person and their carers or between carers, nor does it recognise the fact that social workers have traditionally had to handle this form of conflict as part of their job and that the presence of such competing interests is not a new phenomenon.

Control over resources
The evidence of the case management services which I have described would indicate that control over resources has been a key factor in enabling case managers to respond more effectively to the individual needs of clients. In the absence of control of resources the case manager can merely make pleas to the providers of other services but has relatively little power in effecting the kinds of negotiation necessary to ensure services are sufficiently responsive to adequately meet clients’ needs. This is also clear from another study recently undertaken in Cheshire where case managers not only have the power to buy external resources but also transferred resources to the home care service on a purchase of service basis. This appears to have led to a degree of ‘demand induced sensitivity’ in the home care service to clients’ needs and preferences (Tyrell, 1989).

‘Administrative’ versus ‘complete’ case management
It is possible to define a rather limited form of case management, which I describe as ‘Administrative’ case management where service arrangement and coordination are seen as the central tasks. The other tasks of case management such as counselling, dealing with psychological stresses and tensions arising from caring or providing advice to families would be undertaken by other persons than the case manager. This would of course be compatible with the service dominated traditions of care for the elderly. On the other hand a ‘Complete’ model of case management would undertake all the core tasks including responding to psychological need. The great danger of the ‘Administrative’ model would appear to be how it fits perhaps too easily into existing structures and patterns, permitting an unnecessary and probably undesirable separation of responses to the practical needs of individuals from their psychological needs (Kubisa, 1990). Indeed one could characterise the difference between the
'Administrative' and the ‘Complete’ model of case management as that between service dominated and client centred approaches.

These then are dimensions by which we could see forms of case management developing and varying. If there is variance in the possible forms of the model itself, what problems might we observe in the implementation of case management?

Some problem areas

**The suitability of different personnel as case managers**

Examples exist of multi-disciplinary teams in psychiatry where the whole range of members of the team may act as key workers for individual patients. This could at first glance be seen as an argument for a wide range of personnel to act similarly as case managers. However given the continual flow of new cases into those teams it would be likely that the most effective core tasks of case management which such teams undertake, are those of assessment and care planning. The demand generated by new cases requiring assessment is such that monitoring and long term work with individual cases is at best a poor second in the priorities of members of staff. As such, the model is most effective as an acute or short term intervention rather than a long term model. It is in recognition of this that we are currently developing a case management service within such a multi-disciplinary psycho-geriatric team to provide long term care for demented elderly patients. The members of staff in this service, additional to existing personnel of the multi-disciplinary team, such as medical staff, nurses and psychologists, are two social workers, acting as case managers, who will be responsible for long term work referred by members of the teams. Another social worker is a normal member of the multi-disciplinary team, contributing to the more acute and short term work with which the rest of that team is concerned. Case management is here defined as a complementary activity to the key worker model in the multi-disciplinary team.

The American experience of case management projects would indicate that predominantly nurses and social workers have been those who act as case managers. In the United Kingdom setting, where following Griffiths the responsibility for long term care is to be given to social services, there would appear to be a strong case for social workers to act as the case managers. Indeed, as I have said earlier, the role of case management more closely provides an appropriate
description of the role of social work in long term care than many of the more soul-searching descriptions of the nature of social work which have been written since the Seebohm Report (Cmd 3703, 1968). One real problem of appointing staff who have been used to working in a service focussed way rather than trained in a client-centred approach is the danger of moving to what I described earlier as an ‘Administrative’ rather than a ‘Complete’ model of case management with the attendant dangers of partial responses and perhaps inadequate assessments that have plagued the provision of community care until now. Common sense is no necessary guarantor of competence in a field increasingly open to scrutiny.

Recruitment however is likely to be a problem given the age structure of the population and the similar problems found by health authorities in nurse recruitment. The case for considering more part time posts to bring trained and experienced women back into the workforce is likely to prove to be very powerful, and will require changing expectations of patterns of employment in social work.

**Organisational changes**

In the care of the elderly two groups will have to reconsider their roles most seriously within social services; these are social workers and home care organisers. One positive benefit which the discussion of the development of case management brings is a recognition of the confusion that has arisen over the rather unplanned gradual extension of the role of the home care organiser. The home care organiser is asked to be part budget manager, part personnel manager for a group of employees and part social worker assessing and responding to the needs of clients. This confusion means that embedded within the role of the home care organiser is the expectation of being in part a service manager and in part a case manager, which has ‘militated against a thorough and professional approach to case-management’ (Boyd, 1989b. p.19).

One response to this would be to recognise that there are two significant roles which have become conflated and confused and need to be separated: those of case manager and service manager. If such a clear distinction in staff deployment were to be developed from the existing posts of home care organisers, some with the desires, wishes and aptitude could move to becoming case managers, whilst a smaller number would be required to maintain the purely service management element of the work. For many home care organisers who derive
considerable satisfaction from work with clients this could be a very major personal career gain, while others more comfortable with service management could develop this role. For hard pressed senior managers it would serve to release posts to develop case management from within their current establishment.

The second group of personnel who may well be required to make major adjustments are social workers. The development of case management in long term care may press still further down the pathway towards client group modes of organisation and specialisation of work around the needs of types of client. Such a trend is not new and has been occurring over some years in a large number of social services departments. Indeed there is evidence that the truly generic caseload is a considerable rarity rather than an exception (Challis and Ferlie 1987, 1988). This nonetheless has major implications for training.

Middle managers are another group for whom there will be considerable effects arising from the development of case managers controlling budgets, having considerable autonomy and responsibility for the deployment of such budgets. Autonomy possessed by front line staff is hardly the norm in a local government structure based on administrative hierarchies. Methods of management and monitoring of work will have to focus more on whether staff have achieved identifiable targets in their work and less upon the precise adherence to procedures. This is a focus upon outcome rather than process. This will require the investment of time in new management orientation and information systems permitting those managers to monitor the workload and activity of members of staff in this more indirect way. Training may well be needed for managers in the way in which such information is interpreted and utilised. Information systems will need to provide data about who receives the service, how the staff respond to need and the costliness of packages of care provided. Some work has already been done in a number of authorities (see for example Challis and Chesterman, 1985) but technically a great deal remains to be done, although there are lessons to be gained from education (Vass, 1990).

**Availability and suitability of training**

It would be correct to ask to what extent any staff within social services, including qualified social workers, receive a suitable degree of training to work as effective case managers often crossing health
and social care boundaries to manage the problems of clients with long term care needs. An observation from recruiting staff to case management services is that an area of particular weakness is often a lack of what might be termed clinical knowledge or a client specific knowledge base held by social workers as well as a need for training in particular skills such as negotiation and budget management. As a consequence, those courses which still retain a considerable degree of specialist training may well find that they are no longer the post-Seebohm dinosaurs but may well have major contributions to offer in the future.

The costliness of a new service model
The evidence from the case management projects which I have referred to in this paper indicates that a case management focussed service can provide significant improvements in well-being for the most frail elderly people and their carers at no greater cost. This is obviously a very positive message, but we should not be seduced by this into thinking that the broader development of case management systems will necessarily simply involve the shift of resources from one mode of care to another and result in no greater long term cost. The reason for this is that the people cared for in these projects were those with very high levels of need for whom, in the absence of such a new service, the probability of entry to institutional care was high. In short, in the absence of community care, we should in any case expend considerable resources in their care and the opportunity for resource substitution is quite considerable. However, as we are all aware, the gap between the cost of institutional care and that of the normal maximum available amount of domiciliary care is high and for those people whose needs fall just below that institutional care population the amount currently spent may be relatively small. If we provide a case management service which invests more time in detailed and competent assessments it may well be the case that the unmet needs of apparently less dependent clients cause the average costs of care to rise in the long run. Thus the paradox may be that provision of better community care may prove to be more costly as a consequence of the unmet needs of the less dependent. It is unlikely that the savings which may arise from the non-provision of services to people with relatively low needs who receive them at the moment will be sufficient to offset these greater needs.
Levels of coordination
A final difficulty relates to the meaning of coordination itself. Underlying much of our debate and discussion about case management and the critique by the Audit Commission (1986) and Griffiths (1988) of the service system has been the need to improve coordination of services and the appropriateness of the care provided to an individual person. However, case management cannot be seen as a simple universal panacea, without consideration of the changes which will need to ripple across the whole care system. There are four levels at which coordination takes place where change will be needed for effective long term care. Case management readily pertains to only one of these. These four levels are the level of strategic and joint planning and inter-agency coordination, the level of inter-professional collaboration in multi-disciplinary teams, the coordination of care by an identified key worker around an individual client or case management, and the coordination of activities into fewer workers, the reduction of duplication by many hands-on carers by the amalgamation of the roles of say, a nursing auxiliary and a home help (Challis et al., 1989). A focus upon organisational change in the form of case management alone would be inappropriate as a response to the wide-ranging necessary changes.

Future developments
A positive view, perhaps an optimistic one, of the development of case management could be a move from a care system which is service dominated in a series of vertical hierarchies to one that is client focussed. But this will require recognising the range of levels at which change is needed, precise specification of the problems which have to be overcome, the investment of substantial managerial effort and commitment into an area conspicuous by its lack in comparison with services for children, provision of the resources required for staff, planning and training and a willingness to rethink thoroughly some longstanding habits, practices and modes of organisation. If organisational inertia, and comfortable redefinition of old practices into new language combine with inadequate resources, then case management may in five years time be seen as yet another one of those solutions which were unable to deliver the markedly significant changes in community care which we all recognise are required.
References


