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Case management models and the Care Programme Approach: how to make the CPA effective and credible

Short Title: Case management models and the CPA

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Abstract

The Care Programme Approach (CPA), a form of case management, is a key mental health policy in England yet after over ten years it remains poorly and unevenly implemented with few benefits for service uses, carers or mental health staff.

This paper reviews the wider literature on case management and identifies and considers the principle models that might have informed the development of the CPA. After discussing the evidence for each of the clinical, strengths, intensive and assertive case management models the paper identifies the key components that appear to be central to effective case management across these models. These components are then considered in relation to the CPA. It is argued that the CPA has been undermined by a failure to incorporate and build on certain important features of the major models of case management.

The paper concludes by suggesting the key developments required to make the CPA more effective and to underpin the policy with a unifying philosophy whilst endorsing it with much needed credibility amongst both clinicians and service users.

Keywords: assertive community treatment / case management / Care Programme Approach / clinical case management / CPA / strengths case management

Introduction

The Care Programme Approach (CPA) was introduced in England in 1991 in an attempt to improve the co-ordination of community care for people with severe mental illness (Department of Health, 1990). Despite numerous reforms and refinements (Secretary of State for Health, 1994; Department of Health, 1999; 2001) the CPA is not considered an effective intervention by the NHS Centre for Reviews and Dissemination (NHS Centre for Reviews and Dissemination, 2001).

The CPA remains unpopular and is seen as overly bureaucratic (Deahl, Douglas, & Turner, 2000). It has been undermined by insufficient resources (Phelan, 1996) and unrealistic and unmanageable temporal and logistical expectations (Easton & Oyebode, 1996). It continues to be unevenly implemented (Social Services Inspectorate, 1999) and is invisible or ineffectual to many service users (Webb, *et al;* 2000; Rose, 2001). Operation of the CPA often exacerbates inter-disciplinary tensions within the multi-disciplinary teams (CMHTs) required to deliver the program (Miller & Freeman, 2003; Simpson, 1999b), and the policy lacks an underpinning philosophy of care that might have unified teams (Norman & Peck, 1999). To a great extent and for a range of reasons the care programme approach has failed to fulfil its true potential.

The CPA is based on case management as developed in the US, where a number of models with different characteristics have evolved (Mueser, *et al;* 1998). In England the exact methods to be used in the clinical care of patients

could be decided locally, provided that the fundamental features of the CPA (assessment of health and social needs, provision and regular review of a written care plan, close monitoring and co-ordination by named keyworker) were implemented. In Section I, this paper will identify and describe the primary models of case management. Section II discusses the evaluation of these models. Section III considers this evidence alongside the design and operation of the CPA. The paper will conclude by suggesting key elements of a model of case management that could improve the efficacy of the CPA and endow it with greater credibility amongst clinicians and service users.

Section I: The Principal Models of Case Management

Case management is a process or method for ensuring that service users are "provided with whatever services they need in a co-ordinated, effective, and efficient manner" (Intagliata, 1982: p657). The specific meaning of case management though, depends on the system that is developed to provide it and the particular characteristics of that system are “shaped by the context in which it is expected to operate" (ibid: p657). Case management systems are also defined by their objectives, ideology, functions and structural elements.

When the CPA was introduced there were many different models of case management but the active ingredients were unclear (Holloway, 1991; Huxley, 1991). Mueser, *et al;* (1998) later identified three core models, each containing two models deemed similar. These were standard case management (brokerage and clinical case management models),

rehabilitation-oriented case management (strengths and rehabilitation models), and intensive case management (including both intensive and assertive models).

Marshall *et al;* (2001) also identified key models but produced a different typology. The brokerage model and clinical case management were considered separately this time, with strengths case management and intensive case management creating a group of four. Unlike Mueser *et al;* (1998), Marshall *et al;* (2001) specifically differentiated between case management and assertive community treatment (ACT), a move that has been criticised for failing to appreciate ACT as a development of case management (Rosen & Teesson, 2001). The features of each of the models will now be identified using Mueser et al's (1998) categories.

1. Standard Case Management

(i) Brokerage Case Management

The case manager in the brokerage model tends not to be a mental health professional and works outside of the mental health system acting as an advocate for the service user and as a 'purchaser' of services (Mueser et al., 1998). We shall dispense with the brokerage model, as it was more suited to the US health and social care systems and even there "was soon recognised to be of limited value" (Burns, 1997: p393). It has rarely been adopted within the UK where the vast majority of care co-ordinators are clinically qualified,

are employed within psychiatric services usually as CPNs or social workers (Schneider et al., 1999), and do not simply negotiate the supply of services.

(ii) Clinical Case Management models

In clinical case management the case manager has the ability and skills to develop a therapeutic relationship with the service user in order to accurately assess the ongoing and changing needs of the person with mental illness. Interventions employed will overlap with that of service brokerage but also include psychotherapy, training in daily living skills, family and patient psychoeducation and direct intervention in crises.

Kanter (1989) most clearly outlined this model and stressed that the case manager role requires specific training and skills, as case management should not merely be an administrative function for co-ordinating services. Clinical case management complements the traditional psychiatric focus on biological and psychological functioning. It considers the service user's wider health and social needs with a view to "facilitating his or her physical survival, personal growth, community participation, and recovery from or adaptation to mental illness" (ibid: p361).

Central to the approach is sensitive and flexible continuity of care that emerges out of collaborative relationships patiently and skilfully developed with service users, families and other care givers. Such an approach to case management is given a modern gloss by Watkins (2001):

> Case management requires mental health workers to establish and be committed to long-term relationships with clients, staying with them on their fluctuating journey of recovery. Contact is maintained during crises and through more settled periods. This continuing contact makes it possible for the client's 'relapse signature' to be recognised and for appropriate interventions to be made at an early stage, thus preventing a more disabling and disruptive crisis occurring. It also allows case managers to advocate for the client, should more intensive care become necessary, to ensure that the interventions they find helpful at these times are respected. (Watkins, 2001: p115)

Kanter (1989) also stressed the need to help users manage their own lives by facilitating their personal resourcefulness. Most case managers would overtly support this goal but may attend more to patients' needs and deficits than to their strengths and assets. Many treatment models overlook the ways in which patients participate in their own recovery and ignore the importance of informal networks in the recovery process (Faulkner & Layzell, 2000). This viewpoint overlaps with the philosophy of the Strengths model.

2. Rehabilitation Oriented Models

The Strengths Model

The strengths and rehabilitation-oriented models of case management are often merged and will be considered as one here, with the emphasis on the

strengths model. Both grew out of the social work field in response to concerns that traditional approaches to psychiatric treatment and case management overemphasise the limits and impairments associated with psychiatric illnesses and underestimate the personal assets that patients can harness toward achieving individual goals (Mueser, 1998: p39).

The approach also recognises the potential supports available in the community that can be nurtured and developed with the additional gains of reducing the social exclusion of the service user whilst beginning to address the prejudice and stigma attached to mental illness. The focus of work is on the strengths of the individual rather than pathology and the case manager-patient relationship is central. Contacts with the patient most often take place in the community and interventions are based on patient self-determination. It is acknowledged that people suffering from severe mental illness can continue to learn, grow, and change and resources of the local community are identified and accessed for the benefit of the user (Macias et al., 1994; Mueser et al., 1998; Rapp, 1998a).

The case manager aims to develop a collaborative helping partnership with the service user, gathering information regarding six 'life domains' which appear directly related to successful life in the community with the aim of being able to identify personal and environmental strengths as a basis for work together (Rapp, 1998a). Work between the client and the case manager then focuses on achieving the goals that the client has set with constant discussion and negotiation concerning short-term and long-term goals, tasks

and responsibilities. Over time, the aim is to increase the person's engagement with and integration in the community leading to a planned and agreed 'graduated disengagement' as community support replaces the case manager and mental health services.

3. Intensive Case Management Models

(i) Assertive community treatment models

During the 1970s in the US, when it became apparent that some people were unable or unwilling to comply with 'standard' community psychiatric services, Stein and Test (1980) developed the Program for Assertive Community Treatment (PACT), most often known as 'assertive community treatment' (ACT). Various models evolved with different versions used to target diverse groups or accommodate disparate geographical settings.

Case management tends to stress individual responsibility of case managers for clients while ACT emphasises team working (Marshall et al., 2001). Team members work with clients as and when required and often several members of the team will work together with the same client. Multi-disciplinary ACT teams attempt to provide necessary interventions themselves, preferably in the client's home or place of work. ACT teams always have low caseloads and practice 'assertive outreach', that is, they continue to contact and offer services to reluctant or uncooperative clients. They also place particular emphasis on medication compliance, often offer 24-hour cover and provide

practical supports in daily living such as shopping, laundry and transport (Mueser et al., 1998).

(ii) Intensive case management

Intensive case management (ICM) is either seen as a more intensive version of clinical case management with smaller caseloads, or similar to ACT, employing smaller caseloads and more assertive approaches to particularly needy service users. Whether or not intensive approaches are equivalent to assertive models in practice and research has been subject to debate (Rosen & Teesson, 2001; Sashidharan et al., 1999; Thornicroft et al., 1998). Unlike ACT teams, intensive case management teams do not usually share caseloads. However, this is not always the case, thus further muddying the evaluation waters (Mueser et al., 1998).

Section II: Evaluating Case Management Models

The combination of different and overlapping models of case management, disputes about definitions and service components, and uncertainty concerning the adherence and fidelity of teams to particular approaches has complicated attempts to research and evaluate case management services (Holloway et al., 1995; Burns, 1997; Mueser et al., 1998; Teague et al., 1998; Creed et al., 1999; Tyrer, 2000). Mueser *et al;* (1998) concluded that there was insufficient evidence to draw conclusions on any other than the ACT model.

ACT: the model of choice?

The latest Cochrane systematic review of case management excluded ACT but considered all other models together. It was concluded that case management programs increased the numbers remaining in contact with services but doubled the numbers admitted to hospital. Increased psychiatric bed use was higher in the UK than elsewhere (Marshall et al., 2001). Case management showed no significant advantages over 'standard care' on any psychiatric or social variable, and cost analysis did not look favourable. The one exception concerned the 'strengths' model of case management where there was some evidence of reduced bed use and improvements in psychiatric symptomatology and social functioning (Macias et al., 1994; Modrcin et al., 1988).

In the Cochrane systematic review of ACT, Marshall & Lockwood (1999) calculated that people allocated to ACT were more likely to maintain contact with services, were less likely to be admitted to hospital and to spend less time in hospital than those under ‘standard care’. There were also significant differences for ACT over standard care in terms of employment, accommodation and patient satisfaction but no differences on mental state or social functioning. And although ACT reduced the costs of hospital care, there were no significant cost differences overall.

In comparing ACT and other case management models there was insufficient data on contact with services or numbers admitted, although those under ACT spent significantly less time in hospital with a consequent cost difference. There was also insufficient data to compare clinical or social outcomes and there were no significant differences in overall costs. Nonetheless, Marshall *et al;* (2001) concluded that assertive community treatment should be the model of choice for community mental health services.

There has been a large body of research devoted to ACT but the variation in models has made interpretation of the results difficult (Mueser et al., 1998). Initial studies in Madison, Wisconsin (US), demonstrated benefits in clinical status, independent living, social functioning, employment status, medication compliance and quality of life, as well as reduced use of inpatient services and cost-effectiveness. But replications in other settings produced less favourable results (Burns & Santos, 1995).

Burns and Santos (1995) reviewed a further eight studies from several countries that involved a range of client populations and innovative adjunctive treatments. The results continued to find that users had fewer days as inpatients although there was little effect on the number of admissions compared with other case management programs. Both assertive and other comparison case management programs had a positive effect on clinical symptoms, social functioning and quality of life with no significant differences overall for ACT. Possible explanations for this were discussed including the

difficulty of achieving larger gains in severely mentally ill people, limited follow-up periods and similarity of program content.

Despite this mixed picture and acknowledging the difficulties in determining meaningful comparison groups, the NHS Centre for Reviews and Dissemination effectively dismissed 'case management' (University of York & NHS Centre for Reviews and Dissemination, 2000). They concluded that assertive approaches were required to achieve results more significant than merely maintaining contact with patients, but the CPA " may serve useful administrative functions" (Ibid: p1). However, there have been only limited evaluations of the different case management models in the UK, and no comparisons of any of those models with "standard community care under the CPA" (Thornicroft et al., 1999: p513). There have also been significant criticisms concerning the limitations of systematic reviews (Brugha & Glover, 1998; Rapp, 1998b; Burgess & Pirkis, 1999; Ziguras & Stuart, 2000; Rosen & Teesson, 2001). Gournay (1999) argued that the studies reviewed "were so varied in their settings, samples, design, outcome measures and so on, as to make aggregations meaningless" (ibid: p427). Burns *et al;* (2001) suggested that detailed examination of the studies contained in the systematic reviews of case management and assertive community treatment, "gives little confidence that the two approaches are so different" (ibid: p631).

Different reviews, different story?

Ziguras and Stuart (Ziguras & Stuart, 2000) conducted a systematic review of case management (*including* ACT) that employed a different methodology from the Cochrane reviews, allowing them to include more studies. The case management models included were reported to strongly resemble Kanter's (1989) 'clinical' model whilst sharing features with the 'strengths and rehabilitation' models. The methodological differences concerned the inclusion of quasi-experimental studies, inclusion of domains using non-published scales and parametric analysis of skewed data. The effects of these differences were analysed and discussed and the results of their own systematic review compared with those of the Cochrane reviews (Ziguras et al., 2002).

Ziguras and Stuart (2000) found that both ACT and clinical case management was more effective than standard treatment in just three domains: family burden, family satisfaction with services and cost of care. Work by those nominally working to these models appeared equally effective in reducing symptoms of illness, improving social functioning, increasing client contact, reducing dropout and increasing client satisfaction with services. Both ACT and clinical case management reduced hospital days used, with ACT significantly more effective which the authors considered might be partially due to ACT teams having more power over hospitalisation decisions. From the available evidence, they concluded that both types of case management achieved small to moderate improvements in the effectiveness of mental

health services but ACT had demonstrable advantages in reducing hospitalisation.

A meta-analysis of 24 largely North American and Canadian studies including clinical, strengths and assertive models also found that case management interventions overall were effective (Gorey et al., 1998). Seventy-five per cent of clients subject to case management did better on measures that included client function, quality of life and re-hospitalisation, compared to the average client in a comparison condition. Case management also reduced use of casualty and prison services and lowered costs. But the various case management models did not differ significantly on estimated effectiveness. There was considerable variability around the average effects and the only factor influencing effectiveness was size of caseloads: prevention of re-hospitalisation among those who received intensive case management (with caseloads of 15 or less) was nearly 30% greater than amongst those receiving a less intensive service. Caseload was found to be highly associated with case management effectiveness (r = .73), accounting for approximately half of its variability (r = .53) (ibid: p246). Caseload size will be explored further.

Contact or content?

Early studies found that case managers with smaller caseloads tended to be more proactive, more likely to help users become independent and to enhance medication compliance despite the absence of any detectable

benefits overall (Intagliata & Baker, 1983; Ryan et al., 1991; Muijen et al., 1992; Muijen et al., 1994). But two major studies in England (PRiSM and UK 700 Group) involving intensive input and smaller caseloads found few differences in psychiatric, social or re-hospitalisation outcomes compared with standard community services. Although community case management approaches improved health and social outcomes and was more effective than hospital-orientated services, the model employed and caseload sizes were irrelevant (Thornicroft et al., 1998). Furthermore, intensive services appeared no more effective than standard community care in improving outcomes despite a significant increase in the number of actual and attempted contacts (Burns et al., 2000). This suggested that it is the *content* of that contact, rather than the mere number, that is likely to be important in improving psychiatric and social outcomes (Thornicroft et al., 1998; UK700 Group, 1999). Gournay (1999), amongst others, suggested that care co-ordinators needed to be trained in appropriate psychosocial interventions and that the implementation and impact of such approaches be evaluated.

Bjorkman and Hansson (2000) investigated the impact of case manager interventions on 176 service users with severe mental illness across ten new case management services in Sweden. Users required and received more than just brokerage and care co-ordination from the psychiatric nurse and social worker case managers. A more active rehabilitation approach was reported with younger users and with those in employment and several types of intervention were related to improved outcome. Brokerage, intervention planning and interventions in areas of daily living skills were associated with a

pronounced decrease in the need for care. More time spent on indirect work on behalf of clients related to better outcomes on psychiatric symptoms and social networks.

This suggests that we need to consider the effect of *indirect* contacts as well as the content of direct interventions, which may help explain why studies such as the 'UK700' and 'PRiSM' projects failed to find clear associations between increased case manager contact and patient outcomes. It may also help to explain the finding by Gorey *et al;* (1998) suggesting that caseload size might be a key variable in determining effectiveness of case management. Clinicians require time away from direct client contact to organise and advocate for their clients as well as for supervision, reflection and team development (Waite et al., 1997; Miller et al., 2001). This also suggests that rather than be concerned with specific models of case management, we need to identify the active ingredients of those models.

Impact of the case manager and service user relationship

It has been suggested that the quality of the relationship between the case manager and the service user may be crucial to the success of case management approaches (Burns & Santos, 1995). Yet the effect of the case manager has most often been ignored in analyses of case management (Ryan et al., 1994). One study in the US found strong support for effects that were attributable to case managers and additional support for interventions similar to those advocated by the strengths model that aim to develop the

clients' skills to function independently and increase social inclusion, beyond effects found with more traditional psychiatric approaches (Ryan et al., 1994). A later study reported that there was evidence for case manager effects on five of the ten content areas studied, which perhaps unsurprisingly suggests that case managers themselves may play an important part in determining the course of treatment (Ryan et al., 1997). Other studies suggest the case manager-client relationship may be linked with outcomes and requires further research (Goering & Stylianos, 1988; Priebe & Gruyters, 1993; McCabe et al., 1999). Service users frequently identify the quality of the relationship with their care co-ordinator as important (Beeforth et al., 1994; Repper et al., 1994; Hemming & Yellowlees, 1997; Simpson, 1999a; Webb et al., 2000; Torgalsboen, 2001). A recent review of research on the therapeutic relationship in the treatment of severe mental illness found that the quality of the relationship is a reliable predictor of patient outcome in mainstream psychiatric care and is likely to be an important mediator of other interventions (McCabe & Priebe, *in press*).

Similarities not difference – the key ingredients for effective case management

From the review of the evidence for the principle models of case management and in light of the methodological difficulties identified, it is difficult to make absolute claims for any particular model of case management over another. The major case management and assertive community treatment models appear to provide improvements to service

users across a range of measures including mental state, social functioning and satisfaction although users tend to prefer ACT. Assertive approaches appear to reduce bed use in comparison with other case management approaches, which often increase hospital admissions, with one exception: the strengths model also appears to reduce bed use and lessens the reliance of service users on mental health services and increases social networks. It has also been associated with high levels of user satisfaction as users' value having their strengths and interests recognised and appreciate being encouraged to attain independence.

Although there is limited literature on the case manager-patient relationship it appears central to all approaches including ACT, which posits the building of a strong relationship with the service user, albeit usually through a team of workers. Service users clearly place a high value on the relationship with the case manager and on him/her being accessible, approachable and emotionally engaged. Smaller caseloads are necessary to increase the number of contacts and allow case managers to be more proactive and less reactive to events but increased frequency of contact alone is unlikely to produce superior results. Specific interventions are required before changes in patient outcomes occur and are best delivered by the case manager or team with whom the service user has established a trusting and understanding relationship. Users appreciate support with daily living and practical matters and with tasks such as obtaining financial entitlements, accommodation and employment. They also prefer to be seen at home or

elsewhere in the community than in hospital or offices (Huxley & Warner, 1992; Rapp, 1998b).

Evidently, it is components of the different models that underscore the effectiveness of case management, rather than particular models themselves. Or, more likely, effectiveness lies in complex inter-relationships between different components that include case manager attributes. Rapp (1998b) attempted to identify the common elements of effective case management practice by reviewing 64 research reports largely featuring the strengths and assertive community treatment models. He found that nine out of 15 features across models were identical, with most of the others being a matter of degree rather than points of contention. Developing this further, the key features across the three substantive models identified in this paper are summarised in Table One.

[INSERT TABLE 1 ABOUT HERE]

Section III: Relating Effective Features of Case Management to the CPA

So, having described the key features of effective case management models, what relation is there between them and the CPA? The CPA does not appear to have been developed with any particular model of case management in mind. Rather, it takes a broad-brush approach, with the program's content and guidance "too bland and non-specific" (Bowers, 1994: p11), and there is no underpinning philosophy of care.

The therapeutic relationship, the therapeutic role and the CPA

Unlike the three main models explored, the CPA fails to emphasise strongly enough the importance of the therapeutic relationship. Despite evidence that this relationship may be crucial this is not reflected in the outline and operation of the CPA. Indeed, in a much-quoted paper included in '*Building on Strengths'* (Gupta, 1995, in NHS Training Division, 1995: p241)*,* the strategic development pack to support the local implementation of the CPA, it is stated that the keyworker responsibilities may well conflict with the therapeutic relationship that is seen as central to psychiatric practice.

Just as pertinently, the CPA also fails to stress the care co-ordinator's role as 'therapist'. This is not suggesting a pure role of counsellor or psychotherapist but someone who engages the service user in a range of appropriate psychosocial interventions, such as cognitive behaviour therapy, psychoeducation, family work, medication motivation/compliance therapy, and a range of activities aimed at improving quality of life and social integration. Specific interventions over and above increased contact are central components in the case management models reviewed and are recommended by the NHS Centre for Reviews and Dissemination (University of York & NHS Centre for Reviews and Dissemination, 2000).

Documents outlining and describing the CPA and the keyworker/care co-ordinator role make only scant reference at best to this aspect of the clinicians' work. For example, '*Building on Strengths'* states that care plans

should simply be ”monitored by the keyworker appointed for each individual” (NHS Training Division, 1995: p7). At best, the therapeutic role of care co-ordinator is alluded to in a section outlining the requirements for minimal-level CPA input for people with less complex problems, “the member of the team who will be carrying out care interventions will be the keyworker” (ibid: p13). The therapeutic role is not included under the keyworker's core functions (ibid: p32).

Elsewhere, in the '*Health of the Nation Key Area Handbook Mental Illness, 2nd Edition'* (Department of Health, 1994), whilst the therapeutic relationship is not mentioned at all, there is some acknowledgement of a therapeutic role.

> Most people subject to the CPA are likely to require *supportive counselling* to some degree. Key workers and care managers are likely to provide some of this as a normal part of co-ordinating people's care plans, and acting as their first point of contact. (Department of Health, 1994: p119 [emphasis added])

This makes clear that the expectation was of a relatively minimal therapeutic input by the CPA keyworker. The most recent reform of the CPA continued to underplay the importance of the therapeutic relationship and the provision of psychosocial interventions as key ingredients of effective case management whilst continuing to stress the primacy of ‘monitoring’ and co-ordination (Department of Health, 1999). Additional responsibilities concerning risk assessment and crisis planning were added to the role which, whilst

absolutely essential to effective community care, should ideally evolve out of the trusting partnership that develops between care co-ordinator and service user.

These examples suggest that a therapeutic role was not perceived or portrayed as a central feature of the CPA care co-ordinator's role. It is not suggested that the policy makers necessarily discounted the idea of care co-ordinators offering *any* specific psychosocial interventions, but that their essential and crucial importance within the provision of *effective* case management services was overlooked or greatly underestimated. Such interventions tend to be perceived as 'add-ons', to be provided once the core duties of assessment, monitoring, co-ordination and administration are completed – if time allows. This is evidenced in the commonly reported frustration of clinicians who are educated and trained in the use of psychosocial interventions but are unable to implement those skills in practice, for a range of reasons (Fadden, 1997; Price, 1999; University of York & NHS Centre for Reviews and Dissemination, 2000; Thornicroft & Susser, 2001; Warner et al., 2001).

A strengths philosophy and the CPA

Similarly, there is no evidence that the CPA was designed to incorporate or promote a philosophical standpoint that emphasises the strengths of the individual or the community, despite the evident effectiveness and popularity of such an approach. Reference in the CPA to incorporating the 'views and

aspirations' of the service user is not placed in any theoretical context or understanding of a truly collaborative partnership between the care co-ordinator and the user in which identification of strengths is prioritised over pathology. The word 'strengths' does not appear in any CPA policy document and there is no apparent suggestion of using the resources of the local community, as opposed to referring service users to pre-existing mental health services. Of course, this is of no surprise as the majority of psychiatric services in the UK do not employ a 'strengths' approach to their work as such a stance is at odds with the still dominant 'medical model' (Warner et al., 2001).

There is clear evidence suggesting that the 'strengths' model of case management has certain advantages and that service users appreciate interventions that help to "rebuild meaningful, contributing and satisfying lives despite the continued presence of symptoms" (Burns & Perkins, 2000: p216). In the '*Strategies for Living'* project, service users who identified what had helped them cope and live with mental illness, valued support built on their strengths that helped them become more independent (Faulkner & Layzell, 2000). Similarly, in-depth interviews with people with enduring mental ill health problems living in the community in England, found that the primary goal of responders was to enhance, sustain, and take control of their mental health (Kaj & Crosland, 2001). The building of positive therapeutic relationships with professionals based upon effective communication, trust, and continuity was important to achieving this aim. Other findings were in line

with the philosophy of the strengths model in its determination to increase social inclusion.

> The settings in which their health care took place could affect their attempts to deal with social stigma. Experiences of social isolation, socio-economic privation, and stigmatisation were often pervasive. These compromised responders' opportunities and their capacity to enhance their mental health, compounding their illness and marginalisation. (Kaj & Crosland, 2001: p730)

The successful implementation of the CPA has been inhibited by inter-professional tensions within multi-disciplinary CMHTs and the lack of an over-arching philosophy of care that could unite team members has been identified as a problem (Norman & Peck, 1999). The 'strengths' model of case management could have provided just such a philosophy and may have revolutionised mental health care in England, supported user and government aims for user empowerment and social inclusion (Department of Health, 1999), whilst also reducing the demand on in-patient beds.

Assertive outreach, caseloads, flexibility and the CPA

Whilst there appear to be benefits from adopting certain features of assertive approaches to case management, the majority of CMHTs do not have the staff resources or working hours to provide more than occasional outreach work to users. Neither are they generally able to offer flexible, responsive

services during extended hours. Assertive community treatment teams are now being developed in the UK for a minority of service users in acknowledgement of this (Department of Health, 2001). However, the development of specialist ACT teams will not address the need for care co-ordinators working within mainstream CMHTs to be able to provide more flexible, responsive and 'outreaching' contact with the majority of service users as and when their changing needs demand. Paradoxically, both the clinical and strengths models of case management encompass proactive outreach work. Had they been embraced and employed as integral components of a properly financed CPA the need now for assertive community treatment teams might have been forestalled.

There have been many claims that the CPA cannot be effectively implemented due to the high caseloads found amongst mental health workers in the UK (MILMIS Project Group, 1995; Durgahee, 1996; Pugsley et al., 1996; Moore, 1997; Simpson, 1998a; Simpson, C. 1998; Raven & Rix, 1999; Greenwood et al., 2000). Yet it is clear from the evidence that reducing caseload size alone does not necessarily improve patient outcomes. However, it is also absolutely evident that successful case management programs including ACT operate with caseloads far below those commonly found in England’s CMHTs (Gorey et al., 1998; Mueser et al., 1998; Rapp, 1998b; Ziguras & Stuart, 2000).

Smaller caseloads enable effective case management. They allow time for the development of trusting therapeutic relationships, the implementation of a

range of psychosocial and daily living interventions, support in engaging with local community services and the development of independent support structures. They also allow time for increased indirect contact that involves advocacy, co-ordination, liaison, administration, supervision and planning. Reduced caseloads also allow essential time for teams to reflect and develop in order to work collaboratively (West, 1999; Drinka & Clark, 2000; Miller et al., 2001). Sadly, those operating as CPA care co-ordinators have been handicapped by the insistence that excessive caseloads were not barriers to providing effective and empowering case management.

Conclusion

The CPA was introduced through service managers with the emphasis on risk reduction, registers and paperwork and was consequently viewed as a defensive administrative process. Had it been introduced as 'clinical case management' it might have provided a clear link with the history of case management and emphasised the positive clinical and therapeutic focus of the new policy. This could have been reinforced by clearer 'labelling' of the product supported by targeted education and training that would have emphasised the clinical benefits found in US studies rather than the failure associated with the relatively few cases of homicide in the UK (Shaw et al., 1999; Taylor & Gunn, 1999). It would have also built more explicitly on the therapeutic relationship that will always be at the heart of effective psychiatric care. Additionally, the skilled provision of a range of therapeutic interventions needs to be recognised as a core component of the care co-ordinator role,

rather than something that care co-ordinators do *after* they have met their CPA duties, providing that time and workload allows. Preventing relapse and improving clinical and social outcomes requires such interventions to be integral features of case management.

Had the CPA embraced the positive principles of the strengths model it might have provided the CPA and mental health services with the unifying philosophy that has been found lacking and that continues to undermine collaborative teamworking that is essential in effective case management (Norman & Peck, 1999; Miller & Freeman, 2003). But such an approach would have been at odds, not only with the dominant medical model of mental illness but also the political hegemony of that time. The primary drivers behind the introduction of the CPA were the targeting of restricted resources and the quelling of exaggerated fears of 'homicidal maniacs' (Morrall, 2002), not the empowerment and fulfilment of people with mental illness.

Finally, had the CPA been developed and promoted to incorporate the key 'active ingredients' identified above this key policy might have been more enthusiastically received. However, there is a proviso. The model of clinical case management outlined here demands an even greater commitment by clinical staff with consequent cost implications. Given the economic and political atmosphere at the time the CPA was introduced in the UK, perhaps it is no accident that we ended up with a cheaper, unbranded and ultimately faulty version of case management. We should not be surprised that it was not up to the job.

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Table 1: Key factors indicated in effective case management				
Key factors	**Main case management models**			**Comments**
	Clinical	**Strengths**	**Assertive**	
Small case manager caseloads	Max 6 - ? Depends on level of need	Max 12 - 20 Depends on level of need	Max 10 - 12 Depends on level of need	Low caseloads *essential* but not sufficient for effectiveness. Relat-ionship & interventions crucial
Therapeutic relationship key	Central	Central	Shared across team	Relationship between case manager(s) & user important
Clinical role for case manager	Case manager provides most interventions	Case manager provides most interventions	Interventions by all appropriate team members	Case manager and clinical role usually shared within ACT teams
Psychosocial interventions used	Yes	Yes	Yes	Case managers need to use range of psychosocial interventions
Team Input	Team provide support and advice	Team provide support and planning	Often advocates direct team input for clients	All models suggest access to skilled team members for support, advice and care planning
Experienced team leader	Yes	Yes	Yes	All models stress need for effective team leadership
Supervision & training	Yes	Yes	Yes	Specific training for case managers and regular supervision
Assertive outreach	Yes	Yes	Yes	Targeted outreach to maintain contact with resistant clients
Medication management	Yes	Less stress on medication but advice sought from medics	Crucial	Different emphasise across the approaches towards relative importance of medication management
Focus on using non-mental health services	Yes	Central feature of model	Yes	All models place importance on helping users access and use 'natural' community resources
Maximise user self-determination	Central	Central	Depends - ACT often more directive	Some ACT teams more directive concerning medication, hospital, housing than other models
Long-term relationship with service users	Yes	Yes	Yes	Maintaining relationship important to prevent relapses and diminishing outcomes
Help with housing, finances, employment	Yes	Yes	Yes	Central to all models
Work with family/carers	Yes	Yes	Yes	All recommend involvement of carers/ family psychoeducation
Flexible response to changing needs	Yes	Yes	Yes	Titration of support in response to changing needs advocated
Focus on personal resources and strengths	Important	Central focus	No? Far less explicit	ACT models often more tied to psychiatric views than clinical or strengths models
Responsive to crises & relapse prevention	Yes	Yes	Yes	All models stress need for flexible responses to changing needs & crises to prevent relapse
Most contact in the community	Yes	Yes	Yes	Users prefer home/community contact and it is more effective
24-hour or extended access	Uncertain	24 hour access to case manager or colleague	24 hour access to team usually advocated	24/extended hours access to worker with knowledge of user important
Support in daily living	Yes - offer training in independent living skills	Yes - build on users' abilities towards independence	Yes - central to ACT approach	Support in dealing with food, laundry, bills important