CASE MANAGEMENT FOR PERSONS WITH CHRONIC MENTAL ILLNESS: IMPLEMENTING A NEW SYSTEM

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EXECUTIVE SUMMARY

Massachusetts' "Comprehensive Plan to Improve Services for Chronically Mentally Ill Persons" (Dukakis, 1985) proposed an innovative statewide case management system. By 1989, all Department of Mental Health catchment areas were expected to hire case managers to assist in the evaluation of clients and to help clients secure services. The proposed case management system represented a major step forward in the Department's community-based services and signalled its commitment to helping clients live productive lives outside of institutions.

This report evaluates the implementation of the new case management system, based on interviews with directors of DMH regions and areas. The report describes inter-area variation in the definition of the case manager's role and in case managers' relations with clinicians, hospitals and private service providers; in addition, it identifies the major problems arising during the first months of the implementation process, suggests some of the bases for these problems, and presents possible solutions.

***The meaning of "case management" is determined most importantly by the extent to which case managers function as service brokers or as counselors or clinicians. Although Massachusetts' new case management guidelines emphasized the service brokerage function, actual practices and preferences varied throughout the implementation period. Some areas used case managers to deliver more intensive services.

***Most directors accepted the value of the new record-keeping system, based on development of Individual Service Plans.

***Some directors viewed the paperwork required by the new record-keeping system as excessive.

***Many directors believed that annual planning meetings involving all relevant service providers and family members were not needed for all clients.

***Computerization of case management records could reduce some of the paperwork burden.

***For some long-term inpatients, available records and hospital clinicians may provide sufficient information for completion of case management records, without holding separate meetings.

***Clients differ in their need for regular supportive contact with a case manager. It continues to be a challenge to devise case management regulations that ensure a uniform level of attention to client needs while allowing sufficient flexibility in how those needs are addressed.

***Case managers may work individually or in teams, and may function as specialists or generalists. There are advantages and disadvantages to each approach.

***Different modes of organization may vary in their suitability for different areas, depending on the extent to which case managers are involved as members of hospital or CMHC-based teams, the gravity of clients' needs, and case managers' specific fields of expertise.

***Standards for caseload size must be evaluated in terms of the type of clients to be case managed and the way in which case management is organized.

***The caseload size standard should be viewed as an average for an area, rather than as a uniform requirement for every case manager.

***Relations between clinicians and case managers in the Department's catchment areas ranged from excellent to poor.

***The discrepancy between clinicians' educational credentials and those of case managers often was a source of problems. Systematic on-the-job training of case managers should improve their relations with clinicians. Much of this training should be delivered at the area or regional level, so that it can be tailored to the particular backgrounds of case managers and the current service configuration in that area.

***The expertise of accomplished DMH clinicians should be tapped regularly, perhaps in meetings to review current cases. In addition, outside speakers should be invited to review with case managers the important clinical issues case managers confront. However, the need to ensure a minimum common level of expertise requires that training options be distributed statewide and that training plans be reviewed by the central office.

***The extent of contact between case managers and clinicians was an important determinant of case managers' role performance: when contact was frequent, these inter-occupational relations tended to be positive.

***A variety of physical arrangements allowed frequent contact between clinicians and case managers. In some areas, case managers worked in the same building as a mental health service provider, or in hospitals or multi-service centers. Meetings were often the vehicle for ensuring case manager contact with clinicians.

***Establishing a clear division of labor appeared to be the most important means for reducing distrust and resentment between clinicians and case managers and for enhancing the use of their respective skills.

***In some areas, the division of responsibilities was determined by the clinicians so as to relieve them of more onerous tasks.

***In areas where clinicians were involved in attempting to meet a wide range of client needs before the adoption of the new case management system, the clinicians ofted tried to preserve this intense level of involvement, including performing some case management functions--at least with patients they considered desirable.

***The traditionally dominant role of clinicians is unlikely to change in some areas except as part of a gradual process of meshing more effectively the case management system with clinical work. More discussions are needed with clinicians about the value of case managers for their work.

***Special interoccupational groups regulated admission and/or discharge at some hospitals; the presence of case managers in these groups seemed to increase the acceptance of case managers by hospital staff.

***In those areas in which pressures were severe for decreasing the inpatient census, disagreements with case managers were likely. A common discharge policy is needed for hospital and case management directors in each region; this policy must be publicized to their respective staffs. It is important to stress to hospital clinicians the need to make case management available to inpatients prior to their discharge.

***In order to reduce caseload pressure without sacrificing service quality, one region did not expect case managers to hold annual ISP meetings for long-term inpatients who were not ready to begin the process of transition to community living. When clients were ready to leave the hospital, the region stressed the importance of ISP meetings and case manager involvement in order to identify needed services, even when those services may not have been readily available.

***The recent shift from an area-based to a functionally-based system of hospital organization has increased the demands on case managers. Special efforts should be made to introduce case managers to relevant staff in each functional unit and to ensure the efficient flow of communication between units. Hospital managers should assess the different challenges that each hospital unit presents for case managers.

***Private hospitals may require disproportionate DMH case management resources as a condition of accepting DMH clients.

***Many directors expected a positive effect of the new case management sytem on the delivery of mental health services through vendors: The new system required greater attention to coordinating services, ensured more uniformity between vendors and across areas, and allowed greater control by the DMH area office.

***Improved communication, regular contact and a clear division of labor are needed to ensure that private service providers still function effectively in the new system. In some areas, special efforts are needed to reorient vendors who had been delivering some case management services; in these areas, some accommodations to the preexisting system may be appropriate.

***Directors often reported that case managers were used to make up for the absence of particular services. The availability of services from other units within the Department or from from other agencies reduced pressure to expand the role of case managers or to increase their usage.

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INTRODUCTION

Interest in case management has grown in tandem with concern about the quality of community mental health programs. Case managers can bind together the components of fragmented service systems, support ex-patients struggling to manage on their own, succor those who eschew hospitals and traditional outpatient services. After years of trying to develop cost effective, community-based replacements for institutional care,[1] mental health agencies have found in case management the potential for a breakthrough.

Massachusetts' "Comprehensive Plan to Improve Services for Chronically Mentally Ill Persons" (Dukakis, 1985) laid the foundation for a statewide case management system in Massachusetts. Case management was to have a critical role in an improved community support system: "to identify the chronically mentally ill and allocate service resources effectively" (Murphy, 1987). New case management regulations were adopted officially on January 1, 1989, although the implementation process began much earlier; even after that date, implementation was still in progress in some of the Department's 24 service areas.

This report describes case management practices during the implementation period and identifies the key issues that have emerged as DMH regions and areas have responded to the Department's mandate for a new case management system. Three basic questions are addressed: (1) How has the case manager's role been defined, in practice, in different areas? (2) How have relations with clinicians, hospitals and private service providers influenced the case manager's role? (3) What problems have occurred during the implementation process and which practices have helped to resolve these problems?

POLICY IMPLEMENTATION AND ORGANIZATIONAL CHANGE

By April, 1987, the Governor's Special Message goals were translated by the Massachusetts Department of Mental Health into specific objectives for the case management system: to identify and engage persons with chronic mental illness in services; to maintain continuous contact with these persons; to allocate service resources based on individual client needs; to facilitate access to benefits and opportunities; to monitor the responsiveness, quality

and effectiveness of services to the chronically mentally ill; to provide information on individual needs and identify gaps in services for the purposes of program development and budgeting.

Departmental policy stipulated that case managers are to identify persons with chronic mental illness and allocate resources effectively to them--to create a system of care that is accessible and continuous. These broad goals have been complemented by specific stipulations about some aspects of the work of case managers: Case managers were to function as service brokers rather than as therapists, they were to chair regular service meetings to assess clients and make treatment decisions, they were to work out of the DMH area offices rather than in the offices of service vendors, they could be hired at the entry level with a high school degree and two years of related experience, and they were to maintain a caseload of 35. Other aspects of the case managers' work were left to the discretion of regions or areas: whether case managers worked in case management teams, whether particular types of adult cases were assigned to particular case managers (children's cases were to be managed separately in all regions).

In many DMH areas, the case management system created a new occupational role; in other areas, it shifted responsibility for an existing role from private vendors to the state or modified a preexisting case management role. The different effects of the new case management system on extant service arrangements in different areas meant that some area directors initially were enthusiastic about the new system, while others were disappointed.

> State operated [case management] allows greater administrative control, direct accountability, increased flexibility and advocacy. The leverage issue is a significant factor which is difficult if not impossible to duplicate in a provider operated program. In addition, experiences with mental retardation case managers demonstrates how valuable they are in identifying system gaps. Case managers are system catalysts and are instrumental in long-term planning activities. The potential conflict between agency allegiances versus system needs is greatly reduced. (Kokernak, 1986)

> Ironically . . . most of the continuity and accountability objectives delineated under Section A of the November, 1986 policy statement have been exceedingly well met under the existing arrangement....due to aftercare in small manageable sub-units of mental health clinics,

> closely integrated with other clinic services and organizational resources. The structure has been extremely efficient and cost effective. (Dragon, 1986)

In this process of intra- and inter-organizational change, the formal design of the case management system could neither describe nor anticipate all of the numerous interactions between agency staff, other service providers, clients and community members that would shape actual system operation. By describing the social processes involved in the implementation of the case management system, this report will help to generate accurate assessments of program operation, ensure that program operation is consistent with agency goals and, ultimately, help refine agency policies and practices.

DMH AREAS AND THE STUDY METHODOLOGY

The Massachusetts Department of Mental Health is organized into six regions; within five of these regions there are between three and six catchment areas. All of Region VI, corresponding to Metropolitan Boston and several contiguous communities, is considered to be one catchment area, but within this area services are delivered through four (formerly six) community mental health centers having geographically defined responsibilities.

The current administrative structure grew out of a legislative decision to create a separate Department of Mental Retardation out of the Department of Mental Health. This change, effective on July 1, 1988, reduced the Department's caseload and required numerous administrative changes. Forty catchment areas, grouped in five regions, were reduced to 24 areas, now in six regions. The merger of area administrative structures, and in some cases different service delivery approaches occurred concurrently with implementation of the new case management system, sometimes facilitating implementation and sometimes impeding it.

Within each area, mental health services are delivered through one or more of several different programs: hospitals (including private psychiatric, public psychiatric, and private general hospitals, although not every hospital type appears in each catchment area); residential care units; day/vocational programs; support services; and outpatient services. Some components of this system are both funded and administered by the state, some are funded by the state but administered by private organizations, and some are both privately funded and administered.

This report draws on interviews conducted between October 1988 and May 1989. During this period, I interviewed Department of Mental Health administrators in all six regions and most mental health service areas in the state. In addition to interviewing each regional director (except for Region III, where I interviewed the regional director of case management), I interviewed area directors in Region V, area directors of case management in Region IV, CMHC-based directors of case management in Region VI, and area directors and other area-level administrators in Region I. I conducted some of the area-level interviews in group sessions, but I interviewed individually all of the regional representatives.

The primary goals of this research were exploratory and descriptive: to describe the process of defining, in practice, the role of case managers and their relations with other service providers; to identify problems in the implementation process; to develop tentative explanations for these problems; to highlight methods used by particular areas to resolve these problems. Substantive areas of concern in the interviews were indicated in a semi-structured interview schedule (see appendix), but due to the study's exploratory nature, the variety of actors interviewed and the group nature of some interviews, I deviated frequently from this schedule. My focus during most of the project was on case management services for adults.

Personnel throughout Massachusetts' mental health system were actively engaged in implementing and responding to the new case management system while this study was in progress. Some of the resulting changes were the development and revision of a case management training manual, a reduction in the case management caseload standard, revision of the forms used by case managers for case assessment and planning, and registration of case managed clients in a new computer database to facilitate compliance with new Medicaid regulations. Because of these and other changes, descriptions of area case management activities based on interviews conducted early in my research may no longer have been accurate at the study's conclusion.

The descriptions of practices and attitudes contained in this report should be viewed as representative of the types of issues that have emerged in the implementation process, rather than as a comprehensive characterization of practices and attitudes in any particular area or at any particular time. Improved understanding of these fundamental issues and how they are interpreted by a range

of directors should help to enhance policy now and in the future.

The report is organized to present three different but interrelated perspectives on the case management system. First, the role of case managers is described; second, the relationships of case managers with other actors in the mental health service system is characterized; thirdly, some important features of the larger area environment are identified. Unique features of service history and implementation approach at the area level are highlighted in a separate section.

The interviewees are quoted at length throughout the report, to preserve the original quality of their insights into the case management system. An effort is made to present comments that capture the variation in case management practices and the diverse opinions about them and explanations for them. In view of the method used to select administrators for interviews and the exploratory nature of the interviews themselves, all conclusions from the study must be viewed as tentative. But the interviews did uncover many of the aspects of variation in case management practices and identified plausible explanations for this variation. It seems reasonable to view these data as providing some indicators of the effectiveness of the case management system's implementation and of the policy options that should be considered as the implementation process continues.

THE CASE MANAGER'S ROLE

Even while case managers are viewed increasingly as central to community-based mental health care, the role that case managers should play in mental health service delivery still is being debated throughout the nation and case management practices continue to vary. In some systems, case managers function as service brokers; in others, they deliver some clinical services directly. Case managers may work in teams or individually, they may be generalists or specialists; caseload sizes and training levels also vary between case management programs (Baker and Weiss, 1984; Goldstrom and Manderscheid, 1983; Harris and Bergman, 1988; Johnson and Rubin, 1983; Kanter, 1985, 1988; Levine and Fleming, 1987; Paradis, 1987).

Case Managers' Tasks

Interviewees reported variation along each of these and other dimensions as catchment areas that formerly had used disparate service approaches began the process of implementing the new case management system. Comments were made frequently about the extent to which case managers were involved in clinical services and client assessment, as well as about case managers' clients.

Mode of Service Provision: Direct or Brokered

The Department's new case management system mandated an emphasis on service brokering, but prior to the new case management regulations, some of the DMH areas that provided case management services used a clinically oriented approach in which direct services were provided by the same person(s) responsible for making service connections. Other areas had used case managers as service brokers for years, while some areas had had no case management system. As a result, the system-wide redefinition of the case management role produced, initially, a mix of practices.[2]

Several directors[3] described the service brokerage activities of their region's case managers:

> Case managers are responsible to work with generic agencies external to DMH, help with housing, SSI [Supplemental Security Income], health care. The case managers usually work with people who are not linked with a residential service, since the residence would handle its patients' needs. The case managers advocate on clients' behalf to other agencies and within DMH. They make sure the services called for are actually delivered.

> The thrust is to implement the DMH model: Case managers work on assessment, linking, planning, monitoring, advocacy, but not crisis management (they get clients to a crisis team) or counseling.
>
> All Special Message case managers are at area offices, functioning as full time generic case managers/brokers. Case managers go to hospitals for case planning, ISPs [Individual Service Plans], monthly meetings; case managers do more assessment, planning, linkage and followup than crisis management and counseling.

Other directors emphasized the direct support activities in which case managers often engage.[4]

> Case managers say the most important part of their role is developing interpersonal relations: handholding, education of clients about their illness/meds, etc.; interpret for the client what DMH does. They're much more intensely involved with clients and their families than "service coordinators" would be. Case managers hang out with clients at McDonald's, social clubs, etc.--wherever the clients are; they go shopping with them, etc. This is important in keeping clients in the community.
>
> Case managers do supportive counseling, not traditional therapy; they need to have a clinical sense about what the client needs.
>
> Case management is very much hands on. It is coordination, but also direct care--sitting with clients in agency offices, giving patients a prescription from a doctor. Paperwork takes at least one quarter of the case manager's time.

Concern with the extent to which Departmental policy requires case managers to be service brokers rather than direct service providers was the most frequently discussed case management issue across regions and areas. As the above quotes indicate, some areas restricted case management activities largely to brokering services, while others expected case managers to spend a significant amount of time providing direct support to clients.

Some directors explained the inter-area variation as a consequence of insufficient Departmental clarification of the role case managers were expected to perform:

> The Department needs to specify the difference between the case manager role and that of hospital

> social workers. There's no clear central office policy about the role of case managers and differences between them and others.
>
> There are still differences here about the agency mandate for case management and what it should be: direct service/program oriented or paper processing/coordinating function. It seems that the agency is asking for both. This is not doable, with the available resources.
>
> The case management role has no clear meaning; they should come up with a new title. "Case manager" is like having a sign on your back saying, "kick me."

But most directors interpreted the agency's new case management policy as requiring adoption of a service brokerage model:

> The mandate is clear. Understanding what case management should be is not an issue in the areas.
>
> Currently, the broker/oversight role is critical; clients need a case manager to manipulate the system for them. It's better for management purposes. The whole system of care is the key--- case management is the glue.

In some areas, directors encountered resistance to restricting case managers' work to brokering services, even though they understood this to be the Department's intent. Some directors concluded that a strict service broker definition of the case manager role was neither feasible nor appropriate.

> [Our] case managers don't accept a service broker role; it's not realistic for working with the chronically mentally ill. Case managers would like input into the description of their duties. They're very vocal.
>
> "It" [the state model] can get done here, but it is a challenge--it's the wrong ideology, the wrong direction of movement.
>
> The broker model could decrease face-to-face contact with clients, so therefore we still set 50-60% face-to-face contact; it's not a desk job.
>
> Case managers are spending 30-40 percent or more of their time with their clients--taking clients to interviews, one-to-one counseling, and help

> with referrals--but not all the paperwork is being done. Case managers would want to be 100 percent client contact; now I'm pushing for more paperwork, but it's not going over. In a way, case management requires Master's skills and knowledge, but after they gain experience, much of their time is not spent on professional activities. But it is a professional job: case managers have to deal with other professionals, and if you don't have professional knowledge, they [other professionals] won't talk to you.
>
> Case managers need to be able to do direct service in order to be satisfied, to feel they're having an impact. Paperwork is a distraction to them; it needs to be flexible.

The western region of the state, Region I, had operated under a consent degree for about ten years. As a result, it's system of community care was unique. Service Coordinators served as case managers, but they were required to have MSWs and were expected to provide clinical services to clients. Many directors sought to preserve this system.

> The Service Coordinator [in Region I] is defined as having a more professional function than the [new] case managers; they would see being labelled a "case manager" as a demotion. Service Coordinators have a range of activities focused on the ISP. Service Coordinators are assigned 24 hours after hospitalization (after prescreening) to be an agent for people requiring services. It is assumed that clients can benefit from advocacy for services and that they need the sense of continuity provided by Service Coordinators being there over time, as other staff come and go and client needs change.
>
> The case manager definition: more tracking, more paperwork, less clinical intervention; it fractionalizes the role, removes the sense of empowerment. In the short run, we will retain the current Service Coordinators, but in the long run the state will set the job standards. The Department of Personnal Administration regulations imply that hospital assistants can use case management as a career.

Variation in case managers' involvement in direct service to clients was widespread. Additional efforts to clarify the level of service involvement envisioned in Departmental policy should reduce some of this variation, but many directors simply did not agree with the service

broker role that they understood the Department to have adopted. This disagreement was explained variously as due to the needs of clients, the biases of other mental health professionals, and the intrinsic rewards of direct service work for case managers themselves. Later sections explore these explanations more thoroughly.

Assessment

One of the case management system's goals was to improve the assessment and tracking of clients. This is done through completion of a Comprehensive Assessment Plan when clients enter case management and an Individual Service Plan (ISP) for recording the services to which clients are referred. Service vendors were also expected to develop Program Specific Treatment Plans (PSTP) for DMH clients. Many directors reported that this aspect of the new case management system had had a positive effect.

> The nicest thing about an ISP is that all needs are covered in one report. We're reviewing the individual treatment plans to determine their overlap with the ISPs. The changes have improved the ISP process significantly. PSTPs have been in place for some time. PSTPs tend to be used somewhat differently. Case managers must keep on them, must document that they are in place. The real importance with which PSTPs are viewed, the attention given to them varies with areas and programs. It's simply a question of the value attached to the PSTP. Some areas have greater recognition of the value of the PSTP. Managers should pay attention to detail (this is what the PSTP involves), but there is no hard data on the impact of the use of the PSTP on service delivery. There is no clear variation in the use of ISPs.

In order for assessment to be useful on an ongoing basis, periodic reassessment may be necessary:

> The mentally ill are much less predictable in terms of planning and the need for reassessment than mentally retarded persons, who stay the same. Therefore, formal modification of plans is often required, for example, if someone can't live in a group situation.

But in some areas where assessments already were being made by vendors, the new case management assessment and planning forms were not viewed as necessary.

> Initially, we inspected the directives and developed necessary tools: resources, referral

> forms, charts. Prior to the case management system there were no records or plans recorded. The CMHC prepares a treatment plan and so do the vendors. ISP meetings would be redundant, so we try to integrate this with other meetings, when there are other personnel in attendance (but we don't try to involve family members). We only do ISPs for case managed clients, except for the medically ill/mentally ill.
>
> Some of the clinicians complete ISPs, some don't. We do complete ISPs for children. Only the case manager who is working with inpatients is doing ISPs. Our case manager is doing ISPs for 30 clients per year (the caseload limit); not more than that. It would be a real burden to do more.
>
> It's not feasible to do an ISP on all kids in residential treatment (state facilities), with the [limited] number of staff, and kids in contracted programs already have individual treatment plans: each vendor has their own format; these plans address clinical needs, but not all needs. Kids' needs are being met, but this is not documented since it's not in one report.

Some directors simply disagreed with the need for developing Individual Service Plans for all of their clients.

> ISPs are very time consuming; they should be used for those in the hospital, or in serious danger, or those who are receiving services from multiple agencies. ISPs are overkill for the great majority of clients; a waste of time. ISPs are needed more if services are dispersed between providers.

But other directors modified requirements for the assessment process to reduce some of the objections to it.

> ISP meetings are attended by clinicians, family members and the client and his or her case manager. Now, to streamline the process, there will be less people at the meetings. It's not possible to have all of these people attend meetings when case managers have 25 clients; it takes too much time, when the case managers spend so much time in the community.
>
> ISPs are completed only for community-based clients. The focus of inpatient clinicians is so

insular that it is hard to see them attending ISP meetings in the community.

In some areas, vendors were not completing the PSTPs required by current Department regulations.

ISPs are not resulting in PSTPs; many hospital clients don't have PSTPs. Without a PSTP, the ISP is less useful.

The Department's new record-keeping policies were based on the recognition that comprehensive records are necessary for maintaining effective, ongoing case management of agency clients. Persons with chronic mental illness are likely to be in contact with multiple service providers and different agency staff; family members, friends and other persons are likely also to play important roles during the course of the client's illness. If these multiple actors are not involved in the assessment and planning process, many opportunities for helping clients to manage in the community will be lost.

Yet limited available staff time and limited funds for the assessment and planning process inevitably impose constraints. Computerization of the Department's records could remove some of the burden imposed on case managers by the record-keeping policies but will not reduce the effort required to involve other persons in the process. Serious consideration should be given to the suggestion by some directors that available records can be exploited to yield adequate case management information, without conducting the planning meetings envisioned in the ISP process. It may be possible to rely more on clinicians employed in agency facilities to produce the necessary records for long-term inpatients. When clinicians and vendors understand clearly the Department's record-keeping requirements and are assured that these requirements do not duplicate current record-keeping, they may accept these requirements more readily.

Case Managers' Clients

Inpatient psychiatric care brings all services required to the client (or arranges for transportation of clients to additional services). Community-based psychiatric care requires instead, in most cases, that the client go to or otherwise seek out the services. While inpatient status presumes adoption of a "patient" identity, community-based service delivery lacks this coercive element: service providers must negotiate a self-definition with the potential client; if the client rejects the label of outpatient or DMH client, community-based services cannot be provided.

Regional and area directors interviewed in 1988-89 often cited the attitudinal and behavioral correlates of chronic mental illness when explaining their case management practices.[5] Many directors believed that the type of difficulties their clients experienced required that case managers provide some direct services in addition to service brokerage. In some cases, this belief extended to all chronically mentally ill clients--the entire DMH caseload.

> Brokering? This is an important part of what case managers do, but due to our severely impaired population, case managers must also make sure [basic] needs are met: food, clothes, medicine, quality of life. A case manager may get involved in working with a family...or change family patterns, or engage the family as a support system. This is much more than brokering.

In one area, case managers were assigned the most needy clients.

> Case managers receive the worst clients in the system--clinicians use case management to get rid of the worst clients. The team meetings about discharge are realistic about who needs case management the most--clients that have multiple needs, who need the most help.

Some directors found that some of their clients required more intense case manager involvement, while other clients could adequately be served by case managers who functioned strictly as service brokers.

> There's a big spectrum with clients concerning how much case manager involvement is needed, how independent they are. Some clients--from day-to-day, we help them get through the week.... Case managers tend to get the most difficult clients (for example, clients who have been expelled regularly from inpatient units), so a caseload above 25 is not possible.
>
> The case managers inevitably end up doing more direct service work with clients who need more intensive work; the case manager has to be far more flexible than in the formal description.
>
> We need to distinguish very serious cases, and have case managers who are more than service coordinators. They have to talk to clients more, deal with them until something meaningful happens; work with them, their families, etc. and be

> available so the client can reach you anytime they need you.
>
> The service coordinator may end up being the person who can provide therapy to a client, when she or he resists other services. Service coordinators have carried many cases, for years, with the ultimate intent of moving them out. It has been "incredibly successful." For example, one case had from 25-30 hospital admissions per year and was arrested constantly; this has now been reduced to zero. The client receives outpatient services in the community. This is due to a tight working relationship between case management and emergency services.
>
> The Department needs to be honest: some clients will be carried by case managers, due to their lack of readiness for other services even when other providers are available; therefore case managers need clinical expertise.

The severity of a client's illness did not alone predict whether a more intensive service approach would be of benefit; some clients sought to avoid therapy.

> Case managers provide supportive services to clients when desired, but many case managed clients do not want intensive therapy; support services are reality-based--and therefore better than a clinician and therapy.
>
> Post discharge, some clients will only accept case management, but others require an outpatient therapist, a residential program, a day program. Case managers see that all the pieces are not fragmented.

One segment of the caseload, children, are viewed explicitly in Departmental policy as requiring more intensive efforts and hence a lower caseload. Two area directors explained why this policy was needed:

> Kids' caseloads are very complicated: service bureaucracies, court issues; they need a lower caseload.
>
> There is a steady caseload of children. A large part of the work is getting kids admitted to DMH facilities and getting them into various programs; and dealing with other agencies (often these are cases DSS can't handle, although DMH never has custody itself). But it's more cyclical than

> adults--a lot of kids get better. If a kid is hospitalized, there's a case manager and clinician meeting at admission and after 30 days, then at least once per month. The kids' case managers are trying to complete the ISPs while they're in other meetings about the kids [rather than in special meetings]. Handling emergency placements for kids takes much time--have to negotiate for beds, etc. Often it takes an entire day. It's a major time consumer; you can find yourself doing more reacting to it. It's very stressful; sometimes there's not much relief.

The Department's case management policy recognizes that the wide range of psychiatric maladies and individual personalities and lifestyles among the Department's caseload preclude routinization of the relations between case managers and clients. Some clients, and many clients at some times, require more than a brief contact with a case manager if they are to remain in the community. But while case managers are expected to provide more direct support to some clients, it continues to be a challenge to devise case management regulations that ensure a uniform level of attention to client needs while allowing sufficient flexibility in how those needs are addressed. The next section identifies some of the relevant organizational issues.

The Organization of Case Management

Areas across Massachusetts varied in their use of an individual or teamwork model of case management and in the size and specialization of their caseloads; and strategies for organizing case management at the area level were continuing to evolve.

Individuals/Teams, Specialists/Generalists

> Initially [years before the new case management system], [the area] had a team consisting of a qualified clinician, who made the assessment, an individual program plan writer (social work type) who wrote the plan, and a case manager who picked up the case after the plan and assessment. But there was no one who saw the whole picture, had a sense of the entire process. We decided that the service coordinator had to have whole responsibility in the case; otherwise, each individual only had limited accountability and responsibility (the "assessor" never saw the client again).

> To hire Case Manager I's would be a terrible error; it would never succeed.[6] But the case manager team composition can vary as long as there are some experts.
>
> Our case manager takes on cases when they are in a crisis, then shifts them to others. He's sort of a resource person so far.
>
> Crisis intervention and case management work closely together; there's much coordination regarding hospital bed priorities (to complete a client's stabilization, the case manager controls beds for respite). If the state were to convert another service [to state control, in addition to case management], crisis intervention would be it. If conversion doesn't go through, two separate providers would be involved [for crisis intervention and case management]. It would be a major problem that would derail the system.

Caseload Size

Caseload size varied markedly between areas. Several directors suggested that this variation influenced case managers' role performance.

> The caseload should be 25, since clients have very intense needs and expect response on demand. Service Coordinators do not provide direct case management, as in the CSP [Community Support Program] or DMH models. The caseload is now 25 and it's still difficult, even though there's no direct service role. Supervisors should have lower caseloads (only carry specialty cases).
>
> It is artificial to impose a fixed number of contacts per caseload. Some clients need contact every 2 hours; others, weekly. And then the next month their level of need is reversed. With very intensive clients, a caseload of 4-5 is appropriate; with non-intensive clients, a caseload of 80-90 can be handled.
>
> [Caseloads established by the consent decree in Region I] are 30-35, with 5-10 active cases (the Service Coordinator may have 5-10 people for whom they're it, who are not involved in another program). In some cases, the task is to get clients involved in services; in others, the Service Coordinator will be the provider over the long haul, seen every day; this includes therapy in many cases.

> The proposed caseload (1/35) has not been tested. Our experience in one area was that case managers made the decision not to have so many clients. Case managers go to the hospital, get 10-11 clients, work intensively to place them. Other areas have 1/35, but actually more. Therefore much time with clients is just on the phone.
>
> [One CMHC] tried to do a caseload of 35, but this has been negotiated down to a level of 25. They had been planning on 25. The expectation for the region is now 25 clients per case manager. If there is a mixed population, with special attention to active caseloads, 25 is the best possible if the case manager is to do the job right. Many people believe that 18 is the maximum.

Standards for caseload size have to be evaluated in terms of the type of clients to be case managed and the way in which case management is organized, on an individual basis or in teams, with case managers functioning as specialists or generalists. Different modes of organization may vary in their suitability for different areas, depending on the extent to which case managers are involved as members of extant hospital or CMHC-based teams, the distribution of characteristics among an area's clients, and the specific areas of expertise of particular case management staff.

It is difficult from the interview data to evaluate the feasibility a particular caseload size, but it seems clear that the caseload size standard should be viewed as an average for an area, rather than as a uniform requirement for every case manager. Different areas could be required to maintain the same ratio of clients to case managers, but be allowed to vary this ratio across their case managers, some of whom would carry more cases and some less. And in some areas, where case managers work as specialists on a team, caseload size would only be determinable for the team as a whole.

Case Managers' Location

> The system works best when the Service Coordinator is in an area office, so the distinction between administration and service coordination is not very visible. The area office learns a lot from informal interaction with the Service Coordinators (it would be hard to have case managers in a separate office).

Personnel Policies: Education and Experience

The relatively low educational requirements for the entry level Case Manager I position led to the hiring of former mental health aides, LPNs and others who had relevant experience on inpatient units. Questions arose about the adequacy of case managers' training relative to the multiple skills demanded of case managers and their need to interact with more educated clinicians. Directors in Region I were used to using more highly trained "service coordinators" to deliver case management services; they were frequent critics of the Department's new case management educational standards.

> Service Coordinators are expected to have an MSW; if they have experience (but no MSW) they can be hired if they're enrolled in an MSW program. We conceive of case management as a professional position requiring a high level of clinical skills, but in the DMH job description, there is no sense that the case manager is a professional. We're concerned that the case manager job not be standardized over time to be just a management/ referral position; we would lose high quality work by Service Coordinator Teams. Now there's no separate "case manager" job in [our area]--a variety of programs have a case management capacity.
>
> An MSW is recognized outside DMH; it's necessary for case managers to function in the mental health system and to chair ISP meetings. Case managers are not third party reimbursable [this subsequently has changed]--professionals generate more money. A case manager with a Bachelor's degree is assigned to nursing home clients--they don't require a lot of intervention. In assigning a case, we take account of client needs in relation to the expertise and preferences of specific case managers--it ensures a good match.
>
> Early on in Region I the service coordinator team was too diverse educationally and low paid, so we raised their salary six years ago and adopted the [educational] standard of an MSW. With a paraprofessional staff [as expected with the new case management program], it's basically a "crap shoot" in terms of whether they are able to do the job.

But it was not only Region I directors who believed that a higher educational level was needed among case management staff.

> The consensus among the Centers is they need to determine the required level of preparation for case managers; we need to advocate for higher levels of preparation. There's a question about how many case managers are needed at each level--there's too much emphasis on hiring Case Manager I's. Case managers have a huge responsibility. Their preparation affects their relations with the clinicians. [An agency, such as a] lodging house, [may not clearly have responsibility for a client, but a] low level employee [a case manager] is being put in charge [of the client].

One director described another problem of relying on employees who had not been trained specifically for a job like case management:

> Case managers who were formerly nurses always use the medical model approach; they don't focus on jobs or client socialization.

Whatever the effects of formal education on the way in which case managers perform their job, these effects can be altered by on-the-job training. Some areas had developed their own training program for case managers:

> We provide training through workshops, biweekly training by a clinician on mental status exams, and continuous consulting.

> In Region I, a [training] team works across all areas. The committee that developed the consolidated ISP form traveled to all areas to explain it and provide training. There is one training team for the entire region; it includes a few area people for training in each area.

But some directors expressed dissatisfaction with training provided by the Department for case managers.

> DMH didn't attend to the experiences of those with extensive case management experience. It's insulting to tell people how to do a job they've done for some time. The ISP [Individual Service Plan] training was just distribution of a packet, and reading the guidelines. It was a waste of time and energy. Nobody needs that.

> They should give areas money for specialized training, or set up useful training, for example, about meds or experiential-based insights about outreach to the homeless, etc.

Interpersonal difficulties due to educational differences between more experienced and clinically trained staff and those who have been hired as case managers with less education and training could be lessened in part through providing on-the-job training. Much of this training could be delivered at the area or regional level, so that it can be tailored to the particular backgrounds of case managers and the current service configuration in that area. The expertise of accomplished DMH clinicians should be tapped regularly, perhaps in meetings to review current cases. In addition, outside speakers should be invited to speak to case managers about clinical issues that are frequently of concern in their jobs. However, the need to ensure a minimum common level of expertise by case managers requires that training options be distributed statewide and that training plans be reviewed by the central administration.

INTER-OCCUPATIONAL AND INTERORGANIZATIONAL RELATIONS

The case manager's relations with clinicians and the hospitals, community mental health centers and other service vendors where clinicians work shape both the definition of the case manager's role and case managers' abilities to perform the tasks assigned to that role. These relationships are so important that if they are not cooperative, the case management system is likely to falter. Yet there are ample reasons for anticipating difficulties.

Relations with Clinicians

Clinicians' training and traditional occupational focus differ markedly from those of case managers. Clinicians are trained to accept sole responsibility for making treatment decisions and to believe that clinical knowledge is required for aiding mentally ill persons. The focus of traditional therapy is on intrapsychic processes rather than on the community relations and social supports that are the focus of case managers' work. And in some areas, the role of clinicians had been defined prior to the new system to include case management; as a result, case managers were not seen as useful.

> The clinic staff, social workers, do case management [at some clinics]. Initially, new case managers were expected to manage all the clients' needs, when clinicians were doing this all along. We concluded that case managers can't case manage all clients, and that case managers were to assist clinicians. Case managers now just pick up

> clients who drop through the system. They don't work with long term inpatients.
>
> It is a tightly woven system, clinicians can follow people in and out of the system, everything's so tight and controlled. This makes case management less vital, since everything is so tightly connected. We haven't had a case management system and we don't really have one now. The clinicians make calls for clients, but don't go into the community.

There appeared to be possibilities for improving the delivery of community-based services to clients in such areas by using case managers more effectively. These efforts could involve altering the amount of contact and the division of labor between case managers and clinicians.

Amount of Contact

Some directors suggested that the extent of contact between case managers and clinicians was an important determinant of case managers' role performance: when contact was frequent, these inter-occupational relations tended to be positive.

> The vast majority of clients are known by [both] clinicians and case managers; they are able to work out relations. If a case manager feels that admission is really needed, the clinician will go along.
>
> Case managers have little contact with clinicians (clinical directors, social workers, psychiatrists); it's not clear who should be dealing with case managers. With clinicians, they feel case management is not necessary.
>
> The key feature is group involvement of clinicians and case managers, with team support. Group training sessions. The hardest thing is being out there alone; therefore, group meetings are useful.

Concern about case manager-clinician contact focused on the location of the case managers' office: some directors believed that locating case managers in the area office, usually away from clinicians, was likely to result in a bureaucratic orientation to paperwork and other administrative concerns, with corresponding neglect of interpersonal relations with clients.

> Staff need to have a relation to clients, to be able to figure out what's best for their program.

> When case managers work in a clinical setting with professionals--psychiatrists, etc.--the case managers are exposed to their judgments and they are helpful to case managers. If case managers are in area offices, case managers can become like managers, since they're working under/with the manager. We're concerned with not losing clinical functions--no area offices have their own programs. Case managers should focus on clients and have a clinical focus. In other areas, when case managers work in area offices, case managers could be delegated to help in management functions, since they're right there with the director. For example, case managers could be delegated to develop RFPs, be oriented to paperwork when they're in the area office. This is a REAL HAZARD, since it will reduce service delivery by case managers. If client-focused persons (such as case managers) work for managers [administrators], it is the wrong mix; case managers need to be around and complement clinicians.

A variety of physical arrangements allowed frequent contact between clinicians and case managers. In some areas, case managers worked in the same building as a mental health service provider, or in hospitals or multi-service centers. Meetings were often the vehicle for ensuring case manager contact with clinicians.

> In [one] area, case managers do work in the area office, but the area office is in the same building as the primary mental health service provider; so due to the proximity, the case managers can function in the same way as in other areas, interacting with the clinicians spontaneously as needed. In [another area], the area office is not near the service provider, so it will be a challenge to get case managers focused on clients; when the area office is separate, they're not working with psychiatrists, etc.

> Clinicians rotate here every four months. I [the case management director] talk to new clinicians about case management, but at that point they are overwhelmed with new information. They learn about the system from meetings involving case managers.

> Now case managers are responsible for convening the group, but if there's an established way of

> doing things that is working, it is maintained due to inadequate resources for case management. So, case managers participate in the ongoing meeting structure in their unit, and where necessary convene meetings. There are not many extra meetings called by the case manager [in other words, meetings usually are convened by clinicians]. Follow through is always there, but the functions may differ from the [new] case management plan.

The most important lesson to be learned from these various arrangements is the fact that there were a variety of alternatives for maintaining contact between clinicians and case managers. Although some directors felt that locating case managers in area offices would preclude such contact, this was not the case--regular meetings could also serve this function. But in areas where case management and clinical offices were in close proximity, frequent informal contacts could reduce the need for meetings.

Clinician-case manager contact was not sufficient in itself to ensure productive inter-occupational relations: Whether contact occurred in formal meetings or in informal social interchanges, distrust and resentment could impair the exchange of information.

Division of Labor

Establishing a clear division of labor appeared to be the most important means for reducing distrust and resentment between clinicians and case managers and for enhancing the use of their respective skills.

> There is minimal hostility. At first, the case management committee made recommendations about discharge planning. Now the hospital makes senior staff lead meetings and ensures the work is done. There's been progress, but there's still room for improvement in defining roles and responsibilities, especially regarding benefits and referrals--who is responsible for the package. There are problems on both sides [case management and the hospital] about actions not taken. Each area and unit has worked out its own system, so there's a lack of standardization.

One area expected all clinicians to perform case management functions while the formal case management unit provided support services to clinicians and took on particularly difficult cases.

> The case management staff take on cases that may fall apart and engages in problem-solving. For example, one schizophrenic patient wanted employment, but was not capable of working. He got conflicting messages about this from clinicians. The case management meeting resolved the issues and developed a plan. Most clients are managed by the clinician without the help of the case management staff. Case managers don't see clients, unless a client comes to a planning meeting. Generally, case managers work indirectly with clinicians to help clients. Case managers depend on the rest of the system to flag a case as a problem. If the case management staff is aware of a problem, they can insist, through the case management supervisor, on a meeting or some other action. Providers who feel a client is not getting needed services or clinicians seeking assistance with a particular client usually request the meetings. Normally, the meeting participants reach a consensus, although the clinician may do the work required grudgingly. The case management office is "the demilitarized zone" in the agency, although clinicians' views of the value of the case management arrangement are mixed.

In areas where the division of responsibilities was unclear, relations between case managers and hospital or CMHC-based clinicians could be poor even when contact was frequent.

> All the services are at [the CMHC], including CMs and clinicians. This is in some respects a problem, because interaction tends to be informal and relations aren't worked out as clearly.

But the effect of a clear division of responsibilities between case managers and clinicians did not always result in adoption of the role intended for case managers by DMH. In some cases, the division of responsibilities was determined by the clinicians so as to relieve them of more onerous tasks.

> The case manager is welcome, eg, when no other solution, or very frustrating client, slow successes [ie, when case manager relieves the clinician of a problem]. The case manager is there to meet clients at Dunkin Donuts, etc.

> Therapists offer little resistance to case managers, but this is a function of the role the

> case manager takes--case manager can't challenge a medical [clinical] decision.

Even when there were "turf battles" over the role of case managers, however, management sensitivity to the issue of role definition could resolve the problem so that case managers could make a unique contribution to service provision.

> Clinicians had certain expectations for case managers--that case managers would fill in service gaps, be an annex to the clinician; in general, clinicians viewed case managers as "go-fors." Support by the area director for case managers was critical in getting them respected by the clinicians.

> Case managers don't function as a monitoring agency [vis-a-vis clinicians]. They take clients who have nothing else. The case manager's job is not to tell other people how to do what they do. And in return, they don't tell us what to do.

Relative Status

The different orientations to patient care of professionally trained clinicians and less educated case managers were reported to be a frequent source of tension.

> Many times, the clinician and case manager may disagree about recommendations, but it is the clinician who is paid to make the decision; the case manager gives advice. If you are a case manager, you have to tread lightly, and take in all the information. You can have a profound impact on the situation, by giving your opinion, if the clinician listens.

Some directors believed that the professional qualifications of their clinicians made it inappropriate for case managers to participate in discharge decisions.

> It wouldn't be appropriate for our case managers to advise the Master's-level clinicians, since the clinicians have years of experience and "think they know it all."

> It's a luxury, due to our affiliation with the university, good training, and close monitoring of the physicians. It wouldn't make sense for case managers to tell the chair of the [university] Psychology Department what to do [with patients]. Case managers wouldn't be well-received if they

were to monitor all clients, when they are working with university-affiliated clinicians.

These comments indicate that the responsibilities of case managers are being redefined in practice in many areas so as to accord clinicians a co-equal, and in many cases a superior role in decisionmaking. It is unlikely that this redefinition can be avoided: clinicians' traditionally higher status, their more extensive knowledge of mental illness and their more accepted role in mental health services each serve to decrease the likelihood that case managers successfully can be accorded a dominant role in managing cases. However, the weight of these factors appears to vary with the extent to which clinicians were involved in delivering a variety of services to clients prior to the new case management system.

Clinicians' Involvement with Clients

In areas where clinicians were involved in attempting to meet a wide range of client needs before the adoption of the new case management system, they tended to try to preserve this intense level of involvement--at least with patients they considered desirable.

> Clinicians can follow people in and out of the mental health center, because everything is so tight and centralized [in this particular area]. It makes case management less vital. (We still don't really have a case management system.)

> Clinicians are eager to refer their worst cases, but not their best clients. It makes more work for the clinician if a case manager is also involved, as far as minor case management issues are concerned. Clinicians can get very invested in treatment, especially when they expected low functioning clients.

> At [one CMHC], most clinicians resist case managers doing work on their cases. Case managers are not at capacity because the clinicians are not referring clients.

The traditional role of clinicians is unlikely to change in some areas except as part of a gradual process of meshing more effectively the case management system with clinical work. More efforts to discuss with clinicians the potential value of case managers for their work clearly are warranted.

Relations with Hospitals

Managing the boundary between hospitals and the community is a vital concern of mental health services. Most importantly, boundary management focuses on the movement of clients between inpatient and outpatient status. Clients must be admitted to the hospital when they can no longer function in the community without endangering themselves or others; hospital patients must be discharged when feasible to allow them to return to a more normal status in the community.

Determination of clients' suitability for inpatient or outpatient status is often difficult simply because of the elusive and variable symptoms of mental illness. When clients disagree with a clinical judgment of their appropriate status, this difficulty is compounded. Yet incorrect admission and discharge decisions can result in client deterioration, community opposition, unnecessary expenditures and staff dissatisfaction.

Although hospital-based clinicians have the final authority to admit clients to and discharge clients from the hospital, Departmental policy also accords community-based case managers a role. It is case managers who can determine whether the particular community supports necessary for independent living are present in each case. It also is case managers whose ongoing contact with clients living in the community may lead to an initial determination that a client needs to be rehospitalized. And in many instances case managers are more appropriately situated than are clinicians to provide continuous contact with and support for clients as they move between outpatient and inpatient statuses.

Effective management of the boundary between hospitals or CMHCs is unlikely if clinician-case manager relations are poor, so many of the problems that were identified in case manager-clinician relations reappear in discussions of relations between case managers and hospitals. Since community mental health centers have inpatient beds and employ clinicians, many of the issues that arise in case manager-hospital relations also appear in case manager-CMHC relations.

The structural features and overall quality of relations between hospitals, CMHCs and case managers appeared to vary among areas. Central to this variation were differences in admission and discharge procedures.

Admission/Discharge

In general, directors' comments indicated that more involvement by case managers in the hospitals facilitated admission and discharge decisions.

> Case managers "live there" [at the state hospital]. Each case management team has daily contact with the hospital, although the specific case management involvement may vary with the area [there may be the same or different case managers on different days, etc.]. All clients are admitted and discharged through the core service center (with case manager involvement). Although a hospital doctor formally discharges the patient from the hospital, this must be approved by the service center. DMH is legally required to start treatment planning within 24 hours after admission.
>
> In one area, all case managers were assigned to the state hospital and their relations with hospital staff were great. Subsequently, case managers were taken out of the hospital. They now have their own office, but relations continue to be good due to past experience.
>
> I spend much time meeting with hospital directors; this has been invaluable for when problems arise. They now understand case management and know who is eligible for case management services. Case managers are notified of admissions; a case manager goes to rounds weekly--there's always a case manager at the first treatment meeting [this is a meeting that is mandated to occur within 7 days after hospitalization]. Case managers stay actively involved with short-term clients, not with long-term clients (those hospitalized for more than 30 days).

Special interoccupational groups regulated admission and/or discharge at some hospitals; the presence of case managers in these groups seemed to increase the acceptance of case managers by hospital staff.

> Relations with the admissions unit are very good and one case manager attends the treatment team meetings of the readmission unit. A case manager rotates responsibility for the meetings and reports back to the director. The crisis team reports directly to the area office; (they) work together on discipline/discharge planning. There are good relations with the case management system; they make an attempt to be part of the team, to make rounds.
>
> [We] have a long history of working with the state hospital. There are a lot of admissions.... There's a team for case managers to work with; the

> case managers automatically pick up new clients at admission. The only exclusion is if new clients are not long-term chronically mentally ill (ie, they do not fall in the DMH case criteria). Admissions are ok, smooth; the case manager is at team meetings.
>
> The Interface Unit screens referrals for admissions to ensure appropriate referrals. The IU is composed of some administrators and some social workers, but no treatment staff (clinical social workers). Its workers don't go into the community, and they are glad case managers are there to provide continuity of care. There's so much work that they don't worry about case managers "taking their jobs."
>
> If case managers didn't attend treatment team meetings, the case managers wouldn't get the information on discharges, changes in medications, etc., because the clinicians are too busy.

One director suggested that hospitals at times took advantage of the availability of case management to avoid admitting difficult clients.

> The hospital tends to dump its worst clients onto the DMH case managers. They have experience with clients in the hospital, the clients behave poorly, so the hospital will not readmit them. Instead, they refer the clients to DMH.

But cooperation between case managers and hospitals in discharge planning was most difficult to achieve.

> Discharges are more difficult; the hospital is not always cooperative about notifying case managers of impending discharges.
>
> The DMH mandate is that case managers must participate in the case plan for all discharged clients. But the hospitals don't want case manager/area office involvement in discharges.
>
> Case managers meet regularly with the director, but there's a large census there. There's a potential for problems about discharge, since the hospital is oriented to releasing clients.[7]
>
> Case management staff focus on discharge planning, trying to help with inpatients. The politics get nasty, as everyone tries to gate-keep when there aren't enough inpatient beds or when clients have

behavioral problems. Case management staff try to help when some clients are not accepted by some programs.

In some areas, clinicians and case managers accused each other of failing to attend meetings set up to facilitate discharge planning.

The clinician may decide to release a patient even if their PSTP is not finished, therefore bypassing the discharge plan. This is usually due to pressure to reduce the hospital census, but also to differences regarding the clinical judgment of readiness (eg, clinicians may engage in "lead footing" with medication that stabilizes the patient's behavior, but only temporarily). Hospitals say the community (area office case managers) does not show up for discharge planning. The Hospital says case managers don't come to do planning; case managers say the hospital discharges precipitously, or that clients are sent on leave.

Relations between case managers and clinicians vary. Sometimes, case managers go to hospitals and the patient is on release, or the staff are not available.

But discharge planning in some areas created "no hassles" between clinicians and case managers.

Clinicians desire more outpatient services (such as structured living situation), but realize that case managers often have limited possibilities. A case manager may give clients warm clothes if he or she is going back to the streets or a shelter. There are no hassles about discharge planning, since the pressure due to the inpatient caseload is recognized by case managers and clinicians recognize that there is limited housing.

[Our area has] the lowest hospital census. Service Coordinators spend much time in the hospital, help clients to get out fast; they plan discharges with state hospital staff. Service Coordinators engage in planning and followup regarding the plan; they have computerized discharge plans for state hospitals; they identify what in the community and the state hospital prevents placement. Service Coordinators try to avoid having the client overstay their need for hospitalization, since this is a needless expense.

> Service Coordinators are in the hospital daily, attend all team meetings, are on all the committees, chair the ISP meetings at the hospital, with lots of assistance from clinicians. A Service Coordinator is a discharge planner, working in the state hospital.

In some areas, the director of case management viewed hospital discharge as solely the hospital's responsibility; case managers made suggestions about discharge but did not feel they should play a greater role.

Case managers for children and adolescents tended to follow a markedly different approach, not always successfully.

> Case managers are often contacted by the screening unit when a child needs hospitalization. Case managers follow kids when in the hospital--they monitor and advocate. Seventy-five percent of the children are DSS involved. The role of the case managers is pushing DSS to develop a plan for the kids at discharge. Generally, they [DMH case managers] don't stay involved with the kids on a long-term basis, unless no other agency is involved (some kids are in DMH placements; DMH has the sole responsibility for them.)
>
> [In our area, we] make a conscious effort to stay on top of the cases of children in state facilities, to make discharge plans; see kids once per month.
>
> There's a problem of lack of resources, especially a lack of sufficient locked assessment units. There's too much discharge pressure and lack of money. It's a long process of making arrangements for kids who need residential placement--it's difficult about how a kid manages in the meantime. Kids end up in shelters after they become adults. The system doesn't make sense.

One area director suggested that problems in discharge planning could be lessened by involving case managers.

> For decisions over discharge, they need to attend meetings of the treatment team, rather than just getting the opinion of one person (such as the clinician) over the phone, since that one person may just want to discharge that patient, while other team members may see there as being reasons for keeping the patient in the hospital.

In most respects, the determinants of the case management system's effectiveness in contributing to hospital admission and discharge decisions were similar to the determinants of productive case manager-clinician relations: frequency of contact, type of clients and clarity of the case manager/clinician division of labor were each important. But the different goals of the hospital and community systems created an additional pressure on admission and discharge decisions: when hospitals were concerned primarily with decreasing the inpatient census and case managers were intent on ensuring that patients had adequate community supports prior to their release, disagreements were likely.

Inpatient Services

In some areas, case managers focused most of their efforts on inpatients, while other areas adopted a policy that precluded case manager involvement with inpatients.

> We don't case manage anyone on the chronic unit. A few patients on the longer term ward are case managed when they are awaiting disposition. We don't case manage any clients who aren't going anywhere.

> The hospital is a split system from the community. Case managers have minimal input to inpatient treatment planning and diagnosis; all contact is lost with the area office during hospitalization. Hospitals do not train people to survive in the community. Case managers should identify what clients need for community support.

> Case managers keep in contact with clients when they are inpatients, but only go up there to find out what's going on and to help in the transition. Social workers on the inpatient unit have to do their work.

> The hospital is an ongoing institution; it makes its own decisions. The problem is how case managers should work with hospitals to be involved in inpatient planning. Hospitals have to realize that to get clients out, they need to work with the community. I'm amazed, after all the planning meetings, etc. with hospitals that they now can't convey the plan to hospital staff. They don't realize that another specialty is to be involved. Working relations with area directors is the key. Case managers need to know the hospital's staff and clients, need to be able to know of openings in the community, etc. Training should be done

> jointly with inpatient staff. Both should understand the philosophy of case management.

Several directors emphasized the need to involve case managers with inpatients in order to plan for discharges and to maintain good community relations.

> I still feel that case managers should begin to establish relations with clients, even if they are not to be released, since case managers will have to have a relationship with them to facilitate community planning at some point.

> It's difficult to ask the community to plan for clients we don't know. Needs assessment is not adequate; it's not client-specific enough.

What was missing in some areas was a balancing of the value of community-based and inpatient services:

> Now much of the care focuses on the hospital [including patients coming here for therapy]. It gives excellent care, but, in my opinion, the hospital clinicians see those in the community as not being as needy. There's a high recidivism rate; perhaps if there were more community services it could be reduced. And many clients don't need weekly therapy.

One region shaped its practices about case manager involvement with inpatients to took into account the relative value of case managers for different types of inpatients and the constraints imposed by the lack of sufficient case managers to serve every client.

> If a client is an inpatient for more than 90 days, he or she doesn't need case management [as much as other clients, until the inpatient begins to prepare to leave the hospital]. Instead of having annual review meetings automatically, the case manager should review the situation of long-term clients with basic case management information and determine if there have been major changes that would warrant a new meeting. Or perhaps the case managers should just attend the regular hospital annual review meeting. Also, unstable clients are not appropriate for transportation to a community meeting, and community members [especially service vendors] generally will not come to the hospital for meetings [about inpatients who are not yet their clients]. Whereas ISP meetings are now required for clients admitted for more than 30 days--the clients who don't need it--ISP meetings

> are more appropriate for short-stay clients and for those approaching discharge. The hospitals already complete comprehensive Program Specific Treatment Plans for inpatients.

The point of this region's practices was to allow case managers to concentrate their efforts on those clients for whom they could provide the most assistance, since there were not enough case managers to assist every client. Long-term inpatients who were not ready to begin the process of transition to community living, and who thus would not be using community services in the near future, were not seen to need annual ISP meetings led by a case manager--a community-based treatment plan would have little value in such cases. Planning by hospital clinicians was seen as appropriate for meeting the needs of these long-term patients, although initial ISPs had been completed for these patients in response to an agency directive. However, when clients were ready to leave the hospital, the region stressed the importance of ISP meetings and case manager involvement in order to identify needed services, even when those services may not have been readily available.

The limitation of case management services for long-term inpatients who were unlikely to leave the hospital could reduce caseload pressures in other regions. In any case, the role of case managers in serving inpatients had to be clarified, and the importance of making case management available to inpatients who were likely to be leaving the hospital had to be reemphasized with some clinicians.

Hospital Management

Some directors indicated that relations between their case managers and hospital staff were gradually improving; others were anticipating such improvement.

> Relations with the hospital have come a long way. Initially there were a lot of problems--the hospital psychiatrists thought case managers were just there to take clients out for ice cream. Now it's much better; the doctors respect the case managers. There are a lot of power issues with the psychiatrists, but the case management staff has remained the same and the case managers know what role they're comfortable with. Case managers attend team meetings.
>
> Relations with clinicians are positive. The regional director meets with area directors and the hospital administration weekly; they have monthly meetings with the hospital about

admissions and discharges. Case managers are at the hospital every day.

Case management is not up to speed yet. The hospital clinicians don't yet see case management as a critical point of accountability; they just inform case managers of decisions they have made.

The need to differentiate the roles of case managers from hospital staff paralleled the importance of the issue as discussed in terms of case manager/clinician relations.

There are problems in communicating and role confusion. "I don't know what my role is on the treatment team." There are greater complaints about case managers not attending treatment meetings; also complaints about who is responsible about benefits, etc. They have to describe functions of case management and hospital staff clearly; it would get rid of many problems. There's no hostility; it's more confusion, lack of clarity, and therefore things don't get done. There's especially confusion about who is responsible for benefits and referrals.

The hospital doesn't want case manager involvement; just transportation and paperwork for clients, not other case manager functions.

The hospital now gives too much responsibility to case managers; they have to do a lot more things than they should have to in terms of getting services, etc. Greater planning is needed in regard to programs--blending the systems.

These comments indicate that relations between case management units and hospitals can be mutually supportive; but in some areas the necessary structures, such as regular meetings, and the requisite regulations, about case managers' and clinicians' roles and responsibilities had not yet developed.

The shift in hospital organization from area-based to functional units (intermediate care, transitional, extended care) compounded difficulties in delivering case management services, according to several directors.

Three years ago, the hospital and community systems separated and now geographic units are to be eliminated; there will be functional units within the hospital. Geographic units facilitated involvement of case managers in hospital services and the community. Therefore, it will be more

> difficult for case managers to follow clients once they're hospitalized. A case manager could have clients on five different hospital units.
>
> The area office has a daily presence in the hospital through team meetings or visits with clients. Four to six service coordinators are at the hospital daily, depending on who has clients in the hospital; team meetings are held three times per week. Now the relationship is in a state of flux, due to the change to functional units. Before, there were stable, good relations over time. Now, there are new people who need to build professional rapport. Since there are no longer geographic areas, there's less personal contact with a particular group of clinicians (comprising a smaller group, with a shared constituency). It feels like a tremendous loss, a lack of relations; with recidivists, there was a shared history, and it was more efficient to make decisions [with geographic units].
>
> The change in internal hospital organization from an area basis to a functional basis made case managers' work more difficult, since then they had to keep in touch with clients all over the hospital.
>
> Case managers receive feedback from the hospital through discharge planning, case reviews (team meetings), admissions, the Forensic Unit. There are daily meetings of the respite unit's supervisor, case managers, community treatment programs. There are no conflicts between case managers and hospital clinicians, but now there are problems due to functional separation in the hospitals--it's hard to coordinate services, especially in rehab units.

Although functional units were adopted in part to reduce inter-area variation in the quality of hospital services, there were of course still differences in management styles between functional units; as a consequence, relations with case managers could differ between units. One hospital's intermediate care unit had an aggressive discharge policy and did not acknowledge a role for case managers in decisionmaking. It was difficult for case managers to stop a discharge that was to occur with no plan for the discharged patient. In the same hospital, relations between case managers and the other units were excellent. Another hospital had a special unit for mentally

ill persons with substance abuse problems that caused special problems for case managers:

> Relations with the Special Treatment Unit are difficult, since their philosophy is based on Alcoholics' Anonymous--it's opposed to the philosophy of case management. Occasionally they discharge patients without notifying the case management unit and they only have a half-time clinical staff.

Overcrowding in state hospitals led to diversion of clients to private hospitals, which in turn required disproportionate case management resources.

> The Department places clients throughout the state. Expects of the [private] hospital with diverted clients is that DMH will provide services, including case management, followup, tracking; case management staff are the only employees available at DMH for this. Therefore, it's a use of case managers in ways that were not anticipated. We're just now seeing the impact of diversion on case managers--it's a negative impact, since it is difficult to limit what case managers will do for diverted clients. Since March, more than 150 clients were diverted (most were hospitalized elsewhere); we found out later that some are not mentally ill (they have other disorders, such as Alzheimer's disease), but it is difficult to get other agencies to take responsibility.

Hospital management policies seemed capable of reducing some of the tensions between clinicians and case managers over admission and discharge as well as with respect to inpatient services. In addition to clarifying their respective roles, hospital managers needed to assess the different challenges that each hospital unit presented for case managers and to reduce the unanticipated consequences, for the case management system, of shifting from an area-based to a functionally based system of organization. Making special arrangements to introduce case managers to relevant staff in each functional unit and ensuring the efficient flow of communication between units would reduce an important source of problems. Higher reimbursement levels may be required to reduce the level of resources required to maintain DMH clients in private hospitals.

Relations with Other Service Providers

Historically, the Department has contracted with private service providers ("vendors") for the delivery of many mental health services. In some areas, private vendors provide inpatient services as well as community support programs. The new case management system thus required changes in the functions performed by vendors and in the Department's relations with them. Resources, including some employees and their salary "lines" were moved from vendor to area offices. Non-case management vendor employees could no longer be reimbursed for providing case management services.

In spite of the changes required by the new case management system in relations with vendors, many directors expected a positive effect on the delivery of mental health services through vendors: The new system required greater attention to coordinating services, ensured more uniformity between vendors and across areas, and allowed greater control by the DMH area office.

> Seventy-five percent of staff activities in the residential programs are case management--seeing to clients' daily needs, getting them their medications--but they're [the vendors] not super in making [service] connections.
>
> The clinics are not doing initial assessments of clients and sending information along with the clients (to DMH). The clinics aren't going to do this [without pressure from the region].
>
> Case managers under the new system are an extension of the area office. This dramatically changes the area office's role, flattens the system from three to two tiers, so the area office will manage directly case managers in vendors. The shift is welcomed by vendors, except for the [current] prime vendor of case management. This system makes vendors more equal. The traditional system in Region I has been the core service system, in which a prime vendor delivers all core services: case management, emergency services, respite; other vendors deliver residential, vocational, day, outpatient and intensive case management services. The new case management system makes the agency a direct monitor of services, rather than through contracts.
>
> The case manager needs to monitor the vendor's work, but also maintain good relations. It's easier if control is in the area office. Leadership in the area office is essential. The vendor with ISP service and case management is advantaged in competition for funds, RFPs. The

> competition gets fierce, and eliminating this tension [by making case managers area office employees] is good.

> We expect a positive effect of the new case management system, in terms of tracking, planning, services. Greater uniformity is needed between areas: The programs have their own system for doing casework and it will be better when the state has more control.

Reactions to the new system from vendors themselves seemed, in the view of some directors, to be mixed.

> Vendors have mixed feelings about case management. Initially, they didn't see a need for it, but then they saw it as required. But it duplicates other roles: aftercare (50 minutes every two weeks) and client visits. In terms of coordination, vendors claim they already coordinate with each other, but in fact contact/planning with other programs is minimal and tends to be related to specific clients.

> Some vendors would like to see case management as a billable service, and have case managers "where the action is"--with CMHCs. But others (more of them) feel case managers should be in the area offices, for better management.

And in spite of the many positive reactions, some directors perceived mostly problems with agency-vendor relations due to the new case management system. These problems paralleled those discussed under the headings of case managers' roles and relations with hospitals and CMHCs.

> There have been difficulties in defining the role of case managers in relation to vendors--for example, the difference between aftercare and case management. To some extent, this is a turf issue: vendors say, "we were doing a good job," "why is case management coming in?" There also have been some contract changes. The greater payment to state employees than to vendor employees also causes problems with vendors.

> I [the supervisor of the new area case management unit] met with the clinics and other vendors, but the referrals didn't come, even though the referral form was simple and clinicians had sought case managers in the past. I beat the bushes and got some from the inpatient unit. I met with clinicians--they said they would help out--and I

> met with unit chiefs and attended staff meetings. Many people had been in the system for years and were skeptical about DMH initiatives, thinking it would just make more paperwork. I got some frantic referrals, often inappropriate. In the last year, I got a list of all clients categorically eligible for case management. It was like pulling teeth: at one clinic, they gave me only four names; I had to insist again and finally got 34. I asked vendors again to identify "revolving door" clients for a case management list. The clinics think they already do case management.

In the view of some vendors, case management simply represented a poor use of scarce resources:

> Mental health service providers believe the Department is "croaking" a system that was working, drawing off primary and secondary service resources for tertiary needs (case management). "Case management is a dirty word."
>
> Service Coordinators have a variable amount of contact with clients, but try to avoid day-to-day support regarding food, etc. except when the vendors do not do it. The Service Coordinators spend most of their time with clients in the hospital and those not connected with vendors. The state plan expects case managers to be more involved with private agency clients, but this would duplicate services and require many more case managers. A random check of vendor PSTPs is better.

For others, the problem with the new system was primarily economic and administrative:

> Programs were devastated by the loss of money with the new case management system. Workers who were doing case management were doing other work as well, so returning them to state control affected many operations.

In reaction to what it considered to be adverse effects of the case management system, one vendor appeared to have reduced its cooperation with the Department.

> The area's core service provider (respite care, crisis response, service coordination) has been the clinical arm of the area office--the front and back door to the hospital. Now that the state is operating the case management program, it is

> subject to other influences, such as the Client Registry, and there are now daily meetings of staff from the three units, with Grand Rounds and noon meetings on special cases. Relations with [the core service provider] have been good, but since service coordinators will no longer be their employees, there will be different interests. They may be reticent to involve [DMH] Service Coordinators in early decisions about contracts, etc. One meeting was held recently about planning without informing the (state) director of service coordinators.

But some more powerful vendors had been able to shape relations with DMH case managers so as to enhance their own resources.

> There are difficulties in relations with vendors. They have different ideas about case managers' responsibilities: Case managers often feel the responsibility for taking clients shopping, etc. are dumped on them.

One technique that had been used successfully in some areas in order to lessen problems with private service providers was to provide more information on the new system.

> Private vendors' key concern is: DMH should communicate its expectations, regarding the definition of chronic mentally ill, the ISP as a prerequisite for all services, the ratio of clients to case managers. Are vendors unable to deliver a service if there is no case management plan? We have to get the vendors to buy into the system; there has been no major opposition, but some reluctance to change.

In some areas, regular meetings with vendor representatives resulted in an adequate flow of information:

> One representative from each clinic comes here weekly to share information on inpatients in Treatment Team meetings. Case managers can give information on how the clients are doing in the community, provide transportation, cash checks, etc.

The use of private vendors to deliver publicly funded mental health services can result in poor service coordination and inadequate control over public funds. The new case management system can lessen these problems, while still relying on private vendors to deliver the many services for which their organization and experience most

suit them. Improved communication, regular contact and a clear division of labor are needed to ensure that private vendors still function effectively in the new system. In some areas, special efforts are needed to reorient vendors who have been delivering some case management services to the new system; in these areas, some accommodations to the preexisting system may be appropriate.

THE ENVIRONMENTAL CONTEXT

The environment external to the mental health service system shapes the operation of that system in several ways. The number of potential clients as well as their characteristics and needs vary in relation to levels of social stress and resources in the environment. The characteristics of service delivery staff and of the service system itself may vary across areas. An area's physical size, its population density and transportation facilities influence service utilization and the work required by case managers to maintain contact with their clients. Case managers' ability to aid clients will be determined in part by the labor market and housing conditions in their area.

Interviews with DMH directors provided only limited information on the local environment in which their area or region delivered services, but several important issues were identified.

Alternative Services

The availability of mental health services of various types was cited by several directors as an influence on the activities of case managers. In general, directors found that case managers were used to make up for the absence of particular services.

> There's always a problem due to the clients who have needs that are not met by available services. The case manager sometimes needs to travel with the client, not just prepare the "Triptik." The case manager has to spend more time with these clients, necessarily, seeing how they're doing, going with them to service providers, etc.

> [At medication clinics], clients get meds, have a medical exam, group meetings with a nurse, support groups. This improves client stability and is very cost effective in getting clients to stay on their meds. There's pressure on case managers to monitor compliance with meds when there's no med

> clinic. [The] new med clinic will relieve case managers of this duty.
>
> The clearcut job description does not hold up in practice; it's something of a problem. The key service that clients often can't get is housing. Also, clients may be unwilling to take services, but case management still has to keep involved with the clients; otherwise, clients will decompensate, stop meds, and deteriorate.
>
> But case managers often do crises and counseling by default, due to lack of alternatives.

The availability of services from other units within the Department or from from other agencies reduced pressure to expand the role of case managers or to increase their usage.

> The Clinical Team provides professional consultation to Service Coordinators and providers and helps to coordinate plans of multiple providers for particular clients; it fills in the gaps and performs unique functions, at the request of the case managers.
>
> Now all service coordinators are connected with core service providers--state employees working as case managers in the Berkshire area; in other areas contract employees--all located in core service centers. The core service centers are the front door to the mental health system in the area; they get you moving throughout the system. So every client receives an assessment. Every core center has 24 hour crisis intervention, and a core clinic and respite care.

Laws and Politics

The political and legal environment appears to be one of the important influences on the effectiveness of mental health services. Region I had a particularly favorable political environment.

> In Region I, relations with the community and families are reasonably good. There are monthly community support group meetings; no other major advocate groups. State reps are familiar with mental health issues; the mayor in the town with the state hospital has a chronic mental illness task force; DMH meets with the mayor, etc. There is a more informed electorate concerning mental health issues than in other regions.

Changes in federal Medicaid regulations led to shifts in service delivery activity within the Department; one director believed that these shifts were detrimental to the case management system.

> The Medicaid revenue project makes it very easy to distort what you do to get extra money. Some outpatient clients are making changes to maximize their acquisition of resources. The problem is shifting too much attention to Medicaid eligibility in order to raise revenue, while doing less of what's important for individuals, in terms of housing, etc.

Advocacy Groups

Advocates had had an important influence on mental health services in Region I, but their activity had declined in recent years.

> Advocates formerly were "all over us." They participated in ISP meetings and challenged decisions, forcing discussions and pressuring Service Coordinators to get services for the client and get them out of the hospital. This made for a powerful meeting based on client preferences. There have been fewer advocates available in the last three years. Family members can be advocates but usually they want maximal services.
>
> Every ISP [in Region I] is reviewed by client advocates. The law requires that an advocate must have the option to attend the session; they normally do. In the last year, the five different assessment forms in use in the five areas (now

consolidated to four areas) were standardized to one format.

INTERREGIONAL AND INTER-AREA VARIATION

As a new program is implemented throughout a large statewide department, variation occurs inevitably in the form and pace of change. Since the Department of Mental Health's new case management system affects all aspects of the Department's services, this variation is substantial. Some appears to be rooted in different areas' service histories and arrangements with service providers, some in different management styles, some in socioeconomic forces; often, variation in approaches to case management connotes conflict between the various occupational and organizational actors in the mental health system as they redesign or reevaluate their traditional approaches.

This section describes some of the inter-area variation in initial service configuration and the implementation process, in order to identify unique programs and processes. These descriptions do not characterize fully the case management practices in each area and should not be used to make comparative judgments.

Region I

Mental health services in the four relatively rural areas in Region I are unique in several respects, largely due to the 1978 consent decree involving Northampton State Hospital. The decree required dedication of an unusually high level of resources to establishing a comprehensive system of community residences and support services; at the same time, the advocates who brought the original suit continued to monitor service delivery.

Region I's mental health service delivery system included a strong case management component, but one which varied in important respects from the statewide case management model adopted in 1988. In Region I, some "case management services" were delivered by Master's level clinicians known as "service coordinators." Service coordinators assessed new clients and prepared service plans, visited vendors and checked on the implementation of the plans. Other case management services were provided by paraprofessional "case managers" employed by service vendors. These employees accompanied clients to appointments, helped them with shopping, checked on their food needs, and performed other such functions that did not require extensive training.

One vendor in each area in Region I was designated as the core service provider, responsible for providing service coordination and emergency services and facilitating frequent contact between service coordinators, clinicians and other staff. In the Berkshires, service coordinators worked out of the area office, but in the same building as the prime vendor. In Springfield, case managers worked in a separate unit, specializing in particular areas, while a Clinical Team provided case managers with advice about difficult cases. Until 1985, patient advocates regularly attended treatment meetings throughout the region.

Region II

The three areas in Region II include one city, Worcester, and two predominantly rural areas. A private vendor contracted with DMH for community mental health services and had its own case management staff prior to the Department's new system. One of the Region's areas has adopted a more intensive case management approach than envisioned in the Department's regulations, working with small numbers of clients in order to place them quickly in suitable residences upon discharge from the hospital.

Region III

Region III is home to the most overcrowded state hospital, Danvers State. Case managers in the Danvers/Salem area focus their attention on diverting clients from the state hospital to private hospitals. Since the private hospitals are not required to take the state's patients, case managers must then devote a significant portion of their time to ensuring that the needs of these patients are met while they are in the private hospitals.

Case managers in the Danvers/Salem area have sought to maintain a definition of their role that is broader than service brokerage. Presuming that they must be familiar with hospital patients in order to help in their transition out of the hospital, case managers stay involved with even long-term hospital patients. The relative service delivery responsibilities of clinicians and case managers still are being clarified.

Several cities in Region III's five areas have attracted relatively large numbers of Asian and Hispanic immigrants. The Region's need for bilingual case managers has become acute.

Region IV

Region IV is the state's largest region in several respects: its five areas contain the largest population (1,093,938 adults), the most cities and towns (60) and the most state psychiatric hospitals (Medfield, Westboro, Metropolitan State); at the same time, it is the most affluent region (six percent below the poverty line).[8]

Overall, the new case management system has been implemented more completely in Region IV than in other regions. Region IV's case managers coordinate services, work out of the area office, and conduct ISP meetings as required by departmental policy. In terms of hospital patients, case managers focus their service planning efforts on those inpatients who are ready for discharge, rather than on long-term inpatients who are not expected to leave the hospital.

Inter-area variation in case management practices prior to implementation of the new system indicates some of the challenges that the region has faced in developing a unified case management approach. Prior to the new case management system, Cambridge/Somerville relied on a combined therapist/case management model; Marlboro/Westboro/S. Middlesex had used MSWs and nurses for both case management and direct service; Newton/Wellesley/S. Norfolk had used a case management system more similar to the new one, while Concord previously had had no case managers. The region's management has been able to develop a consistent case management approach across these areas, in part by developing detailed region-wide case management guidelines, as needed, and by meeting regularly with area case management directors.

Region V

Region V's six mental health areas include a higher proportion of rural residents than any other region (33 percent), three large cities and one state hospital. Case management in Region V has been most developed in Brockton, where for years case managers employed by the state have met with the hospital clinical team and with clinicians from other programs. Location of the case management unit in the same building as other services facilitates coordination with hospital- and vendor-based clinicians.

Several areas within Region V have developed specialized case management positions: Fall River has a housing advocate, a housing development specialist and specialized caseloads for elderly, dually diagnosed and veteran patients; all work out of an office located near the greatest concentration of homeless persons.

The case management system and its relations with the hospital system are less developed in Taunton/Attleboro, New Bedford and, particularly, Cape Cod. Previously, the first two areas had integrated case management with the other work of private service providers. Cape Cod is beginning to develop a system of providing different degrees of case management to clients evaluated as at high risk, moderate risk, or low risk.

Region VI (Metro Boston)

DMH's Metro Boston Region is the state's most urban region; it has the highest poverty rate (18.4 percent below the federal poverty line) and the largest percentage of minority group members (25 percent). Many DMH clients are homeless. Six distinct catchment areas in Metro Boston were being consolidated to four in 1988 and 1989; each has a community mental health center with inpatient beds and a separate case management unit, but none contain a public psychiatric hospital.

The Solomon-Carter-Fuller Mental Health Center has had an active case management unit for three years. Particular attention has been given to case managers' needs for training and for regular contact with clinicians. Case managers meet frequently among themselves and with clinicians; training sessions are held weekly; case conferences include clinicians as well as case managers; topical sessions are run by psychiatrists; a support group of case managers meets weekly and the full CMHC staff meets monthly. Case managers submit ideas for special training sessions. Case managed clients may be assigned a clinician from either the outpatient unit or the case management unit; case managers themselves provide supportive counseling, but not traditional therapy. Relations with vendors are sometimes difficult, as case managers often feel they are relegated the tasks of taking clients shopping, etc.

The West Ros Park Mental Health Center now is being consolidated with the Massachusetts Mental Health Center. Prior to this time, it had an active case management program, but one that differed from the model mandated by the Department. Clinicians were required to provide case management (since 1978) as needed and had a mixed caseload of case managed cases and inpatients. Adult case managers worked in the area office as a resource team for the clinicians: one case manager specialized on entitlement information, while others provided clinicians with information or help in locating resources on a walk-in basis. The Case Management Director convened 10-15 case conferences per month as needed to resolve disagreements between clinicians and case managers about specific cases.

The Mass. Mental Health Center is unique. Affiliated with the Harvard Medical School, "Mass. Mental" has long been a nationally-recognized center for psychiatric research and innovative therapeutic practice. Prior to the new case management mandate, case management functions were scattered through Mass. Mental and clinicians were expected to provide case management, even outside the facility itself, as needed.

At the Lindemann Mental Health Center, an Interface Unit refers the most needy clients who are not long-term inpatients to the case management unit. Satellite clinics and two day treatment programs provide clinical services and some case management services. Clinicians at the Bay Cove Mental Health Center tend to refer for case management those clients who have benefited least from mental health services; as a result, case managers try to provide these clients with rather intensive services.

ISSUES AND IMPLICATIONS

Regional and area directors' observations of and opinions about the Department's new case management system can help to identify implementation problems, suggest ways of improving implementation, and highlight critical questions about which further research is needed.

At the time that interviews were conducted for this study of the new case management system, different mental health service areas were at different stages in the process of policy implementation. This variation reflected in part differences in starting points: some areas had had parallel case management systems prior to adopting the new statewide system, some areas had grown accustomed to markedly different case management systems, while other areas had not had any formal case management system prior to the Special Message. But these different starting points also tended to be reflected in different desired ending points: the less similar the preexisting system, the more the resistance to adopting the new system.

Personnel in every area had to make some changes in their approach to case management in order to conform to the new requirements. In areas that already had a case management system, this often meant reassigning case managers as state employees rather than vendor employees and relocating them from vendor to area offices. Some areas strove to change their caseload standards to accord with new norms, while most had to adopt a markedly new system of record-keeping.

The touchstone of an effective case management system is the quality of relations between case managers and clinicians: The problems of chronically mentally ill individuals involve, inherently, both intrapsychic and interpersonal difficulties and conflicts. Without concerted efforts to coordinate service delivery between clinicians focused on the intrapsychic dimension (including biological, psychological and related social processes) and case managers focused on the interpersonal dimension (as it relates to needed environmental supports), case managers' relations with clients will suffer and their ability to inform admission and discharge decisions will falter.

Areas where case manager-clinician relations were relatively smooth, usually areas that had had a case management system for some time, had several characteristics. Most importantly, these areas maintained a high level of contact between case managers and clinicians. This level of contact was achieved through one of several mechanisms: frequent joint meetings, case manager participation in hospital rounds, informal contact resulting from a shared office location, regular case manager participation in admission and/or discharge decisions. Regardless of the method used, frequent case manager-clinician contact seemed to be a prerequisite for an effective case management system.

But contact was not in itself a sufficient condition for effective relations between case managers and clinicians: a clear understanding of the case manager's role also was required. In some areas, change was impeded by insufficient clarification of the desired case management role. Distribution of a short pamphlet or brochure about case management to case managers, hospitals, CMHCs and other service providers should help to lessen this problem. Other areas had delineated successfully the respective duties of case managers and clinicians.

It was relatively common for case managers to be accorded a marginal role in mental health services in areas as a consequence of the preferences of clinicians and/or the hospitals, CMHCs or vendors where they worked. Case managers might routinely be assigned duties that they saw as demeaning, such as accompanying clients to the store, or assigned clients who were too intractable for traditional therapy. In the areas where clinicians and case managers both seemed satisfied with the operational definition of the case management role, clinicians apparently believed that case managers provided valuable information about community supports, reports on clients' needs for hospital admission or discharge, and/or continuity of care for clients in the community.

Most directors approved of the new system of developing comprehensive assessments and periodically updated individual service plans for clients. This basic system had been applied successfully in Region I and met a widely perceived need for more efficient information management.

Problems with the new information system focused on its correspondence with extant systems and the organization of the meetings at which this information was to be collected. Areas in which alternative client information systems were already in use tended to seek to maintain their system. Most areas found it difficult to accord the case manager the task of leading the annual meetings to develop or revise the individual service plans: Clinicians, it often was remarked, did not accept a status subordinate to that of the less educated case managers. In most areas some modification was made so that clinicians played a more prominent role in the meetings. Most areas also found it too difficult to include all relevant parties in the annual meetings and simply reduced the number of parties who were expected to attend.

All four areas in Region I, the Mass Mental Health Center in Region VI, and several other areas had relied on clinicians to deliver case management services prior to adoption of the new system. There was little evidence that the case management services actually provided to clients in some of these areas (Region I and Region VI's West Ros Park were exceptions), were equivalent to those intended under the new system: Clinicians seemed to minimize their involvement in the work of making service calls or traveling with clients in the community while maximizing their involvement in the more professionally prestigious work of therapy.

The success of Region I's clinician/case managers, "service coordinators," was documented by ten years of operation under a court order and the scrutiny of patient advocates. It is not surprising that the thought of changing substantially this system would alarm some local service providers and recipients alike. The new case management system is unlikely to be welcomed unless it can be seen as providing some new benefits in an area.

Development of an effective team-based casework approach at the service delivery level may provide a viable approach for Region I. The efforts of current service coordinators could be expanded and enhanced by adding new case managers, without clinical degrees, to case management teams in each area. Rather than replacing the service coordinators, the new case managers would provide particular services, such as assistance with securing benefits under the guidance of service coordinators, while taking on more

responsibilities for less severely impaired clients and meeting regularly with service coordinators.

In order to be effective, mental health services must be as comprehensive as the illnesses that they confront are variable. Mental illness is, of course, a problem within a person's psyche and brain--the traditional focus of psychotherapy and psychotropic medication. But chronic mental illness also involves problems in relations with others--difficulties in maintaining everyday social relations, coping with stigmatization and developing stable living, learning and working opportunities. These aspects of mental illness are highly variable across persons and throughout the course of the disease, but they are always present in some form and service providers must respond to both.

Ultimately, it is not who provides counseling and other direct support that is important to persons with chronic mental illness; what is critical is whether these services are available at a time, in a place and with a method appropriate to the client's needs and wants. In areas with relatively less accessible clinical services and for clients who reject therapy, case managers may need to shoulder a quasi-clinical role, providing supportive counseling. When clinical services are available readily and with clients who respond well to therapy, case managers may focus their attention only on the "externals"--connections to services. But in any case these two aspects of service provision must be coordinated in order to maximize their effectiveness.

The value of case management varies with the type of client, just as does the value of therapy and medication. Caseload standards must be sufficiently flexible to accommodate this variation, and the means for organizing case management services must include the possibilities of specialized caseloads and variable educational requirements.

Although the role of private service providers has changed, in some cases diminished, in the new mental health service system, these service providers will continue to provide many of the vital services needed by the chronically mentally ill. The case management system provides a means for coordinating vendor efforts more effectively, but in each area a concerted effort must be made to involve vendor representatives in case conferences and service planning. Without such efforts, greater problems of coordination can be expected with some service vendors.

No solutions to particular problems can be expected to be applicable equally in every area. Refinements to the case management system must retain enough flexibility to allow for adjustments to area-specific differences in case

managers' training, past practices of hospitals, vendors and clinicians, and other area characteristics, particularly during the transition to the new case management system. But flexibility need not preclude a unified service system with a consistent statewide case management approach. Area directors and other planners can be flexible in combining the advantages of their local service systems in order efficiently and effectively to meet the needs of clients; hospitals and CMHCs, vendors and their staff must also be flexible in order to allow clients to reap the benefits of a unified case management system.

More systematic research must be conducted to identify the relative importance of the various factors that influence the case management system's functioning. The impact of caseload size and composition on case managers' ability to perform particular roles is one such issue in need of further research; the relation between case managers' education and experience and their role performance is another. Additional research also is needed to determine how the relations between clinicians and case managers affect client outcomes in different areas.

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FOOTNOTES

[1]The Massachusetts state hospital census declined from 23,000 in the 1950s to 3,167 in 1980. The Comprehensive Mental Health and Retardation Services Act (Chapter 735 of the MA General Laws, 1966) was a major step in creating a system of community services. The Act created 7 regions and 39 catchment areas and citizen advisory boards; in 1970, the Mental Health Reform Act (Chapter 123) restricted public hospital access to persons who were more seriously mental ill and without access to other resources.

[2]Formal therapy is the clearest example of providing direct support, although supportive counseling by nonprofessionals and engaging clients in social activities also represent direct support activities. Calling agencies to make appointments for clients is perhaps the clearest case of service brokerage, although advocating with agencies on behalf of clients, monitoring service delivery to clients, and meeting with agency personnel to review client progress are also standard components of service brokerage.

Many support services include some elements of brokering and direct support. Traveling with clients to appointments helps in service brokerage but also provides a context for supportive discussion. Helping families to cope with a mentally ill member has a more clear support component than does educating police about particular clients, but neither activity is a pure case of either brokering or providing direct support services. Accompanying clients to service appointments and advocating for them during interviews may be essential for making service connections, but also provides direct support to clients. Supportive counseling may include discussions of clients' experiences with and attitudes toward service providers, in order to improve the counselor's ability to link clients to these services.

[3]Almost all of the interviewees in this study were directors, at the regional or area level (including directors of case management). The term "director" will be used to refer to all persons interviewed, except when it is important to identify the interviewee's specific role.

[4]But it should be noted that other employees may provide some case management services; as discussed later, this can have important consequences for the efforts of case managers themselves.

[5]A "rehabilitation orientation" that emphasizes the primacy of client needs in service planning ensures that services will vary with client characteristics. But regardless of the extent to which variable client needs and preferences

are taken explicitly into account in service planning, they will affect the service system's operation.

[6]Case Manager I is the lowest classification of case managers. They are not required to have a college degree.

[7]Hospital staff were not interviewed, so the extent of hospital pressure for discharges could not directly be determined. However, differences in patient density and in reported hospital policies suggest there were important differences. In fact, the desire of hospital clinicians to finish a course of therapy and/or medication with patients may have led to some resistance to patient discharge.

[8]Figures from the Comprehensive Mental Health Service Plan, Massachusetts Department of Mental Health, 1989. Edition 1.0.