

Original articles

Developing case management for the long-term mentally ill

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Mental health policies and the focus of psychiatric services have shifted over the last three decades from hospital to community care. Greater care in the community and reduced psychiatric bed numbers have contributed to the discharge or non-admission of many patients with severe and persistent disorders who formerly would have been cared for in hospital. Increasing numbers of the chronically ill in the community will necessitate the development of systems to provide continuous and integrated services for such people.

Caring for People (HMSO, 1989) placed case management (or care management as it is now termed) as one of the main building blocks in developing effective and appropriate community care for priority groups. It is helpful to view care management as a "purchaser" form of case management; the local agency will be social services, the emphasis being on assessment and care co-ordination with budgets devolved, possibly as far as the care manager. The latest guidance on care management (HMSO, 1991) indicates that direct work is quite possible, although it should fall short of being specialist intervention, such as family therapy.

On the other hand, case management may still be developed as a "provider" service (that could be purchased by care managers). While the focus would be direct work with clients, considerable care co-ordination would still be involved. Case managers might have access to funds to purchase small items or even small amounts of care, but would not be able to purchase mainstream care. Case management of this provider nature is more likely to be run by a joint agency or the health service.

The Research & Development for Psychiatry (RDP) Case Management Project aims to develop and evaluate new services for the long-term mentally ill (Ryan *et al.*, 1991). Within the project most of the teams have developed as provider services of case management. This is changing as two teams are now designated as care managers.

The study

In 1990, case management demonstration services for long-term mentally ill began work in four districts with funding from the Department of Health and RDP. This development has grown and currently, case management services are being provided to 700 clients in six districts by 50 case managers. Criteria for entry to the service include: psychotic diagnosis, long duration of illness, impairment in social relations and daily living skills, history of many admissions, use of many service agencies with problems in co-ordination, problems with taking prescribed medication and problems with accessing or engaging with services.

The case managers and the team leaders in the four original districts come from a nursing background (17), social work (12), occupational therapy (5) or are experienced non-professionals (4). All of the case managers are managed by a team leader, irrespective of professional background. Case managers identify appropriate clients, build a working relationship, assess needs, plan and access care, provide care and monitor and evaluate care. The key differences to most multidisciplinary team work are that all aspects of the process of care delivery are the

responsibility of one identified person, assessment and care provision are comprehensive and, as the process is client need centred, there are no (other than legal) boundaries to either the care package accessed or to the care provided directly by the case manager.

The teams aim to be an integral part of mainstream psychiatric services for the long-term client group. The relationship with psychiatrists is seen as important to all the teams but varies according to local circumstances. On one site the consultant is a specialist team member attending weekly meetings but not acting as a case manager. The consultant is clinical director of another service. On other sites the involvement of the psychiatrist is limited to membership of local case management steering groups. On all sites considerable liaison between case managers and psychiatrists has occurred at the individual client level which has enabled the experience and skills of psychiatrists to be accessed.

The implementation of case management, the process of service delivery and cost effectiveness of the service are being evaluated. We report here the preliminary findings on the clients' characteristics at entry to the service and their contact with case managers during the first year.

Findings

Table I shows the socio-demographic characteristics and psychiatric history of the case management clients. These clients were considered to have met the criteria for service entry; a further 87 were ineligible because their problems were not severe enough or because they had a primary diagnosis of alcohol/drug dependency, personality disorder or organic psychosis.

Client characteristics

The mean age of clients was 46, with 55% male and 11% from ethnic minorities. Diagnosis comprised predominately psychotic disorders (85%), with a mean of 22 years since first contact with psychiatric services. Twenty-five per cent had at one time been an in-patient for over one year. Only 16% were married and 45% were recorded as having no social contacts outside of mental health services; any kind of competitive employment was held by 1% of clients. Few clients were under any restrictive section of the MHA at entry (8%) and a minority had a history of self injury (26%) or violence (22%) to others. However, the majority of clients (56%) lived in independent accommodation, 20 (8%) were in hospital, one was in prison and five (2%) were homeless, with the remainder (33%) being in supportive residential care. Finally 39% of clients were assessed as having a current physical health problem at entry to the service. Only nine clients (4%) were not registered

TABLE I
Client socio-demographic characteristics and psychiatric history at entry to study (n = 234)

| | |
|---|--------|
| Mean age | 46 yrs |
| Male | 55% |
| Ethnic minority | 11% |
| Married | 16% |
| Employed | 1% |
| Independent accommodation | 56% |
| In-patient | 8% |
| Homeless | 2% |
| Psychotic diagnosis | 85% |
| Years since first contact with psychiatric services | 22 yrs |
| In-patient stay of 1 year + | 25% |
| Under restrictive section of Mental Health Act | 8% |
| Registered with GP | 96% |
| Access to informal care | 52% |
| 1 + admission in last two years | 54% |
| History of self injury | 26% |
| History of violence | 22% |
| Current physical health problem | 39% |
| No social contacts outside of psychiatric services | 45% |

with a GP. The reliance on mental health services was high, only 52% had access to any form of informal care. Many clients (54%) had had a recent crisis with one or more admissions in the two years before entry to case management.

Service contacts

The client:case manager ratio varied from 10:1 to 25:1. Mean frequency of contact was once a week during the first year, which ranged from a total of 0 (where the client could not be contacted) to 145 contacts per client. Low level of contact with some clients reflected the difficulties case managers found in engaging some clients. Out of 207 new referrals, 12 (6%) clients were still refusing the service despite efforts to establish contact at one year (Ford *et al*, 1992). Up to 50% of case managers' time was taken up by indirect work with other agencies on behalf of the client.

Comment

The process of targeting the most vulnerable group of clients with a long-term illness picked up a heterogeneous group. However, there appears to be two general sub-groups. First, a client group who had an institutional history, were in residential care, totally dependent on services, socially isolated and with poor daily living skills. The second group were

characterised by frequent short admissions and a history of violence to themselves or others and appear to be more akin to those referred to as "revolving door" rather than former long stay.

Case management provides a means of delivering services to a specifically targeted group with long-term mental illness. The group of clients had many disabilities that needed individual packages of care to be developed. Thus, while the main emphasis was on direct work with the client, case managers also had to give a high priority to negotiating care from other agencies. This suggests that a joint health authority and social services purchasing strategy is needed with case management as a central tool. Case managers

can then co-ordinate and provide care so as to comprehensively meet social and health needs.

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A learning disability register – how accurate are the psychiatric data?

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Registers on people with learning disability are widely held (Cubbon & Malin, 1985). They have been set up in a variety of ways, hold differing types of data, and are put to various uses. Service planning and management is a common function for which register data may be required. However, a literature search revealed that no accuracy studies had been undertaken on such registers, apart from a reliability study on the Wessex Mental Handicap Register developed by Kushlick *et al* (May *et al*, 1982). In Wandsworth, an inner city health authority, the Register for People with Learning Difficulties is jointly funded and managed by the health authority and local social service department. The register holds data on just under 1,000 people who use services for people with learning disabilities, and the data are updated annually by questionnaires sent out by the register organiser. The questionnaire includes enquiry into demographic information, functional ability and service use. It also notes the presence or absence of additional complications, including psychiatric disorder and behaviours presenting specific management problems. This article describes a pilot study of the accuracy of the psychiatric and behaviour problem data held on the Wandsworth Register.

The study

Thirty-two of the clients, aged 18 or over, registered or updated within the previous three months, were

contacted by the researcher, and consent by the subject (or agreement by the subject's relatives when the subject was not capable of giving informed consent) was given to participate in the study. A psychiatric assessment was made by the researcher, which included an interview with the subject and the primary carer, who was a relative when the subject lived at home, or a key nurse when the subject lived in an institution. Psychiatric disorder was diagnosed, using ICD-9 codes, as this was the classification system used by the register. The diagnostic interview was not standardised but based on the guidelines for psychiatric interview used in the Division of Psychiatry of Disability, St George's Hospital Medical School (Anness *et al*, 1991). An assessment of inter-rater reliability was made on ten subjects for psychiatric diagnosis, and in nine cases, the researcher's opinion regarding presence or absence of psychiatric disorder concurred with an independent psychiatric assessment by the second rater, a senior colleague in the psychiatry of disability.

During the interview the researcher also made an assessment of any behaviours which presented specific management difficulties. The Maladaptive Behaviours domain (Part II) of the Adaptive Behaviour Scales (ABS) was used by the researcher on each subject at the end of each interview. Part II of the ABS is designed to assess behaviours which cause management problems. As the study progressed, the