

CASE MANAGEMENT VODENJE PRIMERA

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Povzetek

V zadnjih letih se večja zanimanje za vodenje primera. Tradicionalno velja vodenje primera za učinkovito koordiniranje in razporejanje virov. Primarni cilj vodenja primera je podpora ljudem z različnimi zmanjšanimi zmožnostmi pri dostopanju do virov, ki jih potrebujejo za čim bolj samostojno življenje. Vodenje primera se zato osredotoča na možne dogodke v vsakdanjem življenju, kot so zdravje, delo, gospodinjstvo, družina in prosti čas. Nekateri obstoječi modeli vodenja primerov so z leti postali bolj znani kot drugi. To so Assertive Community Treatment (ACT), model Brokerage in model Strengths. V nekaterih modelih vodenja primera bolj iščejo rešitve težav kot pa iščejo možnosti posameznika ali v skupnosti. Vsi ljudje imajo sposobnost rasti, razvoja in okrevanja. Model Strengths izstopa med modeli vodenja primera, ker se opira na posameznikovo moč, ne pa na njegove primanjkljaje in šibkost in ker je posameznikova pravica do samoodločanja pomemben del rehabilitacijskega procesa, pomembni pa so tudi neformalni viri. Model prav tako poudarja pomen ustvarjanja dobrega in zanesljivega partnerstva z uporabnikom ter dela v skupnosti, kjer se nahajajo viri. Med rehabilitacijo ima vodja primera nalogo mobilizirati uporabnikove moči, sposobnosti in talente in tudi vire v skupnosti. Rezultati raziskav vodenja primera po modelu Strengths podpirajo njegovo učinkovitost. Ljudje, ki so bili vključeni v raziskave modela Strengths, so zmanjšali raven koristi zaradi bolezni, izboljšali družbene stike, zmanjšali uporabo zdravil ter izboljšali svojo delovno sposobnost in kakovost življenja.

Ključne besede:

vodenje primera; model Strengths; uporabniki rehabilitacije; viri

Abstract

In recent years, the interest in case management has increased more and more. Case management has traditionally been seen as a way of coordinating and distributing the community's resources efficiently. The primary aim of case management is to support people with various disabilities so that they have access to the resources that are needed for them to be able to live as independent a life as possible. Case management therefore focuses on what happens in day-to-day life scenarios such as health, work, and housing, family and leisure time. Some of the existing case management models have also become better known than others over the years. These are Assertive Community Treatment (ACT), the Brokerage Model and the Strengths Model. Some case management models are focused more on solving problems than on looking at the strengths of the individual and strengths in the community. All individuals have the capacity to grow, develop and recover. The Strengths Model stands out by virtue of its strong focus on the client's strengths rather than shortcomings and weaknesses, and on the fact that the client's self-determination is important as regards the specialisation of the rehabilitation process and the importance of the use of informal resources. The model also emphasises the importance of creating a good and reliable relationship with the client and of working out there in the society where the resources are available. During the rehabilitation process, the case manager has the task of mobilising the client's strengths, abilities and talents as well as the community's resources. Results from several Strengths Model case management studies support the effectiveness of the model. People involved in Strengths Model studies have lowered their sickness benefit levels, improved their social contacts, decreased their drug use, increased their working capacity, and improved their quality of life.

Key-words:

case management; Strengths Model; rehabilitation clients; resources

BACKGROUND

Traditionally, case management has been viewed as a way of coordinating, integrating and distributing society's resources in an effective way (1). The primary functions have been investigation, evaluation and planning, as well as coordinating the work of those care providers drawn into the case via the referral procedure (2, 3). Some case management models are focused more on solving problems than on looking at the strengths of the individual and strengths in the community. By focusing mainly on the disease, this approach shapes the way in which people look at the individual, and it often leads to us helping the individual to live a disabled life rather than making it easier for the individual to live a life in society as though he or she were not disabled. All individuals have the capacity to grow, develop and recover. Strengths Model case management stands out from the case management models by virtue of its strong focus on the client's strengths rather than shortcomings and weaknesses. The primary aim of case management is to provide support to people with various disabilities so that they have access to the resources they need to live as independently as possible. Case management therefore focuses on matters of day-to-day life, such as health, work, the home, family and leisure.

The term Case Management

If we study the considerable literature in the area of case management, a large number of different definitions have been used to describe a range of varied activities in the social area. Different case management models are used in a number of different welfare areas, such as rehabilitation, child care, care of the elderly, the treatment of offenders and the mental health services. What follows is a selection of some of the common definitions that can be found in the literature.

Case management is a method of securing comprehensive, coordinated and timely measures to help people who need these. Along with the client, the case manager is responsible for mobilising these measures and putting them into practice (4).

Case management is a process that helps people with multiple problems to develop a network of resources, while at the same time enhancing people's skills in terms of creating and accessing their own resources (5). Case management consists of two basic functions: "enabling" and "facilitating". The case manager "enables" by enhancing the individual's inherent strengths so that they are able to function independently, and "facilitates" by creating channels to the various resources that the client needs (6).

In the 1970s, the term "case management" had become well established in the social sector, particularly in the United States, Australia and New Zealand.

Case Management models

In the Broker Model, which is one of the oldest case management models, the approach is based on the case manager investigating the needs of the client and then referring the client to whichever player in the field of rehabilitation is best suited to meeting these needs. The work is done principally in an office environment and in close collaboration with the established mental health care services (7). Each case manager is responsible for 40 or more cases. According to the studies that have reviewed the model, the results have been poor in terms of the effectiveness of the model (7, 8).

As a reaction to the approach taken by the Broker Model – and as a result of society not being prepared for the consequences of the closure of mental health hospitals that was taking place, with its attendant increase in poverty and homelessness among the mentally disabled – a range of different case management models emerged in the United States during the 1970s and 1980s. The aim was to develop case management models that facilitated the integration into society of individuals with serious mental health disturbances. Assertive Community Treatment (ACT) and the Strengths Model are examples of case management models that emerged and developed during this period. Interest in these models has also spread outside the United States. The model is now used in the United States not only in the mental health care services but also in caring for drug users, working with children and the elderly, and in the work being done with the homeless and with offenders. Case management has now also been implemented in many countries in Europe (9).

The target group for the ACT model, which is an intensive, team-based form of case management, are people with severe mental illness and people with substance abuse or dependence problems and concurrent severe mental illness. Intensive, team-based case management involves the coordination of care and support measures within a multi-professional team, where both psychiatric treatment and psychosocial measures (including crisis interventions) are available 24 hours a day and, to a large extent, are carried out by the team in the person's day-to-day environment. A multi-disciplinary team may, for example, consist of a case manager, psychiatrist, nurse, welfare officer, psychologist, occupational therapist and physiotherapist, as well as where appropriate a specialist in alcohol and drug problems. The measure is considered 'intensive' because of the small number of clients that the team deals with, usually no more than ten (10, 11). The support and measures are comprehensive, and a hallmark of the work is its flexibility; there is no time limit on this support. Treatment and support are tailored to each individual (12). Teams also have a deep involvement with the clients and the clients' rehabilitation, and they are very well prepared for a recurrence of illness or misuse and for carrying out preventive work to avoid homelessness and the need for inpatient care, with

an outreach programme as a central feature (13). Unlike the Strengths Model, the ACT model adopts a problem-based focus. The model is cost-intensive and, according to Rapp and Goscha (14), should be aimed at the 10–20 per cent in the mental health care system with the biggest care demands. The remainder of this presentation of case management will therefore be about the Strengths Model.

THE STRENGTHS MODEL

The origin and creation of the Strengths Model can largely be attributed to Professor Charles Rapp and his colleagues at the School of Social Welfare at the University of Kansas. The name Strengths Model was chosen because it focuses on the central importance played by the client's strengths when applying the model in practice (15). According to Rapp, the model is built around two assumptions about human behaviour. First, people succeed more in their day-to-day lives when they use and develop their own potential and have access to the resources needed for this. According to Rapp (16), it is evident to anyone working with people with mental illness that many of these have lost their awareness of their inner strengths, abilities and talents. Many also lack the resources required to meet their basic needs, as well as the ability to make the most of the resources that society provides and that should allow them to feel part of that society. The second assumption that the model makes is that human behaviour is, to a large extent, related to the resources available to the individual. Case managers who work using the Strengths Model help their clients to coordinate their wishes, talents and skills with the opportunities and support available around them. In order to succeed with this, the starting point must be the individual's needs and abilities; the rehabilitation plan needs to be an individual one, not a generic one. According to Rapp (17), far too many plans are drawn up in general terms and do not reflect the wishes and needs of the individual. Generic and standardised plans do not take account of what makes each person unique.

The Strengths Model is based on six principles (18):

1. People suffering from mental illness can continue to learn, grow and change their lives.
2. The focus is on individual strengths/opportunities rather than pathology.
3. The community is viewed as an oasis of resources, not as an obstacle.
4. Interventions are based on client self-determination.
5. The case manager/client relationship is primary and essential.
6. An intensive outreach programme is the working method of choice.

The essence of principle number one is that people with mental illnesses are not, for example, “schizophrenic” or “chronically mentally ill” – rather, they are, for example,

“individuals with schizophrenia”; it is just one aspect of their life. Like all the rest of us, they have been through trials that have been painful. They are unique beings, with various gifts and abilities, and they have dreams and wishes just like everyone else. According to the Strengths Model, the work must start on the basis of a belief in the individual and their ability to improve their life. The approach taken to the work throughout the entire rehabilitation process must be based on the words “I can”.

The underlying assumption behind the second principle is that people tend to grow and develop on the basis of their individual interests, wishes and inherent strengths. By turning our attention away from the problems, weaknesses and failures, we avoid undermining the person's motivation. It is important for case managers to be determined and for an atmosphere of mutual trust to prevail.

Principle number three is about the case manager's task being one of making full use of the resources available in society by encouraging cooperation among the various players, with the aim of promoting the rehabilitation of the client. When making use of resources, case managers should primarily give priority to the common and natural resources of society rather than resources that are divisive. Using the natural resources of the community makes it easier to integrate the client into society.

One of the cornerstones of the Strengths Model is, according to principle number four, the belief in client self-determination in terms of the design, direction and content of the planned and implemented initiatives. The case manager should not do anything without the authorisation and approval of the client, and the client must be involved in every decision and step taken in the rehabilitation process.

Principle number five states that a good relationship between the client and the case manager is absolutely vital. The relationship acts as a buffer against stress and helps to mitigate any deterioration of symptoms. A good relationship also provides support to the client as they work to cope with the many demands from their surroundings and other people.

According to principle number six, the case manager should focus on an intensive outreach programme that puts the client at the forefront, which means that the work should be carried out outside the office environment.

The mode of working with the Strengths Model requires great commitment from case managers. The case manager must ensure that the client is involved when planning meetings. In order to develop a mutual trust during the rehabilitation process, the case manager and client also need to meet and socialise more informally. The case manager should make use of every available opportunity to boost the client's self-confidence by pointing out the client's

own strengths and abilities. If the case manager is finding it difficult to engage the client or make progress in the case, there is the option of taking up the case at a group supervision meeting (see the section on Group Supervision).

Types of abilities and talents

A range of personal qualities can act as useful resources to highlight in various environments: honesty, thoughtfulness, hopefulness, industriousness, friendliness, patience and expressiveness are just some examples. Potentially valuable skills and talents in a rehabilitation situation include language skills, mathematical skills, the ability to deal with money, familiarity with computers, a good memory, being good at arranging flowers, joinery skills, a love of classical or popular music, technical knowledge, etc. Resources in the environment may be a family, friends, pets, being a member of a sports club or taking part in various activities in the local area. In the rehabilitation process, it may also be possible to take further and exploit other interests and wishes, such as a desire to attend various training courses or become a musician, or perhaps the person may have an interest in fishing, repairing cars or practising some form of sport.

Almost anything can be regarded as a strength. The knowledge and experience that people gain about themselves when they have fought and overcome adversity, or experienced and yet overcome pain and managed to get back to their feet after having been practically down and out, can be seen as an inherent strength. They have developed their resources. Despite all the dreadful things they have been through they have managed to come out on the other side, and this knowledge and these experiences have grown into an inner strength that they can use and mobilise in a rehabilitation situation. People learn all the time from their experiences, from books, from their family and friends, and from the mass media. Perhaps they are skilled at cooking or working with computers, or they know how to look after children or grow vegetables, or perhaps they are gifted at mathematics or languages. People's knowledge can lie in any area whatsoever, which is something that can become apparent when talking to them about what they can do. People can surprise themselves – and others – with their abilities and talents, or the abilities and talents they forgot they had.

Strengths Analysis – the analysis of the individual's strong points – is an instrument designed to help the case manager and the client to collate the information considered necessary to drive the rehabilitation process forward in a structured, holistic way. The main areas that need to be analysed are: the person's current life, financial and insurance situation; their education and employment situation; their social network, state of health and leisure activities; and also their spirituality and culture. This can be done in a structured way by first analysing the current situation

and then moving on to the person's wishes and hopes before analysing their strengths and resources. This should be done consistently in all main areas. The analysis itself should be done in the form of a discussion; it should be personal but not intrusive, and take place at whatever pace the client prefers. The analysis should also be accurate and comprehensive. This analysis is a continuous process and therefore needs to be updated regularly.

Establishing goals

The long-term goals should be drawn up on the basis of the client's wishes as expressed during the analysis, and they should be written in the client's own words and expressed in accordance with the client's own wishes. Both parties must accept them, and there must be no ambiguities. Examples of long-term goals would be: the client getting a place of their own to live, a job where the client could find an outlet for their knowledge and skills, buying a car, gaining more friends. When a client fails to achieve the set goals this is usually a result of the goals not having been those of the individual, or the client not having had access to the planned measure. Alternatively, it is possible that too many goals were set, or that they were set too high. Another reason why clients fail to achieve their goals is that the goals have not been broken down into practicable parts, or the client has not received any positive feedback from the case manager.

Number of cases and duration of case management

The maximum volume of cases recommended in the Strengths Model is 20 clients (19). According to Rapp and Goscha (14), no positive results have been reported where the number of clients has exceeded 20. Certain models maintain that the client should have access to a case manager 24 hours a day, seven days a week. This, according to Rapp, applies mainly to patients with severe mental illnesses who may require support quickly in a crisis. According to Rapp (16), the job of a case manager is one of great responsibility, requiring a high degree of competence and energy to cope with and resolve difficult situations. As case managers carry out this work alone, 'backup' is needed in the form of a supervisor who can provide support and affirmation and come up with creative solutions to problems.

Group supervision

Group supervision is one of the fundamental components of the Strengths Model. Group supervision is the fuel that keeps the model vibrant and strong at group level. Group supervision itself has been designed to keep the group focused on drawing up creative strategies, rather than becoming distracted by discussing and talking about problems. In the Strengths Model, group supervision has been

developed as the opposite of the team-based case management models such as ACT, which require team members to have expertise in various specialised areas. The Strengths Model uses the specialised knowledge of each case manager in the group supervision process. Group supervision consists of six stages, each one separate and critical to the success of the process. Each discussion about a client's situation should take no more than 20–30 minutes, thus allowing four or five clients to be dealt with during a normal group supervision session. Group supervision is the activity where case managers can feel that they belong to a group that shares a common vision and set of values. It is a place from which the case manager can draw energy (20).

Research

Macias and co-workers (21) and Modrcin and co-workers (22) have shown that patients who were the subject of the Strengths Model achieve better results in terms of social contacts, and are more satisfied with their leisure activities, compared with patients who have been involved in other case management models. In her study, Stanard (23) was able to show that those who had been the subject of the Strengths Model achieved better results with vocational rehabilitation than those who had been the subject of traditional case management. A Swedish study involving people on long-term sickness absence with neck, shoulder or lumbar problems shows that those who were the subject of rehabilitation in accordance with the Strengths Model reduced their sickness benefit levels twelve months after completing rehabilitation to a greater degree than was the case with those who were the subject of traditional vocational rehabilitation (24). Björkman and co-workers (25) found in their study that those who took part in the Strengths Model spent less time at hospital and were also more satisfied with the medical care they received than was the case with patients who had been the subject of traditional case management. In a six-year follow-up, Björkman and Hansson found that the majority of those who had been the subject of case management according to the Strengths Model reduced their sickness benefit levels, improved their social contacts and required less support compared with at the start of the project (9). Another Swedish study by Selander and Marnetoft (26) shows positive results in terms of a return to work by long-term unemployed women on long-term sickness absence. In a study by Lindahl and co-workers (27), all those included in the study were drug users, half of them were on sickness benefit and 30–40 per cent had been homeless for the preceding 30 days. At the six-month follow-up, the proportion abstaining from alcohol and drugs had increased from 0 to 46 per cent among those who had been given case management according to the Strengths Model – 32 percentage points more than those who had been offered initiatives within the social services system. A study by Siegal and co-workers (28) involved veterans with a cocaine or heroin dependence, or who had regularly used other drugs during the preceding six-month period and had not received treat-

ment during the preceding three months. At the six-month follow-up, the study showed a statistically significant difference ($p=0.012$) in the number of days worked in the previous 30 days between those who had been the subject of Strengths Model case management and those who had received conventional group, individual or family therapy.

Professor Charles Rapp, along with a colleague at the University of Kansas in the United States (14), performed a review of case management studies with an experimental or quasi-experimental design that had been conducted in the United States. They found 21 studies that met the inclusion criteria for their review, of which 17 had been conducted according to the ACT model and four according to the Strengths Model. Here, only the results from the studies according to the Strengths Model will be considered, as Rapp takes the view that case management according to ACT should only be aimed at the 10–20 per cent of people with the greatest need of support and therapy. In two of the studies into the Strengths Model, there was an improvement in social functioning and a reduction in symptoms; the people also performed better in their home environment compared with those in the control group. In one study, the individuals' work capacity and quality of life improved, while at the same time their leisure time was enriched and they became better at forming social contacts compared with the control group. In none of the four studies was the outcome worse in the controlled variables than for the control group.

CONCLUSION

The interest in case management has been increasing. Among the existing case management models, the Strengths Model stands out by virtue of its strong focus on the client's strengths rather than shortcomings and weaknesses, and on the fact that the client's self-determination is important as regards the specialisation of the rehabilitation process and the importance of the use of informal resources. The model also emphasises the importance of creating a good and reliable relationship with the client and of working out there in society where the resources are available. During the rehabilitation process, the case manager has the task of mobilising the client's strengths, abilities and talents as well as the community's resources. Results from several Strengths Model case management studies support its effectiveness. People involved in Strengths Model studies have lowered their sickness benefit levels, improved their social contacts, decreased their drug use, increased their working capacity, and improved their quality of life.

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