

CASE MANAGEMENT – A PILLAR OF COMMUNITY PSYCHIATRY

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SUMMARY

This review is describing different models of case management, showing their similarities and differences with regards to the way they operate. Good relationship between patient and case manager, application of the biopsychosocial model, availability of psychosocial treatment methods and rehabilitation programs, and individual treatment plan are all important factors in case management's success. Large number of studies supports the application of case management in practice as effective treatment method in treating people with severe mental disorder, particularly those, who are less co-operative. Therefore, the implementation of case management into psychiatric practice should be supported.

Key words: case management - community psychiatry

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INTRODUCTION

Case management is a form of specialized psychiatric practice developed in those countries with developed community psychiatry in order to treat people with severe mental illness. Case management applies to people with long-term difficulties in recovery, in majority of cases, from psychotic disorders, such as schizophrenia, bipolar disorder and schizoaffective disorder. It includes working with patients in different community services and their homes, comprehensive assessment of patients' health and social needs, coordination of different services within the mental health system and those from the patient's own natural environment, placing the patient in the center of attention in order to help him achieve his or her own personal goals and find their own personal way of recovery (Ryan & Morgan 2004). Compared to traditional psychiatric focus on biological and psychological, case management is addressing the entire psychobiosocial needs of a person with mental illness with the aim to encourage recovery or adaptation to mental illness (Kanter 1989). Case management includes: assessment, treatment according to the treatment plan, coordination of treatments and services, when other services are used. Case management involves activities, which provide a link between treatment services and consumers/patients, and includes coordination of those activities with the aim of

optimal outcome (Oneyett 1992). The main support, the key person in case management system is the treatment coordinator - case manager. Treatment coordination is a process, where one person takes upon him/herself responsibility for long-term maintenance of supportive therapeutic relationship regardless of patient's location and number of other services involved in patient's treatment (Intagliata 1982). Case manager's function is to help the patient identify and ensure inner and outer resources required for independent living in the community (Rapp & Kisthardt 1991). Case manager should be involved in all aspects of patient's physical and social environment including housing, psychiatric treatment, healthcare needs, social benefits, transport, family and social environment (Kanter 1989).

Case manager can be a professional from various different fields associated with mental health, who is treating the patient using his/her professional skills and available treatment services to varying degrees, depending on patient's individual needs. Case manager treats the patient on the basis of an individual or team assessment and helps the patient use other services necessary for his/her recovery, depending on the patient's needs. The ratio between therapy and coordination will depend on patient's needs, his/her personal abilities to find and use services and on availability of different community service, and case manager's education. Case management has to

ensure continuity of care, individually adjusted to patient's needs. Nowadays, it is completely clear that case management is important for treatment of persons with psychotic disorders and that it reduces the need for hospitalizations. It has been shown to be beneficial for treatment of people with long-term difficulties and for treatment of younger people with first psychotic episode. Treatment of people with psychotic disorders requires different skills and knowledge, it is therefore necessary to involve multidisciplinary team in order to achieve the best results.

MODELS OF CASE MANAGEMENT

The case management model was first established in the United States between 1960 and 1970, parallel with the closure of large psychiatric facilities, when it was found that discharged patients have difficulties caring for their own needs, hesitated to seek psychiatric help, were poorly cooperative, had difficulties maintaining continuity of treatment and that community services required for treatment of people with psychotic disorders did not exist (Scott & Lehman 2001). In the UK case management was introduced somewhat later in order to solve the problem of fragmented and poorly coordinated services for people with psychotic disorders living in the community (Doh 1990). Case manager's role was changing in the UK, from "pure" coordinator, who did not treat patients, but only referred them to other services, to development of very intensive therapeutic relationship in the Assertive Outreach model. In order to better understand the role of case manager, here are outlined main characteristics of the most common models.

The common denominator of different case management models is greater continuity of care through frequent contacts with case manager and enabling use of various community services, which patient could not access him/herself so requiring case manager (Orwin et al. 1994). In *Brokerage Model* (Intagliata 1982) case manager identifies/assesses needs and refers the patient to different existing community services, providing for those needs, then continues to monitor and evaluate treatment outcome. So, the services patients require to improve their health exist in the community, but the patients have difficulties finding them and, therefore, require case manager's help. Case manager in Brokerage Model

will have many patients and little contact with them. On the other hand, in *Clinical Case Management* (Harris & Bergman 1988) case manager is actively involved in treatment provision and his/her role includes establishing rapport, assessment, planning, intervention in patient's environment, linking patient with resources in the community, work with families, maintenance and growth of social network, advocacy and networking with other professionals, direct work with patients, including psychotherapy or talk therapies, social skills training, psychoeducation, mental health monitoring and crisis intervention (Kanter 1989). This model demands from case manager various different skills and education, such as psychotherapy, social skills training, psychoeducation, in order to perform his/her role, which involves holistic treatment and coordination.

Assertive Community Treatment (ACT) was developed with the aim of treating poorly cooperative patients with frequent hospitalizations, and it stands for intensive treatment in the patient's home (Stein & Test 1980). It involves multidisciplinary team, most frequently including a nurse, occupational therapist, social worker, psychologist and psychiatrist, with the aim of performing all necessary treatments out of institution, in patient's natural environment, in his/her home or community, instead of doctor's surgery or hospital. The usual number of patients per case manager is 10. This model offers training in activities of daily living, symptom control, medication, therapeutic support, family education, 24-hour cover and possibility of unlimited treatment duration. The team has full responsibility for patients' treatment. In practice there are big differences in application of this model due to patient profile and environmental factors, but also, financial restrictions, difficulties of some clinicians to work in community setting and other factors (Hoult 1990). *Intensive Case Management* (Surles et al. 1992) was devised for patients poorly cooperative with treatment and frequent users of emergency departments/hospitals. This model involves small patient to staff ratio, outreach work and help in activities of daily living. The difference between assertive outreach and this model is its focus on individual work rather than team work, personal responsibility is greater and therefore, greater risk of burn out. *Personal Empowerment Model* (Modrcin et al. 1985, Rapp 1988) identifies a source of patient's power and focuses on

interests, abilities and competencies rather than deficits, weaknesses and difficulties. Patient is looked upon as a person who governs the helping process. It is believed that all patients can change and improve. Treatment goals are agreed upon by the patient, which is leading to increase in satisfaction with treatment services and avoidance of negative reactions because of referrals to services unacceptable to patients (Rapp & Wintersteen 1989). Relationship with case manager is crucial to achieving successful outcome. In *Rehabilitation Model* (Anthony et al. 1993) the stress is, as in the personal empowerment model, on patients' wishes rather than professionals', and on development of the entire rehabilitation plan based on assessment of patient's needs and goals. It is focused on disabilities aiming towards positive outcome. Case manager's goal is to encourage independence. There is also difference between individual and team case management with regards to responsibility for treatment of individual patients. The case manager working individually with the patient (Bachrach 1992) takes upon him/herself responsibility for all aspects of care. In the *Individual Case Management* an intensive relationship with a patient develops, with the risk of overdependence and burn out. In the *Team Case Management* - it is the team which fulfils patient's needs. The team involves large number of different professionals who bring together their view of the patient based on their own expertise, so that it is possible to see the patient from different perspectives and there are more professionals available (Clark & Fox 1993, Olsen et al. 1995). This approach enables team members to learn from each other.

In *Cluster Case Management* (Bachrach 1992, Harris & Bergman 1988) treatment is conducted in a group of patients at the same time. The advantage of this model is in group providing support, reducing isolation and improving social communication. Its disadvantage is that not all patients are suitable for group work (Bachrach, 1992). In the system of case management consumers themselves can join the treatment of other consumers as assistants. Case management assistant is a patient educated to help case manager, most frequently around assisting other patients to come to their appointments. Most important is that this model gives patients hope in recovery (Felton et al. 1995).

Effectiveness of case management has been confirmed in various studies (Issakidis et al. 1999, Burns et al. 2001, Burns et al. 1999, UK700 Group 1999, Mueser et al. 1998). Best researched is the effectiveness of the assertive model (Solomon 1992, Chamberlin & Rapp 1991, Bond et al. 1995, Mueser et al. 1998). Case management is significantly reducing number of hospital days and increasing quality of life (Solomon 1992, Chamberlin & Rapp 1991). Comparison between brokerage model, which requires little individual treatment engagement, with the assertive case management model, showed better results with the assertive model (Burns et al. 1999). At the same time the difference between brokerage model and „treatment as usual“ (without case management) was not so large, confirming that the case manager - patient relationship is very important for treatment success. Assertive model's success is associated with case manager - patient relationship, continuity of care, treatment adherence, good multidisciplinary team and team involvement of psychiatrist applying psychobiosocial model of disease and treatment. The efficacy of intensive case management as compared with standard treatment has been well proven (Holloway & Carson 1998, Aberg-Wistedt et al. 1995). Comparison between the assertive treatment of young people with psychotic disorders and standard care in the mental health center also showed an advantage of the assertive approach (Craig 2004). The difference between those two models was in intensity/frequency of contacts, which is more frequent in the assertive model, so that the patients in the assertive model had on average 13 visits in the first 3 months compared to 5 in the standard model (Craig 2004). Models, which offer frequent contacts with case manager give better results, pointing to great therapeutic importance of the quality of case manager/patient relationship.

WHO CAN BE CASE MANAGER?

No field or specific profession has been identified as the best for case manager's role (Krupa & Clark 1995). Case management is not a profession, but rather area of specialized practice within the profession (Fisher 1996). Therefore, various professionals working within mental health can be case managers. Commonly these are social workers, psychologists, nurses, occupational

therapists and rarely psychiatrists. They all require education for working as case managers. Psychiatrists are less frequently case managers because of their specific position in some countries of Europe, US and Australia, where they have a position of a consultant and leader of the multidisciplinary team performing rehabilitation and case management.

CHOICE OF PATIENTS FOR CASE MANAGEMENT

Patient's condition and cooperativeness are the most frequent guidelines for involving the patient in case management model. The more severe the patient's condition and weaker cooperation the more they are going to require individual approach and case management. Generally speaking, every patient who would need involvement of multidisciplinary team and different biopsychosocial methods for his/her improvement would be a good candidate for case management. Usually, they are patients who are frequently hospitalized and do not cooperate with treatment.

HOW MANY PATIENTS CAN CASE MANAGER HAVE?

The number of patients per case manager is determined by the intensity of care. The more contacts and outreach work is required the less patients can a case manager have. There are some general guidelines, 1:10 for intensive case management, 1:25 for standard case management for full time work. In the „Assertive Outreach Team“ model in the UK, for poorly cooperative patients, where treatment is mostly performed via outreach, it is recommended maximum 15 patients per case manager (Muijen et al. 1994, Muijen et al. 1992, Burns et al. 1999). When case manager has significantly more patients than recommended, research has shown occurrence of negative reactions among case managers, which can negatively affect patients (Samele & Murray 2001). Group work can reduce a need for individual approach and increase the number of patients per case manager. Countries which are now introducing community psychiatry services such as case management, have to develop their own standards.

WHAT CAN WE LEARN/TAKE OVER FROM THOSE MODELS IN CROATIA?

Case management is planned for treatment of persons with severe mental illness, mostly with psychotic disorders, who are poorly cooperative, more frequently hospitalized, and most often have greater difficulties in their social and occupational functioning. Case management model involves case manager performing treatment coordination on the basis of assessment of specific individual needs/difficulties of the patient using case management system. In order to choose effective and achievable model in countries, which have not got developed community psychiatry or are in the process of developing it, e.g. Croatia, there it will be necessary to apply significant modifications or integrate different models with respect to specific situation in the country or region, including appreciation of available services, experts, their skills and knowledge, and characteristics of the area. Therefore, it is necessary in every area to analyse the situation, find out about available community services, how to link the existing services and most importantly, how to encourage necessary changes in a gradual way. It is necessary to determine what can be done immediately, what can we do by ourselves, what will require help from others, and how to obtain it. Regardless of the model we will apply, it is necessary as soon as possible to form the case management services based on biopsychosocial model of illness, treatment coordinator - case manager, availability of different psychosocial treatments and community rehabilitation programs, and multidisciplinary team providing treatment.

In the first Community Rehabilitation Center in Croatia (Ivezić et al. 2009) we are using case management including elements of the Clinical Model, Empowerment and Rehabilitation models. It is important to mention that in the countries applying case management models for people with severe mental disorders, other psychiatric patients who do not require case management are cared for by general practitioners, private psychiatrists and other services. The two types of care are mostly separate (often public vs. private), with some overlapping such as 24-hour crisis intervention teams and acute hospital wards, which are public services covering all patients. Therefore this needs

to be taken into account when planning case management services in countries without developed community psychiatry.

CONCLUSION

Case management is the form of psychiatric practice developed in countries with developed community psychiatry suitable for poorly cooperative persons with psychotic disorders, frequent relapses and hospitalizations, as well as patients with first episode psychosis. Case manager is assisting the affected to be more actively involved in their treatment, use different treatment methods, services and treatment programs available in the community, with the aim of achieving their own goals leading to recovery from illness. In the countries without developed community psychiatry, among which is Croatia, a usual way of conducting outpatient care for people with psychotic disorders is a monthly psychiatrist's review, commonly involving review of clinical status and medication control. Psychotherapy and sociotherapy is available only to small number of patients. Most of the relapses are dealt with through medication increase or change and likely hospitalization. Apart from finding suitable pharmacotherapy, the aim of case management is, through forming good patient-therapist relationship, to assess the patient's needs according to psychobiosocial model of illness and treatment, to apply or ensure availability of other psychosocial/psychotherapeutic methods and rehabilitation programs on the basis of individual treatment plan, which will assist the patient to use other systems such as social security, employment services, consumer organisations and others. In case management model of care patient will learn to utilise many protective factors and to avoid risk factors in order to achieve recovery, allowing him/her to live and work satisfied in the community and achieve his/her personal goals. Case management's success depends upon the quality of case manager-patient relationship, availability of psychosocial methods of treatment and rehabilitation programs, and treatment planning based on individual assessment of psychobiosocial needs. Case management is the method used in psychiatry, which showed its effectiveness, especially with regard to assertive outreach models. This method significantly reduces the need for hospitalization and improves

treatment outcome, therefore, it should be available to persons with severe mental illness with respect to its indications.

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