Reviewing case management in community psychiatric care

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Case management is a process of psychiatric care provision that uses a structured and focused approach to effectively assess individual patient’s needs. The aim of this article is to examine the current status of case management in NHS community mental health care in terms of therapeutic impact and relevance.

The decentralisation of psychiatric services from custodial and institutionalised environments to care in the community has been gathering momentum in the UK since the 1950s. The closure of the old institutions meant that many community services were swamped because of a serious underestimation of the demand that would be placed upon them (Bush, 2003). It has been noted in the media and elsewhere how this pressure has resulted in increasing homelessness for mentally ill people and sporadic occurrences of what might be considered unsafe discharge practices that have led to violent assaults upon members of the public. These in turn have been compounded by deficiencies in the follow-up or aftercare that some patients receive.

The Griffiths Report (1988) and the subsequent white paper *Caring For People* (DoH, 1989) sought to address these issues by proposing a system of ‘case management’, a process of unified assessment, treatment and discharge planning under a concept termed ‘care programme approach’. The benefits of this process and other systems of case management, particularly in light of high-profile failures, continue to remain an issue.

**Background**

Care programme approach as a form of case management was introduced in England in 1991 following prior development in the US (Simpson et al, 2003). The fatal stabbing of Jonathon Zito by Christopher Clunis in 1992 – Clunis being a young man with a diagnosis of paranoid schizophrenia – and the subsequent media attention surrounding it is just one of a number of incidents that have fuelled public concern, even though the risks of such incidents occurring are in fact relatively low. Inquiries into the Clunis tragedy, including one commissioned by the Mental Health Foundation, not only revealed the failure of professionals to liaise properly but also highlighted the failure of central government to give a clear lead to local services on strategy (Rogers and Pilgrim, 2001).

But throughout this era – as mental health systems remained relatively starved of resources and psychiatric hospitals were being closed – the new system of case management struggled to cope (Ryan and Morgan, 2004).

The government’s response included a crucial failure to adequately define the term ‘severe mental illness’, despite citing it as a descriptive label for those individuals considered most in need of effective case management. Further complications resulted from the introduction of more mechanisms for monitoring those individuals who had been poorly defined in the form of ‘supervision registers’ and the notion of ‘supervised discharge’ (Balancio, 1994).

It is against this backdrop that case management has developed and although there is a wealth of evidence depicting the problems, the government is trying to implement reform by integrating the National Service Framework for Mental Health (DoH, 1999) with social services care management systems (Simpson et al, 2003).

The National Service Framework also advocates assertive outreach (or assertive community treatment) as a clinically effective approach to managing the care of severely mentally ill people in certain instances, citing the belief that assertive outreach establishes a more stable community base and reduces time spent in hospital for certain individuals. The definition of ‘severe and enduring mental illness’ now encompasses a range of diagnoses – schizophrenia, bipolar affective disorder, organic mental disorder, severe anxiety disorder and severe eating disorder.

Case management, in terms of care programme approach or assertive outreach, remains an integral strategy in modern UK mental health care provision policy.

Simpson et al (2003) confirmed the existence of different models of case management and narrowed them down to three essential core models:

- Standard case management;
- Rehabilitation-oriented models;
- Intensive case management models.

**REFERENCES**


Department of Health (1989) *Caring For People:* Community Care in the Next Decade and Beyond. London: HMSO.


Discussion

In 1995, the Zito Trust report Learning the Lessons (Sheperd, 1996), sought to summarise the recommendations of 36 inquiries into homicides involving the mentally ill between 1985 and 1995. It organised the recommendations under the headings of health services, social services, monitoring and inspection, GPs and inpatient care. In the opinion of Reynolds and Thornicroft (1999) it provides salutary reading for all mental health services managers and clinicians.

Deficiencies in governmental policy and in existing services relating to the care of those individuals described as suffering with serious mental illness were highlighted. Although of obvious relevance, the findings had a largely negative secondary effect – increase the level of fear among the general public. Fuelled by an incendiary media, psychiatric illness was further equated with violence. Fuelled by incendiary media, psychiatric illness was further equated with violence.

However, on a more ethical and humane note the terms used in the UK for this kind of service provision, including care programme approach, care management and assertive outreach are perhaps less suggestive of surveillance and a ‘gung-ho’ philosophy on the part of mental health professionals than the US term ‘aggressive outreach’ (Pilgrim and Rogers, 1999).

A common thread running through most critiques of case management, especially the care programme approach, care management and assertive outreach is perhaps less suggestive of surveillance and a ‘gung-ho’ philosophy on the part of mental health professionals than the US term ‘aggressive outreach’ (Pilgrim and Rogers, 1999). This is perhaps being addressed to some degree by the introduction of the Thorn training programme or initiative. It represents a methodology of training mental health nurses in key psychosocial interventions (PSI) in order to reduce relapse rates (Gamble, 2005). With a focus on the treatment of psychosis, the Thorn initiative offers training in a variety of skills:

- Engagement;
- Assessment;
- Case management/assertive outreach;
- Individual work;
- Family work;
- Group work;
- Putting change into practice.

There is significant emphasis on working with families, as historically they are seen as being as much burdened by the mental health systems as by the illness (Gamble and Brennan, 2000). Additionally, the Thorn initiative seeks to utilise PSI interventions such as cognitive behavioural therapy to help modify distorted attitudes and problematic behaviour by trying to identify and replace negative inaccurate thoughts and changing the rewards or reinforcements for such behaviours (Harrison et al, 2004). The findings of meta-analytical work by Pilling et al (2002), which looked at family intervention and cognitive behavioural therapy, supports much of the ethos of the initiative. The indications were that family therapy had clear preventative effects on the outcomes of psychotic relapse and readmission, and benefits medication compliance. Cognitive behavioural interventions were seen to produce higher rates of ‘important improvement’ in mental state and were associated with low drop-out rates.

A persistent barrier to effective community care and treatment of the ‘seriously mentally ill’ can be identified in the way in which health care services in the UK are structured. There is a continued need for change, which can only occur if the community mental health services are properly trained and supported. The Thorn initiative is one such scheme.

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adherence to a notion of time, in that everything literally grinds to a halt from the hours of 5pm to 9am on a weekday and from 5pm on a Friday until 9am on a Monday at the weekend. Accessing community psychiatric services during these times is found to be generally problematic. Home treatment and crisis teams warrant flexible implementation in order to successfully bridge these gaps in community psychiatric service. Shepard (2000) affirms that it is important to differentiate between crisis intervention and home treatment teams and the more intensive outreach services. It is useful to understand that intensive support teams have a longer term ideology whereas crisis teams are focused on the short term and more likely to be reliant on the use of medication or hospitalisation with an aim of rapid symptom stabilisation.

Acute psychiatric admission wards could also potentially be used to help fill the service gap more effectively during these times if they were perhaps better integrated with concepts of community care and case management. Very often they are the recipients of the endeavours of the crisis intervention or home treatment teams.

The tendency to view admission wards as somehow separate and distinct entities from community care, and simply as somewhere to deposit patients relapsing or posing other problems when the weekend is approaching, is fast becoming a tired and singularly less than therapeutic cliché. Such units should provide excellent assessment and treatment facilities that could and should be extended in order to maintain and support patients at home without having to resort to arbitrary admission. Yet as Warner (2004) comments, both existing community services and acute admission wards are often prohibited from truly therapeutic intervention in order to successfully bridge these gaps in community psychiatric service.

Shepard (2000) felt that there has been little progress and the general recommendation became that policy makers needed to refocus, for, as established by Barker and Cutcliffe (1999), the traditional focus of psychiatric nursing care in inpatient settings (engaging with patients) appears to be eroding. The continuity of care between the inpatient environment and the community is critically important (Onyett, 2003), and should therefore be considered a priority. The NSF for Mental Health (DoH, 1999) proposed an increase in alternatives to inpatient admissions. The options cited are extended day hospital and day centre opening hours, assertive outreach and home treatment, crisis houses, family placement schemes, respite care and crisis planning, and the loss of high quality staff.

What the research says
Research into the validity and effectiveness of case management in the UK has often proved inconclusive (Ward and Stuart, 2004) and peppered with...
conflicting results across various studies. Marks et al (1994) found that over a period of 20 months, home-based care improved patients’ symptoms and social adjustment over inpatient care and was preferred by them and relatives. It reduced the duration, but not the number of crisis admissions.

In an extensive review of research trials into case management (Marshall et al, 2001) some interesting findings were unearthed that suggested case management helps maintain contact with patients. But the advantage over standard care is small, it actually increases hospital admissions instead of reducing them, and it probably does not improve outcomes in respect of mental state, social functioning or quality of life. It concluded that ‘at least it does not make people worse’.

The most significant recommendation of this review would appear to be the advice that UK policy makers reverse the trend towards case management for all and use the care programme approach to concentrate assertive community treatment on people with severe mental disorder plus a history of multiple hospital admissions and poor engagement with services.

In a similar review by Marshall and Lockwood (2003) concentrating on studies looking at the effectiveness of assertive community treatment, the effectiveness of it as a criterion for maintaining contact, reducing hospital admissions and improving some aspects of clinical and social outcome, concluded that ‘assertive community treatment is an effective way of caring for severely mentally ill people in the community’.

Earlier work by Ziguras and Stuart (2000) that used meta-analysis to combine the results from a number of studies over 20 years found that case management occasioned small to moderate improvements in the effectiveness of mental health services, whereas assertive community treatment was more effective at reducing hospitalisation.

When considering these results and outcomes it is important to remember that the sample groups receiving standard case management and those receiving assertive community treatment should most likely be very different in terms of individual needs and intensity of symptoms and behaviour. The heterogeneous nature of case management intervention and its varying approach to each patient and his or her specific needs may require an individualistic approach to evaluating effectiveness as well (Gage, 2004). It must also be considered what impact funding and resources have on the chances of case management success.

The true relevance of any health care system in operation in any culture or environment can only be fully appraised through the realistic perceptions of its success. Assertive care treatment in the UK, as indicated by a systematic review of the literature (Marshall and Lockwood, 2003) and meta-analysis (Mueser et al, 1998), is said to demonstrate benefits to patients in their accommodation status, employment, patient satisfaction and reduced inpatient use, with either no changes or only modest benefits in both mental state and social functioning.

Studies in North America and Australia imply greater effectiveness whereas in the UK and Europe they fail to show benefits over standard care. This may possibly be due to standard care in Europe being superior to that in the US (Tyrer, 2000). Or that coordinated care, multidisciplinary team working and degrees of joint cooperation between health and social care outreach have existed in most parts of the UK for the past 20 or 30 years, whereas there is an acknowledged absence of coordinated care in US standard practice (Burns et al, 1999). As a result, however, it would appear that assertive community treatment in the UK might be little more than a stylish label for what are essentially more intensive modes of standard case management.

Ward and Stuart (2004) put forward the argument that despite its faults and problems, case management generally addresses patient needs more effectively and flexibly, and that it is well organised and comprehensive. Sectorisation of care, whereby the same team is responsible for an individual’s inpatient and community care, allows for a higher degree of flexibility and response to patient needs. Theoretically, these arguments are substantial. Nevertheless, with a surfeit of evidence indicating somewhat otherwise, the validity of this viewpoint when faced with reality is thrown into sharp relief.

Conclusion
Psychiatric case management that is focused on the individual patient’s needs remains a potentially highly effective intervention. It is based on tried and tested principles and models of care that have been proven to work in a variety of clinical and community environments. Assertive community treatment is considered especially useful and effective in the care and treatment of those individuals prone to partial compliance and frequent relapse.

The provision of appropriate care services in a flexible, collaborative and appropriate manner is a common feature of all case management models. However, without the support of a clear policy, adequate funding, resources and training, and a more effective integration of existing services, the achievement of a true 24/7 multidisciplinary team approach – a high staff to patient ratio, services deliverable at home rather than on an inpatient basis – will continue to remain only a partially realised goal.

REFERENCES